

Implementation of Medical Orders for Life-Sustaining Treatment

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Background: When an outpatient in a northeastern cancer institute requested a Medical Orders for Life-Sustaining Treatment (MOLST) form, the state's approved resuscitation form in all settings, none were available. A project was undertaken to institute MOLST forms into policy and routine practice. Research supports early discussions of end-of-life care in patients with cancer and the use of MOLST as an effective tool.

Objectives: The purpose of this article is to discuss the initiation and facilitation of MOLST implementation into practice and policy at a cancer institute.

Methods: Introducing, overcoming resistance to, piloting, and adopting MOLST in an oncology setting is reported and explained based on the three stages of Lewin's Theory of Planned Change: unfreezing, moving, and refreezing.

Findings: A small pilot of MOLST with palliative care providers demonstrated the feasibility and suitability of using MOLST in the oncology setting. MOLST was adopted into policy and routine practice at the cancer institute.

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Advance directives were developed so patients may communicate decisions regarding end-of-life (EOL) care and treatment before they are unable to do so, but their usefulness is limited because they are not legally binding documents. The Medical Orders for Life-Sustaining Treatment (MOLST) was developed so that decisions regarding life-sustaining measures can be placed in an actionable order that is recognized across healthcare settings and by emergency responders. The purpose of this article is to discuss the initiation and facilitation of MOLST implementation into practice and policy at Roswell Park Cancer Institute in New York based on the three stages of Lewin's (1947) Theory of Planned Change: unfreezing, moving, and refreezing.

Background

Speaking to patients about EOL care and life-sustaining treatment is difficult in any patient population, but, in the presence of cancer, this conversation becomes even more challenging. Discussing EOL care has not historically been common practice in cancer care, even when patients have advanced disease. Ear-

ly discussions are particularly important in this setting because the treatment itself may cause further illness (Ozanne, Partridge, Moy, Ellis, & Sepucha, 2009). Most patients with cancer want medical professionals to include them in the decision-making process (Miccinesi, Bianchi, Brunelli, & Borreani, 2012), but very few actually discuss advance directives with their providers (Dow et al., 2010). In addition, initial discussions about EOL care are best approached when patients are stable, but most are initiated after patients have been admitted to the hospital and when their health may be unstable (Bernacki & Block, 2014).

The proper use of advance directives and early EOL discussions can benefit patients and their loved ones. In a study focused on patients with advanced cancer, 125 (39%) of 322 patients who had discussed EOL care with their physician were more likely to receive care that aligned with their wishes than patients who did not (Mack, Weeks, Wright, Block, & Prigerson, 2010). Families also experienced less anxiety, depression, and stress related to a patient's death when an advance directive was in place (Mahon, 2011). Appropriate communication can prevent patients from receiving unwanted aggressive medical care close to death and allow for a better quality of life for