

# POLST

Minnesota Elder Law Institute  
October 20, 2015

Thaddeus Mason Pope, JD, PhD  
Hamline University School of Law

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# Roadmap

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Unwanted treatment  
Problems w/ ADs  
What is POLST  
Benefits of POLST

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Unwanted  
treatment

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Unwanted  
by patients  
who get it

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75% would trade  
**length** of life  
for  
**quality** of life

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“More important to enhance the **quality** of life . . . even if it means a **shorter life.**”

*National Journal* (Mar. 2011)

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PewResearchCenter

NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

NOV. 21, 2013

## Views on End-of-Life Medical Treatments

*Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive*

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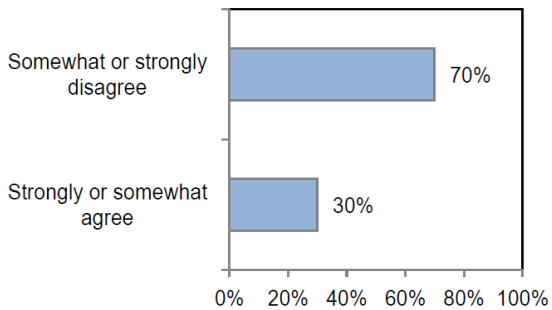
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**If I knew I was dying, I would want medical intervention to keep me alive as long as possible.**



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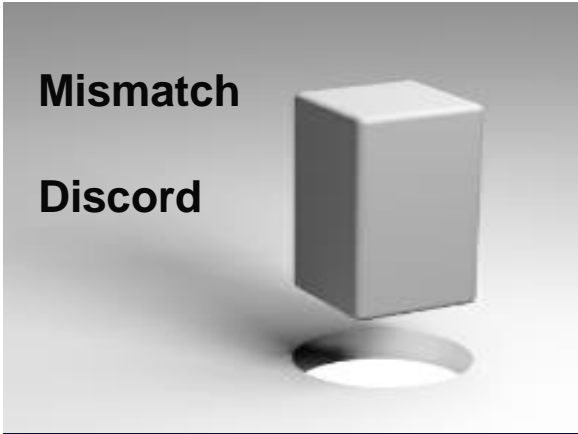
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**End-of-Life  
Care in  
Minnesota**

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# Means to a Better End:



www.lastacts.org.

2002

## A Report on Dying in America Today

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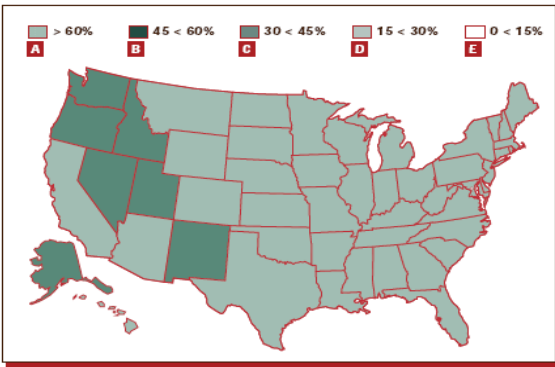
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### Deaths at home, 1997

Range 14.7% - 35.8% Mean 24.9%



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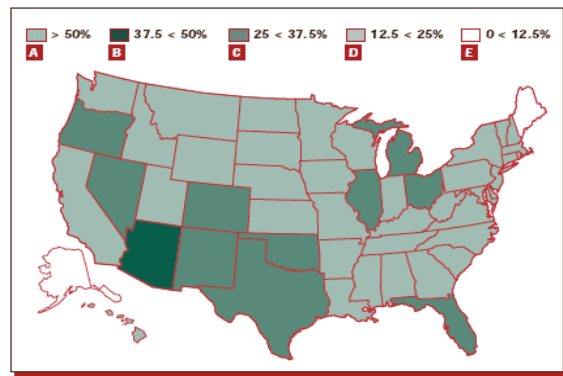
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### People over 65 who used hospice in the last year of life, 2000

Range 4.9 - 42.0% Mean 21.5%



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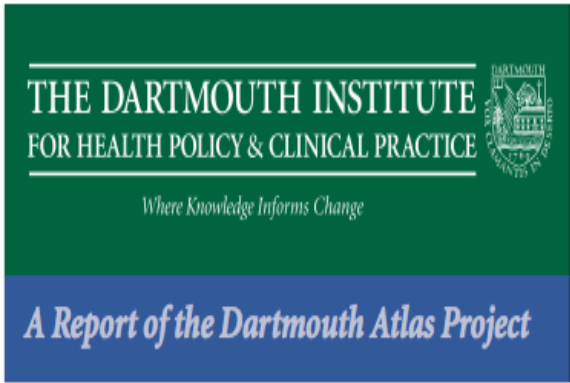
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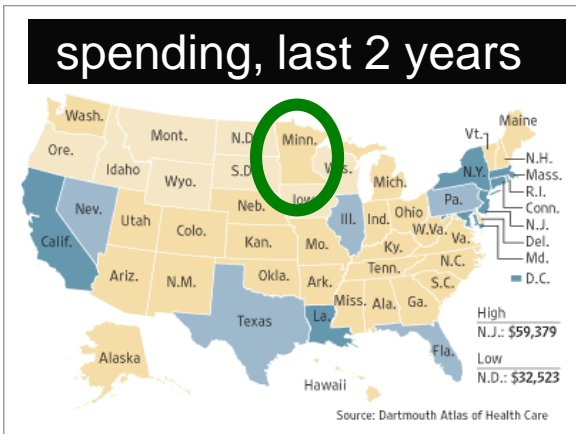
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Who gets  
unwanted  
treatment

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Patients  
**with**  
capacity

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Tool to fix:  
informed  
consent

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Patients  
**without**  
capacity

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Tool to fix:  
advance  
directive

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Limits of  
Advance  
Directives

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Not completed

Not found

Not informed

Not clear

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Not  
completed

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AMERICAN BAR ASSOCIATION

GOVERNMENTAL AFFAIRS OFFICE • 140 FIFTEENTH STREET, NW • WASHINGTON, DC 20005-1022 • (202) 882-1700

30%



28%

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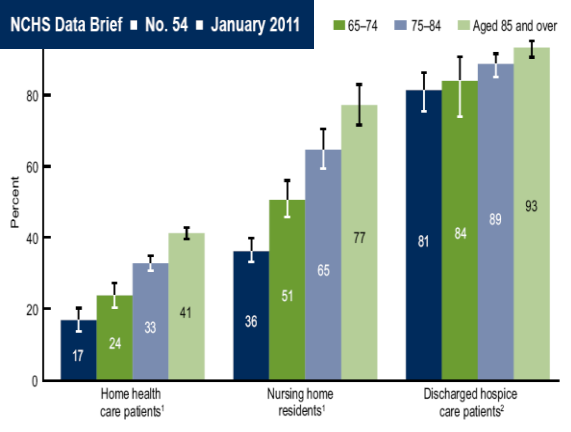
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Not  
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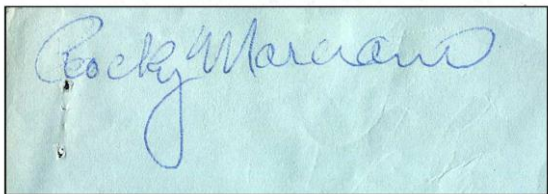
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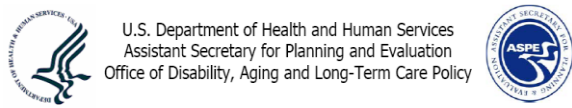
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65-76% of physicians whose patients **have** advance directives do not know they **exist**



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**Individuals fail to make & distribute copies**

- Primary agent
- Alternate agents
- Family members
- PCP
- Specialists
- Attorney
- Clergy
- Online registry

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**Not informed**

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if \_\_\_\_\_,  
then \_\_\_\_\_

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**Trigger terms vague**

“Reasonable expectation of recovery”

75%	51%
25%	10%

Plus: prognosis uncertain

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**Preferences vague**

“No ventilator”

Ever

Even if temporary

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# SITUATION A

If I am in a coma or a persistent vegetative state and, in the opinion of my physician and two consultants, have no known hope of regaining awareness and higher mental functions no matter what is done, then my goals and specific wishes — if medically reasonable — for this and any additional illness would be:

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Please check appropriate boxes:

1. **Cardiopulmonary resuscitation** (chest compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying).
2. **Major surgery** (for example, removing the gall-bladder or part of the colon).
3. **Mechanical breathing** (respiration by machine, through a tube in the throat).
4. **Dialysis** (cleaning the blood by machine or by fluid passed through the belly).
5. **Blood transfusions or blood products.**
6. **Artificial nutrition and hydration** (given through a tube in a vein or in the stomach).
7. **Simple diagnostic tests** (for example, blood tests or x-rays).
8. **Antibiotics** (drugs used to fight infection).
9. **Pain medications, even if they dull consciousness and indirectly shorten my life.**

	I want improvement, stop.	I am undecided	I do not want
	<i>Not applicable</i>		
	<i>Not applicable</i>		
	<i>Not applicable</i>		
	<i>Not applicable</i>		
	<i>Not applicable</i>		
	<i>Not applicable</i>		

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	Yes. I would want to have life-sustaining treatments.	It would depend on the circumstances.	No. I would not want to have life-sustaining treatments.
If I am unconscious, in a coma, or in a persistent vegetative state and there is little or no chance of recovery	Initials <input type="text"/>	Initials <input type="text"/>	Initials <input type="text"/>
If I have permanent severe brain damage (for example, severe dementia) that makes me unable to recognize my family or friends	Initials <input type="text"/>	Initials <input type="text"/>	Initials <input type="text"/>
If I have a permanent condition that makes me completely dependent on others for my daily needs (for example, eating, bathing, toileting)	Initials <input type="text"/>	Initials <input type="text"/>	Initials <input type="text"/>
If I am confined to bed and need a breathing machine for the rest of my life	Initials <input type="text"/>	Initials <input type="text"/>	Initials <input type="text"/>
If I have pain or other severe symptoms that cannot be relieved	Initials <input type="text"/>	Initials <input type="text"/>	Initials <input type="text"/>
If I have a condition that will cause me to die very soon, even with life-sustaining treatments	Initials <input type="text"/>	Initials <input type="text"/>	Initials <input type="text"/>

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More technology  
is the **default**

Patient must  
**opt out**

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ADs often **fail**  
to rebut LST  
presumption

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# POLST

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**POLST**  
Physician  
Order  
Life  
Sustaining  
Treatment

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**POLST**  
**P**rovider  
**O**rder  
**L**ife  
**S**ustaining  
**T**reatment

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**POST** Physician Order for  
 Scope of Treatment  
**MOST** Medical . . .  
**MOLST** Medical . . .  
**COLST** Clinician . . .

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Thaddeus Mason Pope and Melinda Hexum, "Legal Briefing: POLST: Physician Orders for Life-Sustaining Treatment," *The Journal of Clinical Ethics* 23, no. 4 (Winter 2012): 353-76.

Law

**Legal Briefing: POLST: Physician Orders for Life-Sustaining Treatment**

Thaddeus Mason Pope and Melinda Hexum

**ABSTRACT**

This issue's "Legal Briefing" column covers recent legal developments involving POLST (physician orders for life-sustaining treatment). POLST has been the subject of recent articles in *JCE*.<sup>1</sup> It has been the subject of major policy reports<sup>2</sup> and a recent *New York Times* editorial.<sup>3</sup> And POLST has been the subject of significant legislative, regulatory, and policy attention over the past several months. These developments and a survey of the current landscape are usefully grouped into the following 14 categories:

1. Terminology
2. Purpose, function, and success
3. Status in the states
4. Four legal routes of implementation
5. Which professionals can authorize POLST?
6. Is the patient's signature required?
7. Can surrogates consent to or incapacitated patients?
8. If a POLST conflicts with an advance directive, which prevails?
9. Is obtaining POLST mandatory?

10. What are the duties of healthcare providers?
11. What is the role of electronic registries?
12. What is the role of the federal government?
13. International adoption
14. Court cases

**1. TERMINOLOGY**

While the POLST paradigm is established or developing in almost every U.S. state, it goes by at least 14 different names.<sup>4</sup> For the sake of clarity, this article will use the acronym POLST, as it is the acronym used by most states. Even among these states, POLST stands for three different terms. In most of the states, POLST stands for physician orders for life-sustaining treatment.<sup>5</sup> In Minnesota and Montana, it stands for provider orders for life-sustaining treatment.<sup>6</sup> In Pennsylvania, POLST stands for Pennsylvania orders for life-sustaining treatment.<sup>7</sup> The remaining states use 11 additional ac-

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Many acronyms

Same concept

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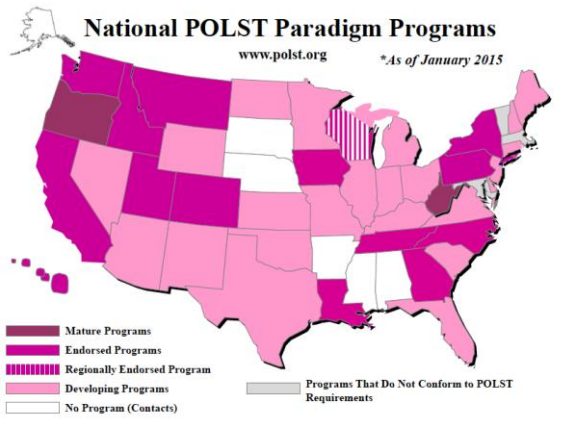
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What is  
POLST

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**C** INTERVENTIONS AND TREATMENT

Check All That Apply

**ANTIBIOTICS (check one):**

- No Antibiotics (Use other methods to relieve symptoms whenever possible.)
- Oral Antibiotics Only (No IV/IM)
- Use IV/IM Antibiotic Treatment

**NUTRITION/HYDRATION (check all that apply):**

- Offer food and liquids by mouth (Oral fluids and nutrition must always be offered if medically feasible)
- Tube feeding through mouth or nose
- Tube feeding directly into GI tract
- IV fluid administration
- Other: \_\_\_\_\_

Additional Orders: \_\_\_\_\_

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# Order for LST

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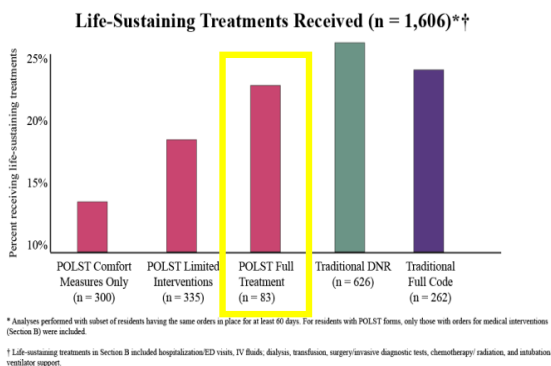
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JGIM 25: 1241-1248, 2010. A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices versus the Physicians Order Set and Self-Directed Treatment (POSET) Program  
Susan E. Hillman, PhD, Christine A. Nelson, PhD, Nancy A. Perrin, RD, Alvin H. Moss, MD, Bernard J. Hammes, RD, and Susan W. Tolle, MD

# For whom

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Terminal illness  
Advanced chronic  
progressive illness  
Frailty

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In last year of life  
Others who want  
to define care

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Would you be **surprised** if your patient died in next year?

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POLST

**supplements** AD

Does not replace

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**Both**

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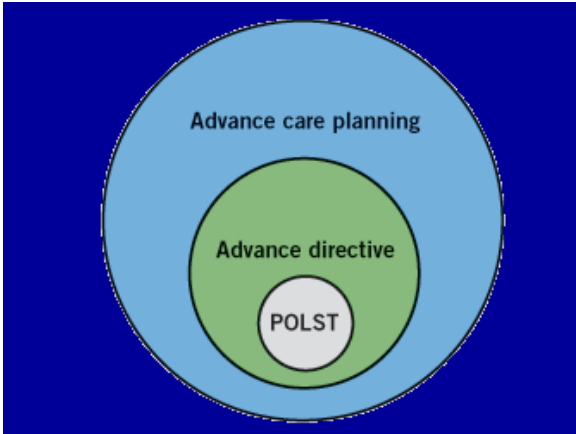
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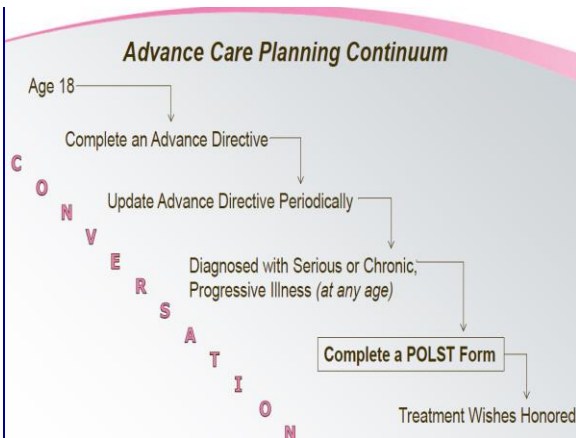
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**POLST**  
**benefits**

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Seven horizontal lines for writing.

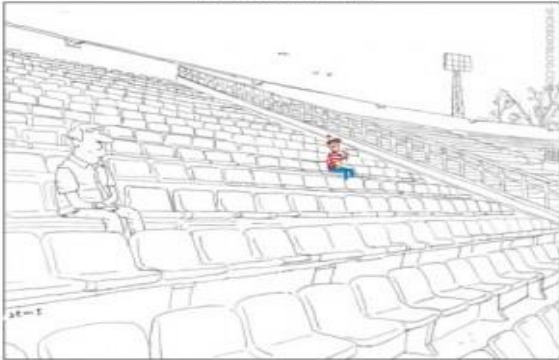
1. Bright color

Seven horizontal lines for writing.

<p><b>Population Culture</b></p> <p><b>A</b> <b>Common name:</b> Bismuth or BiPAP. Used for respiratory and hearing.</p> <p><b>B</b> <b>Medical Indications:</b> Bismuth is used for respiratory and hearing.</p> <p><b>C</b> <b>Contraindications/Precautions:</b> Bismuth is used for respiratory and hearing.</p> <p><b>D</b> <b>Equipment:</b> Bismuth is used for respiratory and hearing.</p>	<p><b>INDICATIONS WITH PATIENT RESIDENTS WHO ARE TRANSFERRED OR DISCHARGED</b></p> <p><b>MOIST</b></p> <p><b>Medical Orders for Life-Sustaining Treatment</b></p> <p><b>A</b> <b>Respiratory Support:</b> Bismuth is used for respiratory and hearing.</p> <p><b>B</b> <b>Cardiovascular Support:</b> Bismuth is used for respiratory and hearing.</p> <p><b>C</b> <b>Fluid Management:</b> Bismuth is used for respiratory and hearing.</p> <p><b>D</b> <b>Other Support:</b> Bismuth is used for respiratory and hearing.</p>
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Seven horizontal lines for writing.

# Where's Waldo? FOR DUMMIES



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Original POLST printed  
on **lilac** card stock

But a **copy** has the  
same force as original

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## 2. Single page

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# 4. More informed

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# The present Here & now

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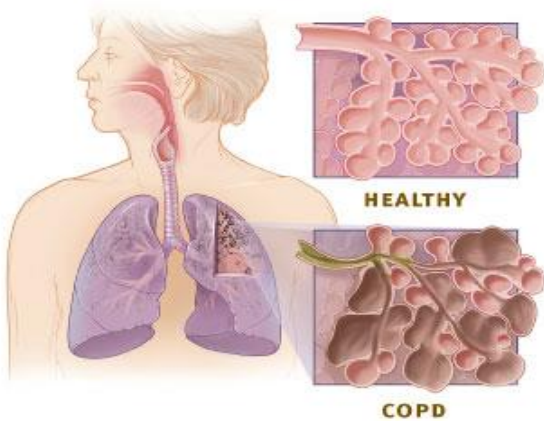
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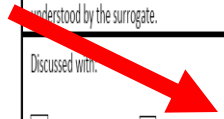
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# MEDICAL ORDERS for life-sustaining treatment (MOLST)

**F** **SIGNATURES:** Preferences have been expressed to the health care provider whose signature is found below. This document reflects those preferences. If signed by a surrogate, preferences must reflect patient's wishes as best understood by the surrogate.

Discussed with:	PRINT - Physician/APN/PA Name	Phone #
<input type="checkbox"/> Patient	<input type="checkbox"/> Parent of Minor	Physician/APN/PA Signature (mandatory)      Date
<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> Next-of-Kin	Physician Co-Signature if PA Signs Above (mandatory)      Date
<input type="checkbox"/> Health Care Agent		



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5. Immediately actionable

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Provider  
**Order**  
Life  
Sustaining  
Treatment

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No need to “interpret”  
advance directive

No need to “translate”  
into orders

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6. Easy to  
follow

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**A** CARDIOPULMONARY RESUSCITATION (CPR):  
Patient has no pulse and is not breathing.

Check One  CPR/ATTEMPT RESUSCITATION       DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C. | An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."

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# 7. Better honored

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# Can follow **Will** follow

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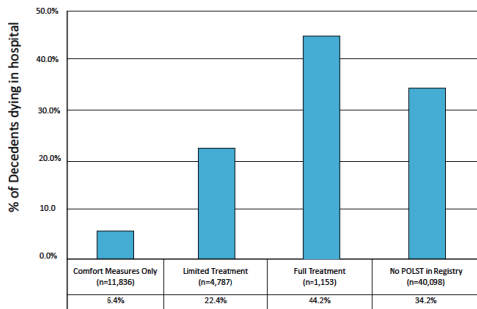
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Patient's preferences recorded as medical orders on a POLST Form and how those orders match with death in the hospital



JGIM. Fromme et al 2014 62: 1246-1251

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# 8. Portable

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Home

LTC

Hospital

EMS

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Linda Sandhei  
(71)

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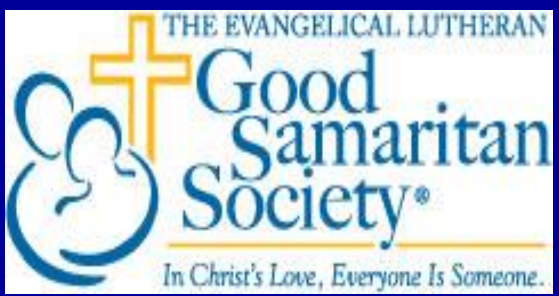
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Maplewood (Aug. 2015)

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Vomited in sleep

**NH staff** finds unconscious, not breathing; begin CPR

Maplewood **paramedics** arrive, resume resuscitation

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**Husband** asks paramedics to halt efforts

Medics honored his request

Linda dies 20 minutes later

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“Until properly completed **orders** are presented, pre-hospital personnel will . . . proceed with standing orders for resuscitation . . . .”



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# 9. Updatable

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POLST does **not** expire

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MOLST can be revised or revoked at any time

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Review with change in condition or location

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Can be completed by **surrogate**, if patient lacks capacity

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70% patient  
30% surrogate

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10. Proven  
Effective

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### POLST is Evidence Based

- Major academic research in 3 POLST states: strong evidence base of efficacy of POLST in ensuring preferences are elicited, documented, honored, w/ pain and symptom management equivalent to those without POLST order

Hickman et al. "A Comparison of Methods to Communicate Treatment Preferences: Traditional Practices versus the Physician Orders for Life-Sustaining Treatment Program" J Am Geriatr Soc 58:1241-1248, 2010.

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Closes gap  
between what  
people **want** and  
what they **get**

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**POLST**  
**concerns**

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1	MINNESOTA STATUTES 2014	145C.01
<b>CHAPTER 145C</b>		
<b>HEALTH CARE DIRECTIVES</b>		
145C.01	DEFINITIONS.	145C.09
145C.02	HEALTH CARE DIRECTIVE.	145C.10
145C.03	REQUIREMENTS.	145C.11
145C.04	EXECUTED IN ANOTHER STATE.	145C.12
145C.05	SUGGESTED FORM: PROVISIONS THAT MAY BE INCLUDED.	145C.13
145C.06	WHEN EFFECTIVE.	145C.14
145C.07	AUTHORITY AND DUTIES OF HEALTH CARE AGENT.	145C.15
145C.08	AUTHORITY TO REVIEW MEDICAL RECORDS.	145C.16
		REVOCATION OF HEALTH CARE DIRECTIVE.
		PRESUMPTIONS.
		IMMUNITIES.
		PROHIBITED PRACTICES.
		PENALTIES.
		CERTAIN PRACTICES NOT CONDONED.
		DUTY TO PROVIDE LIFE-SUSTAINING HEALTH CARE.
		SUGGESTED FORM.

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Adopted by Minnesota Medical Association, Emergency Medical Services Board, growing number of health systems, physicians . . .

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ww.health.state.mn.us/  
directory/surveyapp/  
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Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report  
PUBLIC

115 Living Center  
100 Street North  
St. Paul, MN 56103  
County

Report #: H5490012

Date: November 1, 2013

Visit: September 9, 2013  
Visit: 4:00 a.m. – 11:00 a.m.

By: Carrie Euerle, R.N., Special Inves

STATE OF MINNESOTA

DISTRICT COURT

COUNTY OF BROWN

FIFTH JUDICIAL DISTRICT  
CASE TYPE: WRONGFUL DEATH

Eric J. Whitman, trustee of the  
next-of-kin of Karen A. Whitman,

Court File No. \_\_\_\_\_

Plaintiff,

COMPLAINT

v.

Highland Manor, Inc., d/b/a Oak Hills  
Living Center, a Minnesota corporation,

Defendant.



Issue 15 July 2015

End-of-life care: A patient safety issue

**DNR is mistaken as Do Not Treat**

Table 3. Interpretation of a Living Will by Subgroup

Group	DNR (%)	of Code (%)	P Value	Correct Code (%)	of Code (%)	P Value
Overall	77%	23%	0.759	83%	14%	0.001
Female	78%	22%	0.847	82%	15%	<0.001
Male	76%	24%	0.847	84%	14%	0.001
Age	77%	23%	0.847	83%	14%	0.001
Education	77%	23%	0.847	83%	14%	0.001
Insurance	77%	23%	0.847	83%	14%	0.001
Religion	77%	23%	0.847	83%	14%	0.001
Marital Status	77%	23%	0.847	83%	14%	0.001
Advanced directives training	77%	23%	0.847	83%	14%	0.001
Site	77%	23%	0.847	83%	14%	0.001

Table 4. Demographics and Treatment Decisions\*

Group (%)	Correct Response (%)	P Value
Female	55%	0.008
Male	54%	0.008
Age	55%	0.008
Education	55%	0.008
Insurance	55%	0.008
Religion	55%	0.008
Marital Status	55%	0.008
Advanced directives training	55%	0.008
Site	55%	0.008

DNR = Do Not Resuscitate orders; PM = Family Medicine; EM = Emergency Medicine; IM = Internal Medicine; SS = General Surgery; PGP = postgraduate year.

12/15/13 J. J. Emanuel, M.D., 2013. May 4(215):511-20. doi: 10.1016/j.jamcoll.2013.07.015. Epub 2013 Nov 17.

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