■ Article

Implementation of Medical Orders for Life-Sustaining Treatment

Janette N. Evans, RN, MS, ANP-C, Lisa S. Ball, PhD, RN, FNP-BC, and Camille P. Wicher, PhD, Esq., MSN, RN

© monkeybusinessimages/iStock/Thinkstock

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.

Janette N. Evans, RN, MS, ANP-C, is a nurse practitioner for Infinity Medical Group in Williamsville; Lisa S. Ball, PhD, RN, FNP-BC, is an associate professor in the Department of Nursing at Daemen College in Amherst; and Camille P. Wicher, PhD, Esq., MSN, RN, is the vice president of clinical operations and corporate ethics at Roswell Park Cancer Institute in Buffalo, all in New York. The authors take full responsibility for the content of this article. The authors did not receive honoraria for this work. The content of this article has been reviewed by independent peer reviewers to ensure that it is balanced, objective, and free from commercial bias. No financial relationships relevant to the content of this article have been disclosed by the authors, planners, independent peer reviewers, or editorial staff. Evans can be reached at janetterush@roadrunner.com, with copy to editor at CJONEditor@ons.org. (Submitted December 2014. Revision submitted April 2015. Accepted for publication May 6, 2015.)

Key words: Medical Orders for Life-Sustaining Treatment; advance directives; cancer; end of life; communication; dying

Digital Object Identifier: 10.1188/16.CJON.74-78

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. Early 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

Downloaded on 05-17-2024. Single-user license only. Copyright 2024 by the Oncology Nursing Society. For permission to post online, reprint, adapt, or reuse, please email pubpermissions@ons.org. ONS reserves all rights.