



## Medical Orders for Life-Sustaining Treatment (MOLST)\*

### 8-Step MOLST Protocol

1. Prepare for discussion
  - Review what is known about patient and family goals and values
  - Understand the medical facts about the patient's medical condition and prognosis
  - Review what is known about the patient's capacity to consent
  - Retrieve and review completed Advance Care Directives and prior DNR documents
  - Determine who key family members are, and (if the patient does not have capacity), see if there is an identified "Agent" (Spokesperson) or responsible party
  - Find uninterrupted time for the discussion
2. Begin with what the patient and family knows
  - Determine what the patient and family know regarding condition and prognosis
  - Determine what is known about the patient's views and values in light of the medical condition
3. Provide any new information about the patient's medical condition and values from the medical team's perspective
  - Provide information in small amounts, giving time for response
  - Seek a common understanding; understand areas of agreement and disagreement
  - Make recommendations based on clinical experience in light of patient's condition / values
4. Try to reconcile differences in terms of prognosis, goals, hopes and expectations
  - Negotiate and try to reconcile differences; seek common ground; be creative
  - Use conflict resolution when necessary
5. Respond empathetically
  - Acknowledge
  - Legitimize
  - Explore (rather than prematurely reassuring)
  - Empathize
  - Reinforce commitment and nonabandonment
6. Use MOLST to guide choices and finalize patient/family wishes
  - Review the key elements with the patient and/or family
  - Apply shared medical decision making
  - Manage conflict resolution
7. Complete and sign MOLST
  - Get verbal or written consent from the patient or designated decision-maker
  - Get written consent from the treating physician, and witnesses
  - Document conversation
8. Review and revise periodically

\*MOLST is a medical order form designed to provide a single, community-wide document that would be easily recognizable and enable patient wishes for life-sustaining treatment to be honored. It is a tool created by a workgroup of the *Community-Wide End-of-life/Palliative Care Initiative* in Rochester, New York. MOLST is adapted from the Oregon Physician Orders for Life-Sustaining Treatments (POLST) and incorporates New York State Law.