

出國報告（出國類別：進修）

預立照護計畫與護理研究

服務機關：護理部

姓名職稱：柯莉珊 護理師

派赴國家：澳洲墨爾本

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摘要

此次於澳洲 Monash 大學、Barwon Health、Northern Health 和 Eastern Health 學習預立照護計畫、老人護理、護理研究，為期 6 個月。透過 Monash 大學的優良師資 Dr. Margaret O' Connor、Susan Lee，以及圖書寫作專員 Allie Ford 的指導，完成 2 篇研究論文的撰寫，題目分別為「護理人員對老人執行預立照護計畫的看法:系統性文獻查證和質性研究整合分析(nurses' views regarding implementing advance care planning for older people: a systematic review and synthesis of qualitative studies)」和「影響加護病房護理人員對提供癌末病人人工營養與水分行為意向之因素(the factors impacting on ICU nurses' behavioral intentions toward providing artificial nutrition and hydration to terminal cancer patients)」。於醫院學習和觀察預立照護計畫的溝通過程、運作方式、人員訓練，以及檔案管理等，特別是預立指示的管理方法，獲益匪淺。建議院方可考慮將病人或家屬所簽屬的意願書或同意書進行電子化的管理。

關鍵字: 預立照護計畫

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一、背景

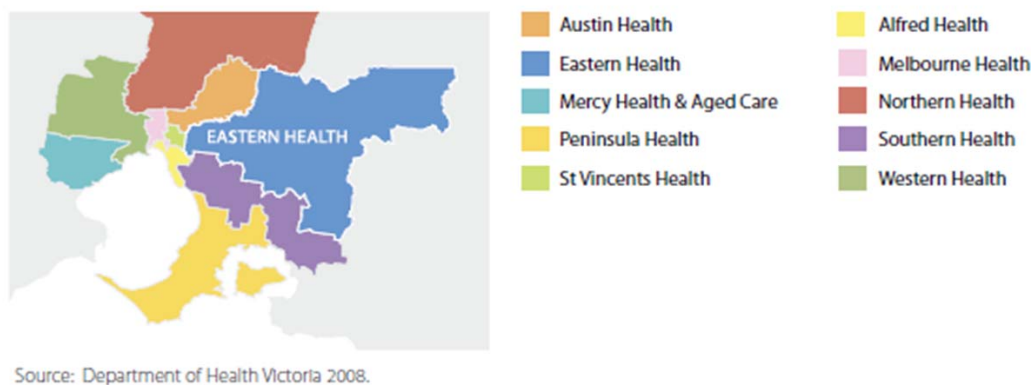
根據行政院經濟建設委員會(2010)指出65歲以上老年人口占總人口比率持續上升，將由2010年的10.7%至2060年增加為41.6%，且其中80歲以上之高齡人口占老年人口之比率，亦將由2010年24.4%至2060年大幅上升為44.0%，此也意味著未來的老人不僅愈來愈多，且也愈來愈老。老人較年輕人有多重的疾病、較差的身體功能，以及認知功能的障礙，老人主要死於心血管疾病、失智(dementia)或衰弱(frailty)，較少死亡原因為癌症(Piers et al., 2011)。老人的年齡和健康狀況使得老人成為無能力決策的高風險群(Brown, 2003)。在急性照護的醫院場域，病人面臨末期狀況，若無預立醫療指示(advance directives; ADs)，醫院可能會常規性的施予維生設施和心肺復甦術(cardiopulmonary resuscitation; CPR)，也有許多文章指出針對末期病人和非常衰弱的老人，應該避免這些不必要措施(Seal, 2007)。

預立醫療指示(ADs)係指一個人在意識清楚且具有決策行為能力時，為自己未來可能失去決策能力的情況，預先為個人所期望獲得的末期醫療處置和照護進行規劃，並將此意願做書面說明(胡文郁、楊嘉玲，2009；楊嘉玲、陳慶餘、胡文郁，2008；Teno et al., 1997)。國內行政院衛生署提出四種ADs表單，分別為「預立選擇安寧緩和醫療意願書」、「不施行心肺復甦術同意書」、「醫療委任代理人委任書」和「選擇安寧緩和醫療意願撤回聲明書」。預立醫療照護計畫(advance care planning; ACP)係指病人、健康照護專業人員，以及家屬或決策代理人，針對未來病人可能無法思考自身的醫療照護，事先進行未來醫療照護方式的期望和偏好之討論，是一個持續的過程(Robinson et al., 2012; 胡文郁、楊嘉玲，2009)。縱使行政院衛生署提出四種ADs表單和國內學者近幾年開始探討ACP的執行層面，但臨床上如何開口與病人和家屬談論有關末期醫療照護仍是一大挑戰，ACP的概念在台灣仍屬萌芽階段，需要和值得我們進一步學習國外臨床運用的實際情況，並帶回國內。

澳洲之維多利亞州(Victoria)已有ACP的相關法律的制定，包括Medical Treatment Act 1988和Guardianship and Administration Act 1986，並以已發展一套完善關於ACP執行模

式，如：「尊重病人選擇模式(the respecting patient choice model)」，此模式為訓練護理人員或社工做為協調者(facilitator)，與醫師合作，和協助病人完成將來的醫療照護選擇之書面記錄，包括設立決策代理人，以及生命末期時對於維生設施和CPR的想法。此「尊重病人選擇模式」已在澳洲健康照護體系廣泛推行，特別是在老人照護方面，且此「尊重病人選擇模式」也透過許多研究的實證，可以增加醫療照護以符合病人的期望、增加病人和家屬的滿意度，以及降低家屬的壓力、焦慮和憂鬱情形(Detering et al., 2010)，故十分值得前往學習。在加上蒙那許大學(Monash University)名列澳洲八大名校(Group of Eight)的成員之一，也名列全球大學四十強之一，創校於1958年，並經由澳洲的國會通過建立，因此成為澳洲維多利亞州最早成立的大學，學校資源豐富。研究方面又是國際知名，故計畫前往澳洲蒙那許大學護理系學習獨立研究，以及至墨爾本醫院學習ACP，期望所學習之預立醫療照護計畫和護理研究，能與全球同步並與國際接軌。

二、目的



於澳洲維多利亞州，透過參訪 Northern Health (Bundoora)、Barwon Health (Geelong) 和 Eastern Health (Box-Hill)，並與協調者討論和觀察，以及參與 workshop 以了解以下目的：

1. 了解 ACP 於醫院和社區運作的型態
2. 了解 ACP 討論進行的方式
3. 習得成為 ACP 協調者的知識
4. 了解 ACP 檔案管理方式

5. 了解護理人員於 ACP 的角色

透過實際參與蒙那許大學之相關課程，與教授和同學交流，已達下列目的：

1. 了解老人 ACP 之實證相關研究
2. 完成老人 ACP 之相關實證研究報告
3. 投稿 SCI 雜誌

三、過程

(一) 預立照護計畫

在預立照護計畫的學習過程，透過實際參與和觀摩三家醫療院所，分別為 Barwon Health、Northern Health 和 Eastern Health 之 Wantirna 院區，詳述如下。

1. Barwon Health

Barwon Health 位於墨爾本西部的 Geelong，為墨本爾大學和迪肯大學(deakin university)的附設醫院，擁有 406 張床位，主要專責為癌症、心臟科和心肺手術的專責醫院。此次參訪的是尊重病人選擇(Respecting Patient Choices)之預立照護計畫部門，此為獨立部門，不隸屬於醫療部門或護理部。此預立照護計畫部門共有 6 位成員，分別為：1 位行政人員、1 位協調師(coordinator)和 4 位 ACP 諮詢師(consultant)，除行政人員外，皆為護理師。部門的硬體設備包括接待室、成員辦公室，以及 2 間具有隱私性的會談室。此部門主要服務對象為 Barwon Health 的住院病人和 Geelong 地區的民眾。所有對 ACP 有興趣的人都必須透過轉介與此部門進行預約，住院病人透過醫院電腦系統通知該部門；一般民眾的轉介由民眾的家庭醫師(general practice; GP)負責，亦可直接與此部門預約。

此部門的主要任務包括教育、諮詢、以及協助完成和更新預立照護計畫。在教育部分，包括舉辦工作房教育醫療相關人員和定期於社區和 Barwon Health 所屬單位內舉辦衛教活動，如復健中心和加護病房。此次參訪過程隨同協調師至心肺復建中心進行衛教，幾乎所有的病人都需要使用氧氣，而他們對他們的生命末期照護計畫都想進一步了

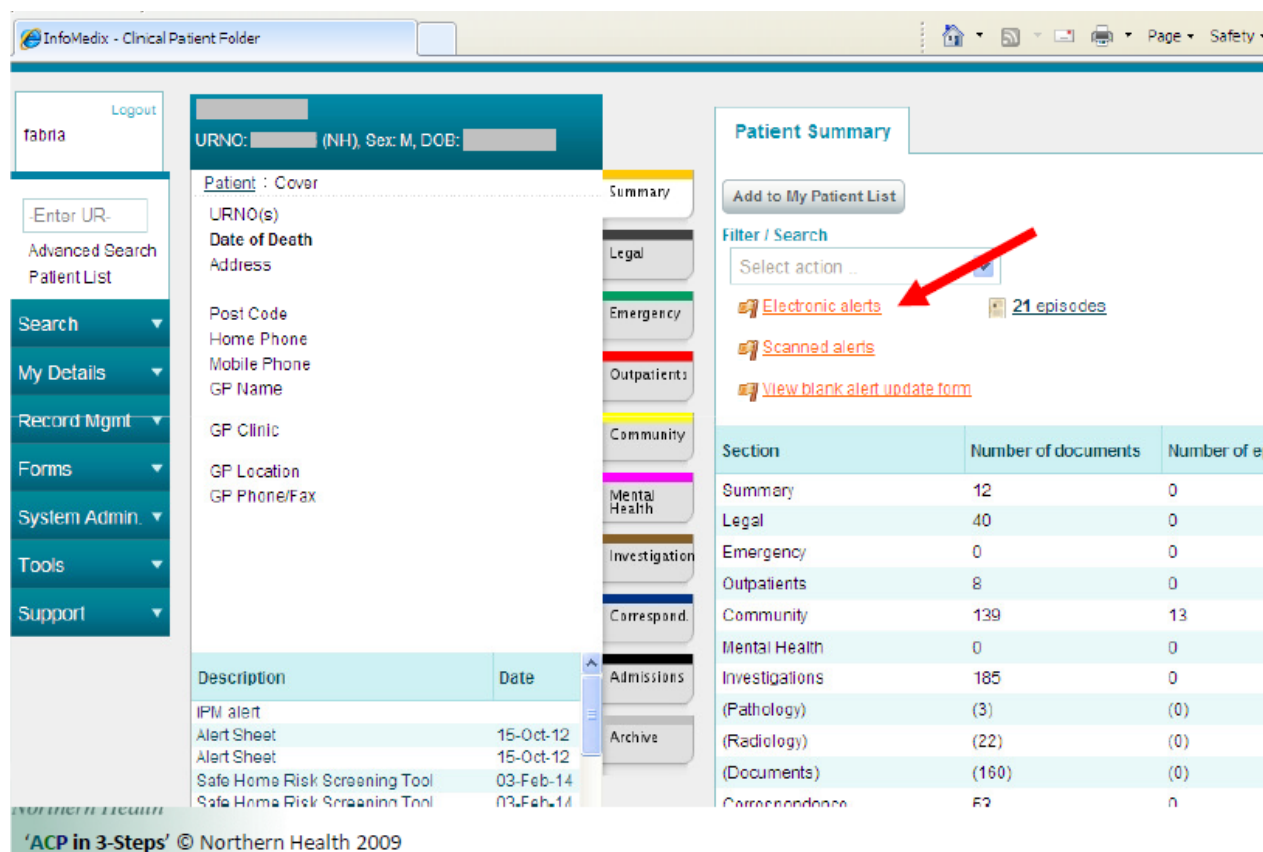
解和想知道如何完成預立醫療指示。在諮詢方面，採預約制度，協調師和諮詢師會依病人和民眾的健康狀況至病房或至個案家中進行諮詢，健康狀況良好則於部門中的會談室進行諮詢。諮詢過程鼓勵個案與家人共同參與，其諮詢的方法為事先提供單張(見附件一)讓個案先思考有過去健康有關的相關經驗、目前健康狀況，以及對未來照護的想法，諮詢時利用開放式問題進行引導。每次諮詢的時間為 1 小時，不限諮詢的次數，在諮詢後個案若需協助完成預立醫療指示，協調師或諮詢師會協助建立文件檔案，包括預立照護計畫聯絡資訊、治療選擇，以及拒絕治療(詳見附件二)，之後請個案帶文件與親友和其 GP 討論，經過討論後其親友和 GP 必須在見證人處簽名，此文件非常重視 GP 的簽名，有二個目的，第一，醫師可以判斷個案是否具有決策能力或是憂鬱症，使文件更具效力、第二，讓其主責醫師清楚知道個案的意願。完成所有簽名後，再將此文件影印數份，正本個案留存，影本給家人、相關醫療人員存證，以及一份給此部門進行 Barwon Health 醫療體系的電子病歷上傳，此文件受到澳洲維多利亞州認定的法律文件。若病人完成預立醫療指示則每 1-2 年郵寄提醒個案是否變更其意願；如個案在諮詢後仍未確定是否完成預立醫療指示則此部門會發郵件給個案的專責醫師和 GP，提醒醫師病人有興趣但尚未完成預立醫療指示，且會約 3~6 個月再以郵件提醒個案，如仍要諮詢可再與此部門預約。此部門的工作績效，以每個月個案的轉介人數、諮詢時數、衛教時數、追蹤個案預立醫療指示等呈現。



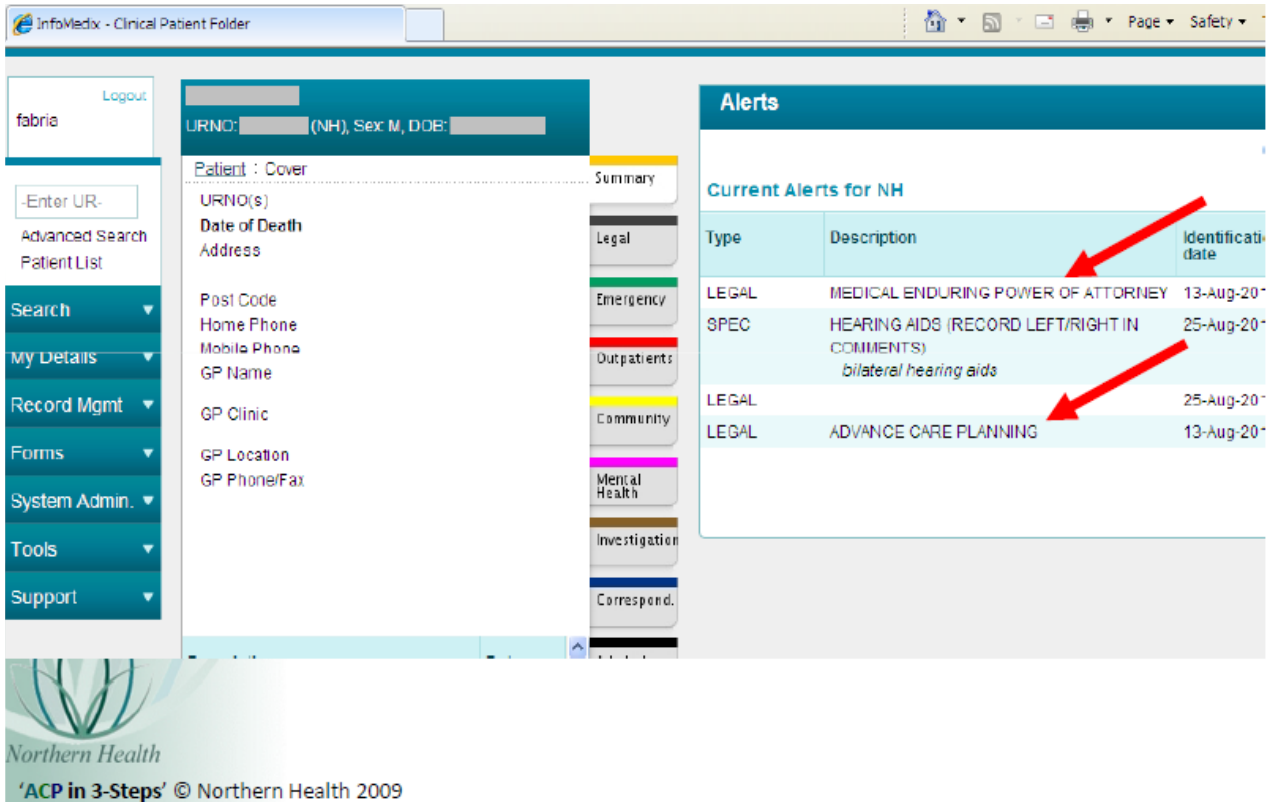
圖一 與 Barwon Health 之協調師(Jill Mann)和諮詢師合影

2. Northern Health :

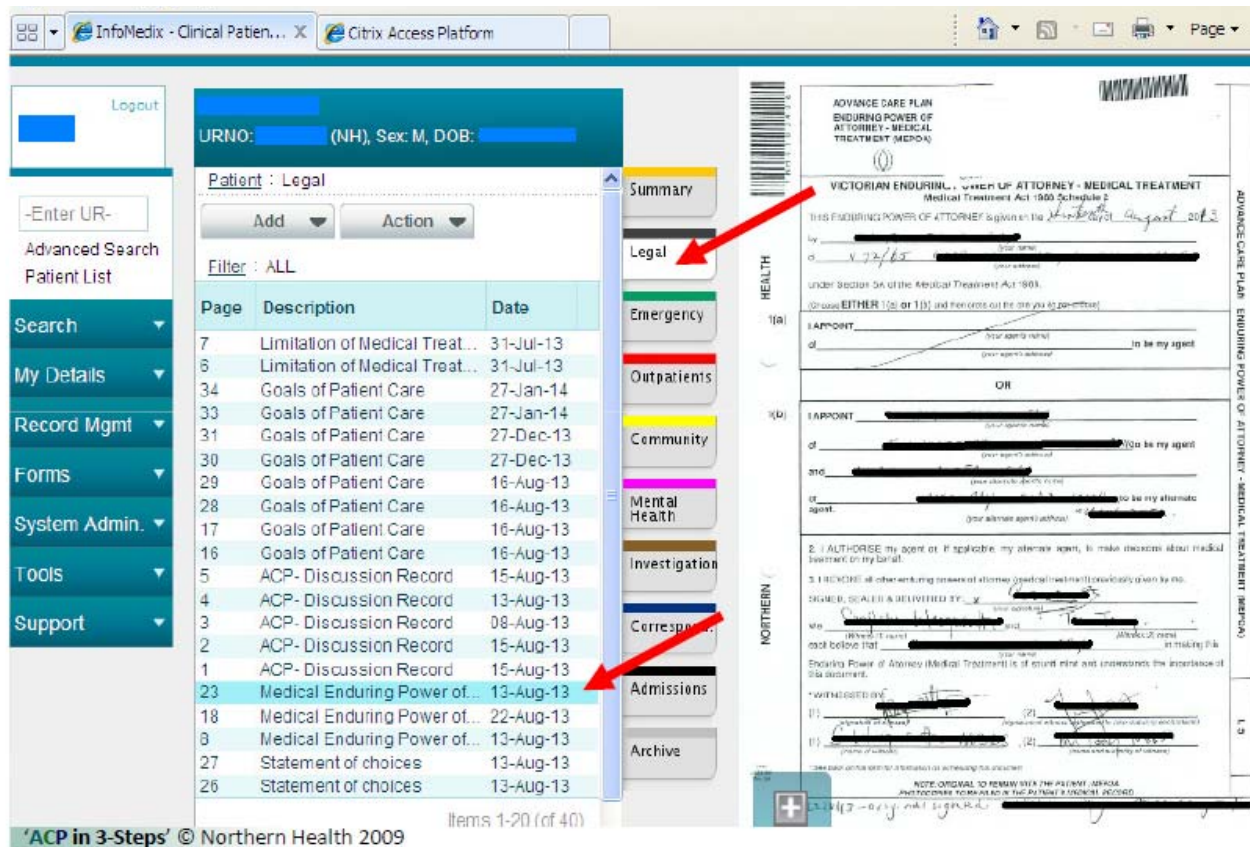
Northern Health 是維多利亞州最忙碌的醫院之一，擁有急性和亞急性的健康服務資源，服務當地約 728,000 人。此次參訪的單位為預立醫療照護單位，此單位有一位主治醫師和一位護理師，主要工作包括教育、諮詢、協助完成、更新預立照護計畫，以及 ACP 相關研究計畫。在此醫院 Barbara Hayes 醫師推動醫師教育並已獲得該院之核准，於每一位新病人入院時，醫師皆須完成再次確認病人的照顧方向。以及此醫院內有一套完善的電子資訊系統，病人的 ACP 和 ADs 資訊，為每個病人必須評估的項目之一，與我們醫院在 3270 內註記“D”有雷同之警示，但此會連到病人或家屬親自簽屬的 ADs 之 scan 檔，也可連到每次 ACP 討論的相關紀錄，十分完善。此醫院非常重視病人和家屬所簽屬的所有文件，透過同時上傳 ACP 會談資料和 ADs 文件可了解病人的意願與所簽屬之 ADs 有無一致，已確實尊重病人之選擇。以下以圖示介紹此電子資訊系統：



圖二 電子病歷中的警示

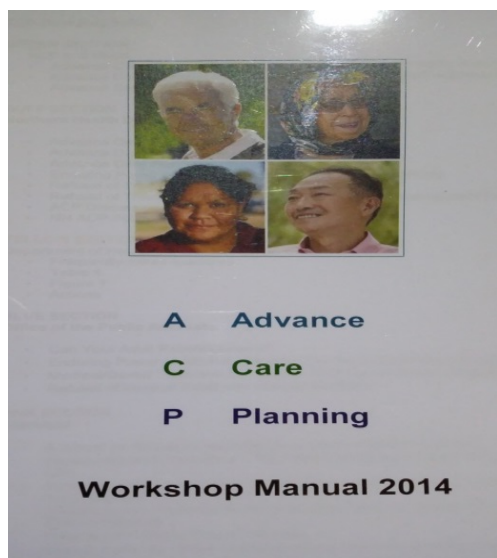


圖三 由警示點入可連結 ACP 的相關紀錄和 ADs 檔案

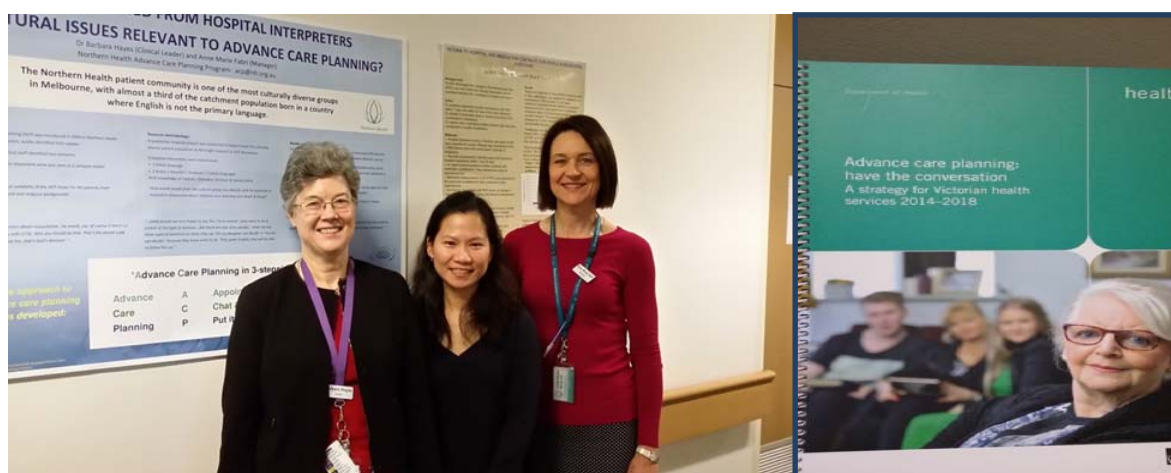


圖四 點選後會出現於此醫療體系內所有 ACP 相關紀錄和 ADs 文件

於 Northern Health 學習期間，參加 ACP 促進者的 workshop，學習如何開啟 ACP 的對話，並聽到來自不同單位，包括急性單位、慢性單位，居家等護理師和社工，於 ACP 推廣所面臨的種種困難，以及大家腦力激盪的解決方式。在 workshop 後接受課後評估，並取得此 workshop 之證書。



圖五 ACP 課程手冊



圖六 與 Northern Health 醫師 Barbara Hayes 和護理師 Ann Marie 合影

3. Eastern Health

Eastern Health 是在維多利亞州服務區域範圍最廣的醫院，擁有 7 家醫院和超過 8 千名員工和服務維多利亞州大約 700,000 人。參訪的單位為尊重病人選擇(Respecting

patients choices)，此單位的主要任務為提高 ADs 的簽署率、提供專業人員 ACP 訓練、ACP 的相關政策制定和推展，於參訪期間隨專科護理師進行家訪，和實地觀察 ACP 的討論；也與 ACP manager 和護理師一同至醫院向醫護人員宣導 ACP 的討論，和如何註記病人的 ACP 討論和 ADs 於 Eastern Health 體系的電子病歷系統，以及隨同 ACP manager 和護理師至診所和小醫院，進行 ACP 的電子病歷和轉介流程的宣導。



圖七 與 Eastern health 護理師合影

在澳洲 ACP 的推行，很重要的是他們提倡的是了解病人的價值觀和信念，以及重視與家屬的討論，他們會去檢視病人 ACP 的討論與病人或家屬所簽署的 ADs 有無一致。因重視病人與家屬間的討論，所以澳洲 ACP 的推行是鼓勵病人預立醫療代理人，而不是去詢問病人要不要插管、要不要呼吸器、抗生素、人工營養與水分等。透過病人的價值觀和信念，讓家屬了解，由家屬代理當病人失去意識期間的決策(ACP 價值與信念討論單張詳見附件三；預立醫療代理人意願書詳見附件四)。

(二)老人護理與護理研究

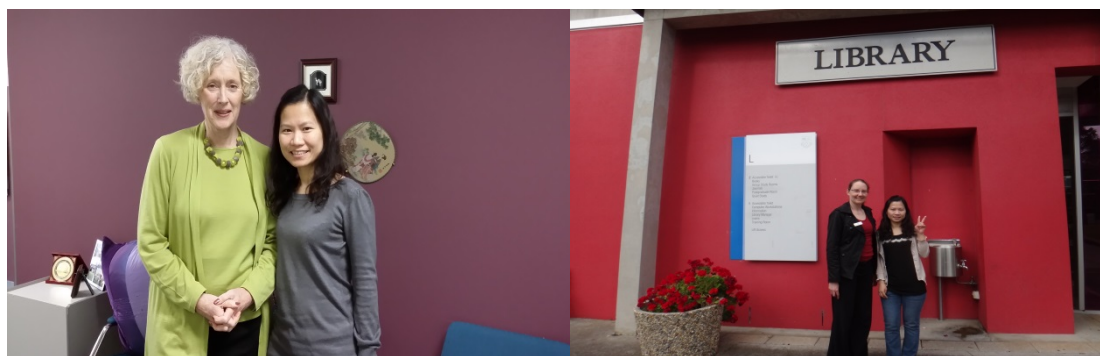
於 Monash 大學與 Dr. Margaret O'Connor 和 Susan Lee 學習護理研究。這次在澳洲嘗試了做質性研究的系統性文獻查證和整合(systematic review and synthesis of qualitative studies)，在每 2-3 週的兩位教師的 meeting 中，學習做研究的思考和批判能力。透過參與課程和與同學的交流，學習了書目管理 Endnote 和質性資料整理軟體 Nvivo

的使用。在學習期間，撰寫英文文章，並經常與圖書館員討論和修改英文文法，並完成一篇質性研究整合的文章、一篇過去所執行的院內研究，以及一篇為共同作者的文章。

質性研究整合的文章題目為「護理人員對老人執行預立照護計畫的看法:系統性文獻查證和質性研究整合分析(nurses' views regarding implementing advance care planning for older people: a systematic review and synthesis of qualitative studies)」，並投稿至 Journal of Clinical Nursing，目前審查中。

過去所執行的院內研究題目為「影響加護病房護理人員對提供癌末病人人工營養與水分行為意向之因素(the factors impacting on ICU nurses' behavioral intentions toward providing artificial nutrition and hydration to terminal cancer patients)」，並投稿至 Research in Nursing and Health，目前審查中。

共同作者(第三作者)的文章題目為「兒童研究之倫理和方法學議題:系統性回顧(Ethical and methodological issues in qualitative children research: systematic review)」，投稿 Nursing Ethics，目前審查中。



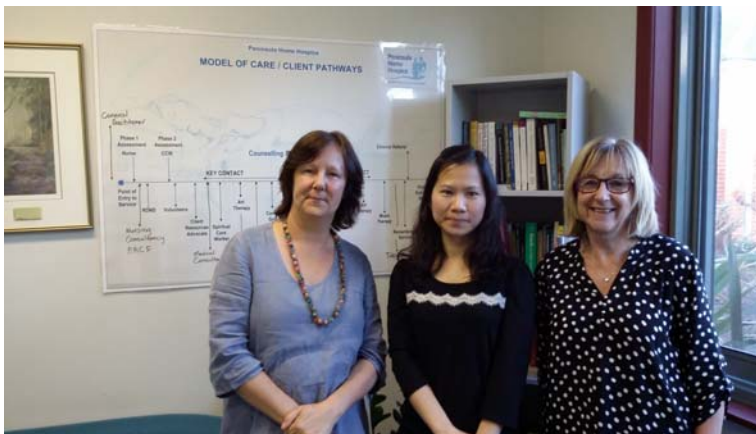
圖八 與大導師 Margret O'Connor 合影

圖九 與圖書館員 Allie Ford 合影



圖十 與二導師 Susan Lee 和同學合影

在 Monash 期間，亦與 Peninsula Palliative Care 聯繫，前往參訪安寧居家，在 Peninsula Palliative Care 提供多樣化的活動，包括居家音樂治療、藝術治療、復健、護理、心理諮商等，團隊更包括了心理師、護理師、復健師、藝術治療師、音樂老師等，所提供的服務十分充沛。



圖十一 與 Peninsula Palliative Care 之 Managers 合影

四、心得

在此 6 個月的學習，收穫匪淺，雖然在出國前惡補了英文，出國後對於澳洲的口音，仍是有點 shock，連買個東西都聽不懂，漸漸聽懂了，時間也差不多該返台了，6 個月的時間過得真快。十分感謝醫院長官和同事們的支持與協助，使我能擁有這次珍貴的學習。在 Monash 大學，學校讓我以訪問學者的身分，在校進行實證研究，擁有自己的辦公桌和電腦，以及享有等同 Monash 的教師和博士班學生的資源，因此可以自由選課、

借書、論文編修，無限度的複印和館際合作。值得一提的是圖書館的館際合作，以期刊為例，只要該校無電子期刊，則都可以申請館際合作或複印，申請後也不需支付任何費用，也不需至圖書館取回所申請的文件，所有的文件會被掃描成 PDF 並直接寄至申請人的電子信箱中；書籍的借閱也採自助式借還書，若該校區沒有想要借的書籍，透過電腦申請，書會送至該校的圖書館後亦用自助式借還書方式。

在澳洲期間視野也變得開闊，Monash 一所國際性學校，在學習期間遇到來自不同國家的博士班學生和教師，包括：澳洲、馬來西亞、中國、沙烏地阿拉伯、新加坡、香港、印尼、日本，也見識澳洲的多元文化。在與這些同儕相處時，發現溝通並不是那麼的困難，也增加使用英文的自信心。在這 6 個月的時間，我非常感謝兩位導師 Margret O'connor 和 Susan Lee 的耐心教導，以及圖書寫作專員 Allie Ford 對於英文論文撰寫的專業指導，使得從未自己完成一篇完整英文論文撰寫的我，也完成了 2 篇論文的撰寫，過去從未有護理人員出國進修為期 6 個月的計畫，我也懷著感恩的心，非常謝謝各位長官和同儕的幫忙，讓我有如此難能可貴的寶貴經驗。

五、建議事項

此次進修主要為於墨爾本醫院學習 ACP，以及於 Monash 大學學習老人護理之護理研究。透過此次的學習，有以下建議：1.目前國內對於 ACP 的推廣似乎僅有安寧協會在舉辦相關在職教育和製作少許文宣，許多民眾和醫療人員並不清楚，而 ACP 亦是安寧推廣的主要主題之一，除建議鼓勵各單位派員參與 ACP 的相關研討會，吸收知識外，和建議依單位特性製作文宣和小手冊。2.關乎生死之議題，永遠都是大問題，宜更加謹慎小心。目前雖然所有護理站皆可讀取病人的健保卡註記，以及 3270 上也有註記，但電子病歷上並看不到病人或家屬所填的意願書或同意書，有時病人或家屬是上一次住院填寫的，身為第一線我們往往擔心上一次的同意書或意願書在舊病歷裡，所以常會請病人或家屬重填。所以建議我們醫院也參考澳洲利用掃描的方式，掃描病人的 ADs 上傳至電子病歷，包括家屬所填之 DNR，很重要的是這些文件都有簽屬日期、親筆簽名

ADs，甚至有上見證人的資料，在臨床上偶會遇到病人本身已有簽有拒絕急救之意願書，但因病人意識不清和家屬間意見不和，導致病人善終過程波折，有此份文件更有非常明確知道病人的意願，以尊重病人選擇。在澳洲維多利亞州的所有醫院會在病人一入院，不論病人有無 ADs 都常規性詢問有無 ACP 方面的知識和更改需求，若有需求即會轉介給相關人員進一步的協助，美國的醫院也是於病人一入院時即會詢問，但礙於風俗民情的不同，病人入院時，常規性的詢問或許不見得適用於台灣，但整合 ACP 的相關紀錄和文件之電子病歷，是值得參考和學習的，特別是掃描 ADs 上傳至電子病歷。

再者，目前不管是醫院和學校都在推廣實證研究，文獻資料管理軟體 Endnote 在書目管理占有非常重要的地位，且大部分的同仁也非常熟悉軟體的操作；而另一個軟體值得介紹為 Nvivo，對於做質性研究的人可能較熟悉，步驟如同 coding 的方式，但最後文獻整理時不會有遺漏，特別是同時整合十幾篇以上的文獻時，所以建議院方也可舉辦 Nvivo 的相關課程或研討會。

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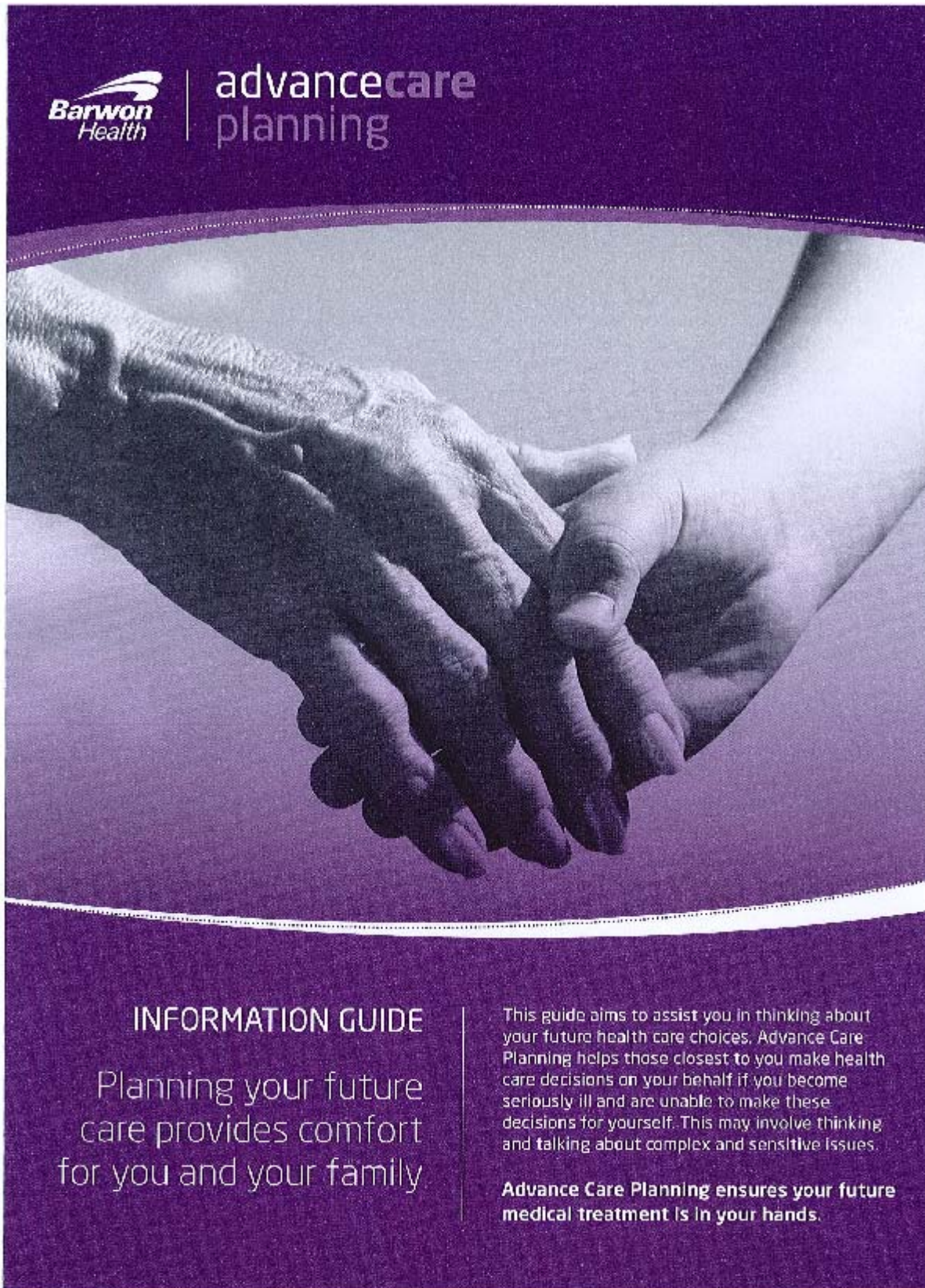
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七、附錄

附件一 ACP 討論單張

The image shows the cover of an information guide for advance care planning. The background is a deep purple color. At the top left is the Barwon Health logo, which consists of a stylized white wave above the text 'Barwon Health'. To the right of the logo, the words 'advancecare' and 'planning' are written in a white, sans-serif font, with 'advancecare' on the top line and 'planning' on the bottom line. Below the text is a large, circular photograph showing two hands clasped together. The hand on the left is older, with visible veins and wrinkles, while the hand on the right is younger and smoother. The lighting is soft, highlighting the texture of the skin. At the bottom of the cover, there is white text. On the left, it says 'INFORMATION GUIDE' in all caps, followed by 'Planning your future care provides comfort for you and your family' in a larger font. On the right, there is a short paragraph of text, and below it, a bolded sentence: 'Advance Care Planning ensures your future medical treatment is in your hands.'

YOUR PAST EXPERIENCES

Your past experiences and current beliefs can shape your views about medical treatment. You may have had an experience with a family member or friend who was faced with a decision about medical care near the end of life. This may have been a difficult experience and led you to have certain views regarding what kinds of medical treatments you may or may not want under similar circumstances.

Your thoughts...

Have you or anyone else you know had a positive or a difficult experience with health care?

Are there things that you wish could have been done differently?

Are there any medical treatments that you have experienced or seen others experience that influences your views?

Do you have any questions about these medical treatments that you wish to ask your doctor?

YOUR CURRENT HEALTH

At present, you may be healthy or experiencing health problems. It is worth thinking about your health while keeping in mind the things that you value, goals you may want to achieve and the place of spirituality in your life.

Your thoughts...

Thinking about your health now, list any significant health problems that concern you.

Describe what provides you with quality in life and how your values or beliefs about religion or spirituality might affect your choice of medical treatments.

YOUR FUTURE HEALTH

You may have thoughts on the kinds of health problems that could affect you in the future. The medical treatments that you choose may also be based upon your values and goals.

Your thoughts...

What short or long-term goals do you have?

If you are receiving medical treatment how might the treatment help or hinder you in accomplishing these goals?

WHO SHOULD MAKE DECISIONS?

It is a good idea to think about whom you would want to make decisions about your health if you are unable to make these decisions for yourself. Many people select a close family member, but you can pick any adult whom you think could best represent you. You can legally nominate someone for this role (the form for this differs in each State and Territory).

The person that you choose needs to be:

- aged 18 or over
- trusted to follow your values and instructions
- willing to accept this responsibility
- available to take on the role if required
- able to make decisions in stressful situations

Your thoughts...

How would you want decisions regarding your medical treatment to be made if you could not make them for yourself?

Who would you want to make these decisions for you?

Would you also like your family and/or other members from your community (e.g. religious adviser) involved?

HOW TO MAKE DECISIONS

It helps to plan for situations where you may:

- Become unexpectedly incapable of making your own decisions, and
- It is clear you will have little or no recovery, and
- The injury or loss of function is significant.

Such situations might arise because of an injury to the brain from an accident, a stroke, or a slowly progressive disease like Alzheimer's disease. To plan for this type of situation, some people state: "If I'm going to be a vegetable, let me go." Or "Don't keep me alive on machines." Or "I want everything". While these remarks are a beginning, they need to be more specific to guide decision-making. Clearer statements such as "I do want/do not want treatments that can keep me alive" can assist in planning. Your doctor can help you understand this. It is important to discuss these choices with those closest to you.

Your thoughts...

Write down the aspects of your life that you value. This may include your independence, activities you enjoy, communicating with your loved ones etc.

If you could no longer participate in these aspects of your life, are there any circumstances where you would regard life-prolonging treatments to be overly burdensome and prefer them to be stopped or withheld?

TO DO

- Discuss your thoughts with those close to you: your family, chosen decision maker, your GP and other involved health care providers.
- Ask your doctor any questions that you may have regarding your health and medical treatments.
- Legally nominate your chosen decision maker for medical treatment on a Medical Enduring Power of Attorney form (or equivalent) and advise this person/these people.
- Your doctor can witness this form.
- Complete an Advance Care Plan or Advance Directive, which can formally record your choices.
- Give copies of your Advance Care Plan or Advance Directive and Medical Enduring Power of Attorney (or equivalent) to your doctor/s, hospital, other health care providers, your chosen decision maker, family and those involved in your care.
- Discuss any changes to your choices as soon as you think of them and also make these changes to your forms.

WHAT NEXT?

How do you make sure that your choices will be respected? First make sure that you talk about them with your doctor, family, friends and significant others. You can then put your choices in writing in the form of an Advance Care Plan or Advance Directive. Ask your doctor about this or a Respecting Patient Choices® Facilitator can assist you. You can also find more information on advance care planning by contacting a Respecting Patient Choices® office or by going to the RPC website: www.respectingpatientchoices.org.au

For more information about this FREE service, please call
1300 715 673 between 9am-5pm Monday to Friday.



附件二 拒絕治療意願書

BARWON HEALTH
REFUSAL OF TREATMENT CERTIFICATE -
COMPETENT

PATIENT LABEL
 REQUIRED HERE

Refusal of Treatment Certificate - Competent Person

Sections 3, 5(2)
SCHEDULE 1
 Medical Treatment Act 1988

We certify that we are satisfied that

(a) [name of patient] _____

has clearly expressed or indicated a decision, in relation to a current condition, to refuse -

- *medical treatment generally;
- *medical treatment, being _____

_____ [specify particular kind of medical treatment]

- (b) the patient's decision has been made voluntarily and without inducement or compulsion;
- (c) the patient has been informed about the nature of his/her current condition to an extent which is reasonably sufficient to enable him/her to make a decision about whether or not to refuse medical treatment generally or of a particular kind (as the case requires) and that he/she has appeared to understand that information; and
- (d) the patient is of sound mind and has attained the age of 18 years;

Dated: _____ Signed: _____
 [Registered Medical Practitioner]

Signed: _____
 [Another Person]

Patient's current condition

The patient's current condition is _____

_____ [describe condition]

Dated: _____ Signed: _____
 [To be signed by the same Registered Medical Practitioner]

Verification to be completed by patient, if physically able to do so.

In relation to my current condition, I refuse

- *medical treatment generally;
- *medical treatment, being _____

_____ [specify particular kind of medical treatment]

*Delete whichever is not applicable



REFUSAL OF TREATMENT CERTIFICATE - COMPETENT

BARWON HEALTH
REFUSAL OF TREATMENT CERTIFICATE -
COMPETENT

PATIENT LABEL
REQUIRED HERE

I give the following instructions as to palliative care:

Dated: _____ Signed: _____
(Patient)

NOTICE OF CANCELLATION

(for completion where patient cancels the certificate under section 7 of the Medical Treatment Act 1988)

I cancel this certificate

Dated: _____ Signed: _____
[Patient]

or

The patient clearly expressed or indicated a decision to cancel this certificate on [date] _____

Dated: _____ Signed: _____
[Person witnessing patient's decision]

Delete whichever is not applicable

NOTES:

"Medical treatment" means the carrying out of

1. an operation; or
2. the administration of a drug or other like substance; or
3. any other medical procedure

but does not include palliative care.

"Palliative Care" includes

1. the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or
2. the reasonable provision of food or water.

The refusal of palliative care is not covered by the Medical Treatment Act 1988.

Additional information:


Section 5E of the Medical Treatment Act 1988 provides that a copy of this document and any cancellation of it must be -

- placed with the patient's record kept by the hospital or nursing home
- given to the chief executive officer of the hospital or nursing home
- given to the principal registrar of the Victorian Civil & Administrative Tribunal at 55 King Street, Melbourne 3000, within 7 days of completion or notification of cancellation.



HEALTH

NORTHERN

 ADVANCE CARE PLAN / DIRECTIVE	AFFIX PATIENT IDENTIFICATION LABEL HERE (Office use only) U.R. NUMBER: _____ SURNAME: _____ GIVEN NAME: _____ DATE OF BIRTH: ____/____/____ SEX: _____
Advance Care Plan for: Name Date of Birth Address..... Completed by: <input type="checkbox"/> myself Or <input type="checkbox"/> (name / relationship)..... 1. Current health problems include: 2. I understand that it is important to discuss these healthcare preferences with my doctor, and my family / friends, including the Medical Enduring Power of Attorney (if appointed). 3. I request that these preferences, and the beliefs and values on which they are based, are respected. 4. I understand the importance and purpose of this document. I may complete all or part of this document. It is a guide for future medical treatment, and will be taken into account when determining treatment. <input type="checkbox"/> I have appointed a Medical Enduring Power of Attorney: Name:..... Relationship:..... Contact number/s: OR <input type="checkbox"/> I have NOT appointed a Medical Enduring Power of Attorney, but I would like the following person to be responsible for consenting to medical decisions on my behalf if I am unable to make my own decisions: Name:..... Relationship:..... Contact number/s:	
Name:..... Signature:..... Date:	

ADVANCE CARE PLAN / DIRECTIVE

Last updated Jan '13



Northern Health

ADVANCE CARE PLAN / DIRECTIVE

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: ____ / ____ / ____ SEX: _____

Values and Beliefs

The things that I most value in life are: (for example: independence, enjoyable activities, talking to family and friends, spiritual or religious beliefs):

What I would like known that may help with future medical decisions.

If unable to be cared for at home, the following would be important:

If nearing death, the following would be important: (eg music, spiritual care, customs or cultural beliefs, family present)

I am a registered organ donor

Name:..... Signature:..... Date:



ADVANCE CARE PLAN / DIRECTIVE

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: ____/____/____ SEX: _____

Health Care Goals and Life Prolonging Treatments

You may wish to inform the doctors about treatment preferences.

To do this, please sign in chosen box or boxes below:

<input type="checkbox"/>	<p>I would like life prolonging treatment that is suitable for my medical condition - in order to prolong life as long as possible</p> <p>Other comments:</p> <p>.....</p> <p>.....</p>
--------------------------	--

OR

<input type="checkbox"/>	<p>I would like life prolonging treatments; however, I do not want treatments that would be too burdensome or likely to result in a health outcome that is too burdensome.</p> <p>For me, 'too burdensome' treatments or outcomes means:.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
--------------------------	---

OR

<input type="checkbox"/>	<p>I would like doctors to provide treatments that are non-burdensome and mainly aimed at relief of pain and other symptoms.</p> <p>When dying, please allow me to die naturally and do not prolong my dying by medical interventions, except those for the relief of symptoms and suffering.</p> <p>Other comments:</p> <p>.....</p> <p>.....</p>
--------------------------	---

You may wish to add further information (*Sign in box or boxes*)

Specific treatments that I do NOT want even if they may prolong life are:

<input type="checkbox"/>	<p>I do NOT want Cardiopulmonary Resuscitation (CPR) if my heart stops beating</p>
--------------------------	---

<input type="checkbox"/>	<p>I do NOT want other treatments listed here:.....</p> <p>.....</p> <p>.....</p>
--------------------------	--

Name:..... Signature:..... Date:



ADVANCE CARE PLAN / DIRECTIVE

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: ____ / ____ / ____ SEX: _____

This is a true record of my healthcare preferences on this date.

Print Name:

Signature: Date:

Witness' name (*Print*):
(preferably *Medical Enduring Power of Attorney*)

Witness' signature: Date:

I, Dr believe that
(*Registered Medical Practitioner*) (name)

is competent and understands the importance and implications of this document.

Doctor's signature: Date:

The contents of this advance care plan have also been discussed with:

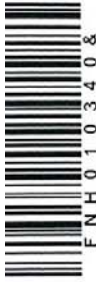
Name	Name
Relationship	Relationship
Signature	Signature
Date	Date

Name	Name
Relationship	Relationship
Signature	Signature
Date	Date

It is recommended that an Advance Care Plan is reviewed, and updated / re-written if necessary, every year, or when there is a change in personal or medical situations.

Date of review and / or update	Signature

Name:..... Signature:..... Date:



HEALTH

NORTHERN

1(a)

1(b)

ADVANCE CARE PLAN
ENDURING POWER OF
ATTORNEY - MEDICAL
TREATMENT (MEPOA)



AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: / / SEX: _____

VICTORIAN ENDURING POWER OF ATTORNEY - MEDICAL TREATMENT
Medical Treatment Act 1988 Schedule 2

THIS ENDURING POWER OF ATTORNEY is given on the _____ day of _____ 20____

by _____
(your name)

of _____
(your address)

under Section 5A of the *Medical Treatment Act 1988*.

(Choose **EITHER** 1(a) or 1(b) and then cross out the one you do not choose)

I APPOINT _____
(your agent's name)
of _____ **to be my agent**
(your agent's address)

OR

I APPOINT _____
(your agent's name)
of _____ **to be my agent**
(your agent's address)
and _____
(your alternate agent's name)
of _____ **to be my alternate**
agent.
(your alternate agent's address)

2. I AUTHORISE my agent or, if applicable, my alternate agent, to make decisions about medical treatment on my behalf.

3. I REVOKE all other enduring powers of attorney (medical treatment) previously given by me.

SIGNED, SEALED & DELIVERED BY: _____
(your signature)

We _____ and _____
(Witness (1) name) (Witness (2) name)
each believe that _____ in making this
(your name)

Enduring Power of Attorney (Medical Treatment) is of sound mind and understands the importance of this document.

*** WITNESSED BY:**
(1) _____ (signature of witness) (2) _____ (signature of witness authorised to take statutory declarations)
(1) _____ (name of witness) (2) _____ (name and authority of witness)

* See back of this form for information on witnessing this document

**NOTE: ORIGINAL TO REMAIN WITH THE PATIENT / MEPOA.
PHOTOCOPIES TO BE FILED IN THE PATIENT'S MEDICAL RECORD.**

ADVANCE CARE PLAN ENDURING POWER OF ATTORNEY - MEDICAL TREATMENT (MEPOA)

L 5

Last updated Feb 09

WITNESSING A PATIENT'S SIGNATURE ON A SCHEDULE 2 DOCUMENT / ENDURING POWER OF ATTORNEY – MEDICAL TREATMENT (see NH POLICY INF.3.6 for further information)

If a patient wishes to complete a Schedule 2 document / Enduring Power of Attorney – Medical Treatment, it is important for an appropriately experienced member of medical staff to be one of the witnesses, as the doctor needs to determine that the patient has capacity to understand and complete this document). A medical practitioner is a witness able to take Statutory Declarations for the purpose of a Schedule 2 Document.

A note must be made in the patient's medical record by the doctor with the entry dated and timed and clearly indicating the patient's capacity at the time of signing, and that an Enduring Power of Attorney – Medical Treatment has been appointed. Signatures must be followed by the name in capitals and designation of the person making the entry.

It is acceptable for other Northern Health Professionals to be the other witness.

INFORMATION FOR WITNESSES (Office of the Public Advocate, 2007. <http://www.publicadvocate.vic.gov.au>)

As a witness, your responsibility goes beyond making sure that the signature of the person making the power is genuine. You also need to state that you believe that the person, called the donor, is of sound mind and understands this form.

The donor should be able to tell you things like:

- what sorts of powers the agent will have
- what sorts of decisions the agent will have the authority to make
- when and how the agent will have the authority to exercise that power
- the effects that the agent's power could have on the donor
- how the donor may cancel or change the arrangement in the future.

WHO CAN WITNESS STATUTORY DECLARATIONS? (Office of the Public Advocate, 2007)

- (a) A justice of the peace or a bail justice
- (b) A notary public
- (c) A barrister and solicitor of the Supreme Court
- (d) A clerk to a barrister and solicitor of the Supreme Court
- (e) The prothonotary or a deputy prothonotary of the Supreme Court, the registrar or a deputy registrar of the County Court, the principle registrar of the Magistrates' Court or a registrar or deputy registrar of the Magistrates' Court
- (f) The registrar of probates or an assistant registrar of probates
- (g) The associate to a judge of the Supreme Court or of the County Court
- (h) The secretary of a master of the Supreme Court or of the County Court
- (i) A person registered as a patient attorney under Part XV of the *Patents Act* 1952 of the Commonwealth
- (j) A member of the police force
- (k) A sheriff or a deputy sheriff
- (l) A member or former member of either House of the Parliament of Victoria
- (m) A member or former member of either House of the Parliament of the Commonwealth
- (n) A councillor of a municipality
- (o) A senior officer of a Council as defined in the *Local Government Act* 1989
- (p) A registered medical practitioner within the meaning of the *Medical Practice Act* 1994
- (q) A dentist
- (r) A veterinary practitioner
- (s) A pharmacist
- (t) A principal in the teaching service
- (u) A manager of a bank
- (v) A member of the Institute of Chartered Accountants in Australia or the Australian Society of Accountants or the National Institute of Accountants
- (w) A secretary of a building society
- (x) A minister of religion authorised to celebrate marriages
- (y) A person employed under Part 3 of the *Public Sector Management and Employment Act* 1998 with a classification that is prescribed as a classification to which this section applies or who holds office in a statutory authority with such a classification
- (z) A fellow of the Institute of Legal Executives (Victoria)