Life Prolonging Treatment Policy
A guide to life prolonging treatment and limitation of treatment

Staff this document applies to:
All medical, nursing and allied health staff at all campuses.
This policy does not apply to involuntary patients under the Mental Health Act unless otherwise specified.
This policy does not apply to minors -- refer to sections 7.6 and 8.2 of Austin Health (Informed) Consent (to Diagnosis and Treatment) Policy.

State any related Austin Health policies, procedures or guidelines:
Respecting Patient Choices Policy
(Informed) Consent (to Diagnosis and Treatment) Policy
Medical Emergency Team (MET) Call

Purpose of the Life Prolonging Treatment Policy
To guide health professionals regarding the appropriate provision of life prolonging treatment or, in some circumstances, the limitation of treatment. This process should ensure that the provision of life prolonging treatment or withdrawal of active treatment is clinically appropriate and in the patient’s best interests and takes into account the patient’s and family’s wishes.

Policy Objectives
Many Austin Health patients have multiple progressive incurable medical conditions where it may be appropriate to make medical decisions to limit medical treatment. Patients may also have wishes regarding types of treatments that they would, or would not, want to receive. There are also circumstances where patients receive inappropriate or unwanted treatment due to lack of written information in their medical history regarding these issues.
The purpose of the Life Prolonging Treatment Policy is to assist with, and encourage, timely and appropriate medical decision making in Austin Health patients, ensure that there is an appropriate process of communication regarding such decisions between Austin Health clinicians (clinician to clinician) and between clinicians and patients/families. The Resuscitation Plan is the document used at Austin Health to ensure communication between medical teams and patients, facilitate appropriate medical decision making, and to allow this information to be readily available when required.

Policy Index
1. Decision Making Framework for Medical Treatment (including limitation of treatment)
2. Resuscitation Plan
3. Completion of the Resuscitation Plan
4. The relationship between advance care planning (ACP) and the Resuscitation Plan
5. Approach to dispute resolution between Austin Health staff and patients and or families
6. Definitions
1. Decision Making framework for Medical Treatment (including limitation of treatment)

1.1 Steps involved in medical decision making (refer also to back page of resuscitation plan)

First Step. Is the proposed treatment medically indicated? (for more explanation see 1.2) If the treatment is not likely to benefit the patient then it should not be offered, or should be withdrawn if it has already been commenced. If the proposed treatment is likely to be medically beneficial then it is offered to the patient as set out in Second Step.

Second Step. What are the patient’s wishes regarding the medically indicated treatment? In the competent patient the proposed treatment and the potential benefits and burdens of the treatment need to be discussed, and the patient makes the decision as to whether the treatment is to be given (see 1.3). The competent patient may request the assistance of the family, or others, to make the decision. If the patient is not competent then refer to 1.4.

1.2 Is the proposed life prolonging treatment medically indicated?

1.2.1 Life prolonging treatments are judged to be medically indicated after careful consideration of the patient’s chronic health status, current medical condition, expected response to proposed treatment and likely outcome. The judgement formed should be based on whether the patient is likely to benefit from life prolonging treatment.

1.2.2 Patients with severe organ failure, advanced malignancy, severe dementia, terminal disease, poor pre-morbid functional state and advanced age are unlikely to benefit from life prolonging treatment either because the treatment will be unsuccessful or the treatment burdens will outweigh any benefit to the patient.

1.2.3 If it is determined that a particular treatment is not in the patient’s medical interests (i.e. not medically indicated) there is no obligation to provide the treatment even if the patient / family request that it be provided. When a medical decision is made to limit treatment the competent patient or the Person Responsible (if the patient is not competent) should be informed of the decision. This should not be viewed as seeking consent to the withholding and/or withdrawal of medical treatment. The final responsibility for the decision as to whether the treatment is in the patient's medical interests, and whether to proceed, rests with the doctor.

1.2.4 Decisions to withhold or withdraw treatment should be made by the consultant unless the consultant delegates the responsibility to the registrar. It may be appropriate to support a decision to not institute or maintain medical treatment on medical grounds by obtaining a second medical opinion as to the patient's diagnosis and prognosis and the expected benefit of the treatment. This would particularly apply if there was a dispute with the patient's family (see 5.2.1). If there is uncertainty about the medical indication for life prolonging treatment, either due to lack of information about the patient's condition or lack of consensus amongst the treating consultants, it would be appropriate to plan to provide life prolonging treatment until sufficient information has been obtained and a more considered assessment made. If there is a disagreement between treating consultants, regarding the appropriateness of medical treatment that cannot be resolved, it should be referred to the Chief Medical Officer for resolution.

1.3 Decision making for the competent patient if treatment is medically indicated.

1.3.1 A competent patient must always be involved in the decision making process regarding offered medical treatment. A patient is competent if he/she is 18 years or older, can receive and understand information about the illness and treatment options, weigh up the benefits, risks and burdens of each choice, understand the consequences and take responsibility for the choices and communicate a decision. Competence may be affected permanently or temporarily by physical illness, acute delirium (encephalopathy) or mental illness (depression or psychosis). Competence may fluctuate from day to day and a patient may be competent to make some decisions but not others. A patient's ability to make a decision needs to be judged by the doctor at the time that the decision is to be made. If in doubt, seek the assistance of an appropriate specialist -- geriatrician, neurologist or psychiatrist.

1.3.2 A competent patient may refuse treatment at any time. It is the responsibility of the doctor to endeavour to provide the patient with adequate information to make an informed decision.
Competent patients’ wishes to refuse treatment take precedence over others’ wishes including those of the family, and those of the treating doctor. If there is a concern that the patient’s refusal of treatment is being inappropriately influenced by the patient’s mental state, degree of pain, or other symptoms then a professional opinion may be required from a psychiatrist, pain specialist or palliative care specialist.

1.3.3 If a competent patient refuses treatment, it is desirable (but not essential) that a Refusal of Treatment Certificate be completed. The Refusal of Treatment Certificate acts as proof in legal proceedings that a patient has validly refused medical treatment. A Refusal of Treatment certificate must be completed whilst the patient is competent and be signed by the patient, and must be witnessed by a doctor and another person. It should clearly state whether medical treatment generally, or a specific medical treatment, is being refused.

1.3.4 If the certificate is not completed, the fact and circumstances of the patient’s decision must be detailed in the patient’s medical record. The medical record should also note the fact of consultation with the patient and where appropriate other relevant family members.

1.4 Decision making in the non-competent patient if treatment is medically indicated.

1.4.1 Where a patient is not competent to make a decision regarding his/her medical treatment, and is not likely to become competent in the near future, and where a medical treatment is indicated, the offer of treatment for the patient is made to the Person Responsible who then makes the decision (see 1.4.3 regarding how to determine who is the Person Responsible).

1.4.2 The Person Responsible is required to make the decision as a substitute decision-maker, that is, to make the decision that the patient would make if they were competent to do so. Under section 38 of the Guardianship and Administration Act 1986 (G&AA, 1986), the Person Responsible is required to base their decision on what is in the patient’s best interests. The following should be considered by the Person Responsible in making the decision:

- The previously expressed wishes of the patient, when competent. This may include wishes documented formally in an advance care plan or expressed verbally;
- The wishes of family members. The wishes of the patient if known, however, would usually take precedence;
- Consideration of the potential benefits and burdens of the proposed treatments, and whether any other alternate treatments are available

1.4.3 The Person Responsible means the first person listed below who in the circumstances, is reasonably available and willing and able to make a decision:

a) An agent - a medical enduring power of attorney (MEPOA) appointed by the patient under the Medical Treatment Act 1988
b) A person appointed by VCAT (G&AA 1986) to make decisions about proposed treatment;
c) A guardian – appointed by VCAT (G&AA, 1986) with health care powers;
d) An enduring guardian – appointed by the patient with healthcare powers;
e) A person appointed by the patient in writing to make decisions about medical and dental treatment;
f) The patient’s spouse or domestic partner with whom the patient has a close and continuing relationship;
g) The patient’s primary carer, (including carers in receipt of a Centrelink Carers payment but excluding paid carers or service providers);
h) The patient’s nearest relative over the age of 18 which means in order:
   - Son or daughter;
   - Father or mother;
   - Brother or sister (including adopted persons and ‘step’ relationships);
   - Grandfather or grandmother;
   - Grandson or granddaughter;
- Uncle or aunt;
- Nephew or niece

**Note:** if the patient is an involuntary patient under the Mental Health Act 1986, the decision maker regarding the patient's treatment follows the hierarchy as set out in section 5.8 of the Austin Health Consent Policy.

1.4.4 The Person Responsible has the authority under the Guardianship and Administration Act to provide consent to medical treatment. Although they do not have authority to refuse medically indicated treatment (unlike the MEPOA, who can refuse treatment, see 1.4.5), they do have the right to not consent to the proposed treatment. It is then the duty of the doctor to consider whether the Person Responsible who is withholding consent is acting in the patient's best interests. If the doctor believes that the Person Responsible is acting in the patient's best interests then the doctor must not provide the treatment in question. If, however, the doctor believes that the Person Responsible is not acting in the patient's best interests, then the doctor is required to consult the Chief Medical Officer or the Clinical Ethicist regarding the need to refer the case to VCAT. Whatever decision is made it is important that the doctor records the decision and the reasons for it in the clinical notes.

1.4.5 A MEPOA or a Guardian appointed by VCAT (to make medical treatment decisions) may refuse treatment on behalf of a non competent patient if:

1. The medical treatment would cause unreasonable distress to the patient, or there are reasonable grounds for believing that the patient (if competent, and after giving serious consideration to his/her health and well-being) would consider the medical treatment unwarranted; and
2. The MEPOA or appointed guardian has been informed about the nature of the patient’s current condition to the extent that would be reasonably sufficient to enable the patient (if competent) to make a decision about refusal of medical treatment, and the agent/guardian understands this information.

Where there are concerns that an agent or guardian is not acting in the patient's best interests the Chief Medical Officer should be notified.

1.4.6 In order to ensure that any decision is being made in the patient's best interests it is important to take the time to seek the views of family and others in order to establish whether that patient would consider the treatment to be warranted.

## The Resuscitation Plan

The Resuscitation Plan (L0.5) is the document used at Austin Health to document the medical decisions regarding urgent treatment decisions for patients. This form includes the option for full treatment, including full resuscitation.

### 2.1 Guide to Emergency Response – Code Blue / MET

At Austin Health emergency response calls include Code Blue and MET calls. At the Repatriation campus a MET call is referred to as a MER call. For the purposes of the Resuscitation Plan instructions MET calls include MER calls for patients when they are at the Repatriation campus. At the Talbot campus acutely unwell patients receive medical assistance or are attended by ambulance staff. An ambulance would not be called for Talbot patients whose Resuscitation Plan documents that they are not for Code Blues or MET calls.

In **Section A** of the Resuscitation Plan, each of the four options guides the staff regarding the eligibility of the patient for Code Blue or MET calls.

**Section B** of the Resuscitation Plan guides clinical staff that the patient is not for any active medical treatment (Code Blue/MET calls) but is to receive treatment aimed at relieving symptoms causing distress, pain and suffering.

### 2.2 Decision Making Framework
The framework as set out on the reverse side of the Resuscitation Plan guides the decision making process regarding whether life prolonging treatment would be in the patient's best interests.

The Resuscitation Plan should only be used to document decisions. At all times, accurate and complete notes in accordance with this policy must be maintained in the patient's medical history.

### 3. Completion of the Resuscitation Plan

#### 3.1 Which patients must have a Resuscitation Plan completed?

**3.1.1 Medical Indication**

The Resuscitation Plan should be completed on all Austin Health inpatients for whom there is a *reasonable* risk that a Code Blue or MET call may be required during their inpatient stay. This includes the following patients:

- i. those over the age of 75;
- ii. those with significant neurological, cardiac or respiratory failure;
- iii. those on dialysis AND with higher risk of cardio-respiratory arrest and/or of those with significant comorbidities;
- iv. those with advanced dementia;
- v. those with advanced malignancy (metastatic disease with end-organ failure);
- vi. those with conditions determined by individual unit policy.

**3.1.2 Patient / MEPOA / Person Responsible Request**

The Resuscitation Plan must also be completed for any patient who has requested limitation of treatment, including where there is an advance care plan with a wish to limit treatment.

#### 3.2 When should the Resuscitation Plan be completed?

For the above patients, the Resuscitation Plan should be completed as soon as possible and no later than 48 hours into their admission. This should, preferably, be completed by the parent team rather than the emergency department staff and should not delay the transfer of the patient from the emergency department to the ward.

#### 3.3 Who is responsible for completing and filing the Resuscitation Plan?

**3.3.1** The Resuscitation Plan is to be completed, signed and dated by a doctor at the level of registrar or consultant, or by a medical resident under the direct supervision of a registrar or consultant. The Consultant in charge of the patient should approve the decision unless they delegate this responsibility to their registrar.

**3.3.2** The doctor completing the Resuscitation Plan is responsible for ensuring it is filed at the front of the inpatient’s current history;

**3.3.3** The doctor completing the Resuscitation Plan is responsible for ensuring that the limitation of treatment is recorded on the MedTrak alerts system.

3.3.4 Upon discharge the ward clerk is responsible for filing the Resuscitation Plan behind the legal divider.

**3.3.5** Each Unit Head is responsible for ensuring that points above are adhered to.

#### 3.4. Does this apply to day admissions?:

Patients admitted for day admissions, i.e. day oncology, day surgery, are exempt from the completion of the Resuscitation Plan for each admission episode. The treating medical consultant may consider that it is still appropriate to complete a form for these patients.
these cases, the Resuscitation Plan should be reviewed every three months, or if there is a significant change in the patient's medical condition.

Appropriate dialysis patients (see 3.1.1) should have a Resuscitation Plan which may be reviewed at regular intervals or if there is a significant change in their medical condition, or if the patient requests a further limitation of treatment.

3.5 Inter-campus/ward transfer

If a patient is transferred from one Austin Health campus/ward to another, the Resuscitation Plan must accompany the patient in their inpatient medical record to the new destination and remains valid unless revoked or replaced by a new plan.

3.6 Review of the Resuscitation Plan

3.6.1 The Resuscitation Plan must be reviewed if:

- There is a significant change in the patient’s medical condition or expected prognosis. For example the patient may deteriorate leading to a medical decision to limit treatment, or the patient may make an unexpected improvement.
- The patient requests that certain treatments are not provided.

3.6.2 How to revoke a Resuscitation Plan: In the event that the Resuscitation Plan is to be revoked or replaced it should be crossed through, marked **VOID** and signed and dated by a doctor at the level of registrar or consultant, or by a medical resident under the direct supervision of a registrar or consultant. It must not be destroyed but filed in the front of the patient’s inpatient medical record. It is the doctor’s responsibility to ensure the new Resuscitation Plan is completed and filed appropriately in the patient’s record.

3.6.3 On discharge all Resuscitation Plan/s are to be filed by the ward clerk in the legal section of the patient’s medical record.

3.7 Duration of the Resuscitation Plan

3.7.1 The Resuscitation Plan will remain valid for the patient’s current admission irrespective of the duration of the admission, or whether the patient moves between Austin Health campuses and/or wards unless it is revoked and replaced by a new Resuscitation Plan.

3.7.2 A new Resuscitation Plan is required for all subsequent admissions to Austin Health.

3.7.3 When a patient is readmitted to Austin Health the doctor is to consider any previously completed Resuscitation Plans, and to use these to assist with the completion of a new form. It can also guide the need to inform the patient and/or family. If limitations of treatment were set in place on the previous admission, and the patient/family informed, it may not be necessary or appropriate to reinform the patient/family if the same limitations will be reapplied.

3.8 Completing the Resuscitation Plan

3.8.1 The doctor must complete **either** Section A or Section B of the Resuscitation Plan.

- **Section A** refers to patients who will be provided some form of urgent treatment, for example, CPR, intubation, electro-cardioversion, non-invasive ventilation or inotropic support. There are four options within Section A and the doctor must choose one of these options. In the fourth option, the doctor is able to specifically state the types of active treatment the patient is to receive, for example intravenous antibiotics, enteral nutrition, etc. The option chosen in Section A also directs clinical staff to the type of emergency care required e.g. Code Blue/MET calls.

- **Section B** is to be completed for those patients whose treatment is aimed at symptom management. These patients must be prescribed medication to treat or prevent symptoms that cause distress, pain and suffering at end of life. These patients are **not** for Code Blue or MET calls (A MET call may be required if the patient is in distress and the
nursing staff are unable to adequately treat the distress and cannot get urgent medical assistance).

3.8.2 The **Reason for Decision** must also be completed. There are tick box prompts (tick all that apply) to indicate how the decision was made and who was involved or consulted in the decision making process.

3.8.3 It is important to record the **information provided to the patient and/or family**. If consultation with the patient and/or family is not possible immediately on admission, the completion of the Resuscitation Plan should not be delayed, especially if a clear medical decision to limit treatment has been made, or if there is clear evidence of advance care planning (where a patient has previously stated, or has documented in a Statement of Choices, or a Refusal of Treatment Certificate, or in some other form, that they would not want certain treatments). This is to ensure there is a clear guide in place for all staff regarding the treatment plan for an acutely unwell patient, and to prevent the delivery of inappropriate or unwanted treatments or investigations. The Resuscitation Plan should be completed, and the patient and/or family informed as soon as practicable. The Resuscitation Plan is used to document decisions. At all times, accurate and complete notes in accordance with this policy must be maintained in the patient's medical history.

3.8.4 The Resuscitation Plan must be signed and dated by the doctor completing the form. The Consultant in charge of the patient should approve the decision unless they delegate this responsibility to their registrar. The approving consultant's name should be recorded. If the patient was not competent, the name of the MEPOA or Person Responsible must also be documented.

3.8.5 The doctor completing the Resuscitation Plan is responsible for ensuring that the limitation of treatment is recorded on the MedTrak alerts system.

**4. Treatment Limitation and Advance Care Planning**

4.1 If a decision is made by the patient to limit life prolonging treatment, or to refuse a medical treatment, the patient and their family are to be encouraged to complete an advance care plan to ensure that there is a clear message of their future healthcare wishes. The Advance Care Plan should, wherever possible, include a Statement of Choices, a Refusal of Treatment Certificate or another type of written document, signed and dated by the patient, outlining treatment wishes. A person trained in advance care planning or the Respecting Patient Choices office can be contacted to assist with this.

4.2 If a competent patient or the nominated agent of a non-competent patient (MTA, 1988) chooses to complete a Refusal of Treatment Certificate (RTC), the original certificate should be filed behind the legal divider of the medical record. A copy of the certificate is to be forwarded to the Chief Executive Officer. A final copy must also be forwarded to the Victorian Civil and Administrative Tribunal (VCAT) within seven (7) days.

4.3 If a patient presents with an Advance Care Plan (ACP) or an RTC completed on non-Austin Health paperwork a copy must be placed behind the legal divider and for the RTC another copy must be sent to the Chief Executive Officer. No ACP documentation, either on Austin Health or non-Austin Health paperwork, should be destroyed or removed from the legal section within the patient’s history.

**5. Approach to dispute resolution between Austin Health staff and patients and/or their families**

5.1 Disputes between Austin Health staff and patients and/or their families may occur when there are either:
5.1.1 requests by the patient or family to cease a treatment that is thought to be medically indicated. This may occur in a situation where a patient may have unrelenting pain, or other symptoms, may be depressed or have another mental illness, or may have other concerns about the treatment. It is important to discuss the treatment with the patient and identify why the treatment is not wanted. If there are concerns regarding the patient’s mental state, degree of pain, or other symptoms then advice from other appropriate professionals is required. (Psychiatrist, pain specialist, palliative care). It is also important to understand the patient’s underlying disease trajectory and the likely future prognosis. It may be appropriate to negotiate with the patient or Person Responsible to continue treatment for a period of time with some clear goals, and a plan to then review the situation. However if the patient is competent, is fully informed and continues to request to not receive treatment or to cease treatment then this must always be respected. If it is believed that the Person Responsible, in withholding consent to medically indicated treatment, is not acting in the patient's best interests, then it is important to consult the Chief Medical Officer or the Clinical Ethicist.

5.1.2 requests from the patient or family to commence or continue treatment that is not medically indicated. Such requests occur in the following circumstances:
   i. the patient’s condition continues to deteriorate despite optimal medical care
   ii. the treatment would not be successful in producing the desired clinical effect
   iii. the treatment may be successful in producing a clinical effect but still fail to achieve important and critical patient goals, for example, survival to hospital discharge, improvement from severe irreversible brain damage.
   iv. The patient/family have an unrealistic expectation about what treatments can achieve.
   v. The patient/family is not ready to accept the patient’s inevitable death and instead are requesting that “everything is done”.

5.2 Approach to resolving disputes where patients/ family request treatment that is not medically indicated.

5.2.1 The treating team need to be clear as to why they feel the treatment is not medically indicated. If there is an uncertainty with respect to this then other doctors involved in the patient’s care, including the general practitioner, should be consulted. If required, or requested by a patient or their family, a second opinion should be obtained.

5.2.2 From the outset it is essential that good communication is established and maintained with the patient and/or family. The consultant (and the registrar) is (are) responsible for maintaining contact with the patient and family, and ensuring that they provide regular updates of the patient’s condition. Often it is not appropriate to delegate this responsibility to the intern or resident who does not have be knowledge or skill to handle delicate communications. It is advisable to limit the number of staff that are communicating directly with the patient/family in an attempt to avoid giving conflicting messages and creating mistrust. In many circumstances it is advisable to ask the patient/family to nominate an individual to be the point of communication for the family.

5.2.3 An early family meeting should be arranged.
   a. All relevant hospital staff should attend, including the consultant and/or registrar directly responsible for the patient’s care. Any other medical staff involved in the patient’s care may also be required to attend.
   b. The patient, all relevant family members and anyone else the patient/family nominates (priest, close friend) should be offered the opportunity to attend.
   c. During this meeting it is important to explain, in simple English, the medical condition and prognosis of the patient, and why the proposed treatment is not likely to be beneficial.
   d. If the patient/family do not speak fluent English a professional interpreter is required (Do not use a family member)
e. Listen carefully to the patient/family’s viewpoint including their motivation for wishing the treatment to continue. Ensure that they understand the likely outcome of treatments. Keep the focus of the discussion on what is in the patient’s “best interests”.

f. Establish current goals for treatment. In some circumstances it may be appropriate to negotiate on a time limited continuation or trial of treatment aiming for specific treatment goals and a clear plan of review, and action if goals are not achieved. This should only occur where the trial is in the best interests of the patient, and where the treatment is not considered futile or overly burdensome from the outset.

g. Ensure the patient/ family know that even though some treatments are inappropriate and will not be provided the patient will continue to receive other care including symptom relief, and that they will not be abandoned.

5.2.4 Often more than one family meeting is required. It is important to give the patient/ family some time to accept the situation.

5.2.5 When dealing with the patient/family it is important to listen to their concerns. Be consistent with the information being provided.

5.2.6 In some circumstances a second opinion from another clinician, or from ICU may be helpful.

5.2.7 Ensure that there is good documentation in the medical records regarding the patient's condition, medical treatment decisions that have been made, evidence to support the decisions, opinions from other medical specialists regarding the patient, and all communications with the patient/family, including discussions at family meetings. Note: Good documentation and demonstrates good process and adequate communication with patient/family.

5.2.8 Seek assistance from the clinical ethicist. This may help address and clarify the concerns of the patient/ family, and may help find agreement where a dispute or impasse has occurred. They are also able to assist in supporting hospital staff, and the patient/family.

5.2.9 If the dispute or impasse with the family cannot be resolved with consensual agreement all with acceptance by the family that the doctors are in a position to make a decision regarding the limitation of medical treatment based on what is in the patient's best interests, It Is appropriate to inform the Austin Health Chief Medical Officer and to seek advice regarding the appropriate next step. If this stage has been reached it is important to review the decisions that have been made and the evidence to support those decisions and to ensure that all pertinent information has been carefully documented.

5.2.10 If the patient is not competent, it may be appropriate to seek assistance from The Office of the Public Advocate (OPA). The OPA staff are trained to provide general advice and to assist in specific cases. They will advise on the need to refer the case to The Guardianship Tribunal List at VCAT. If necessary VCAT will appoint a Guardian if a decision regarding medical treatment needs to be made. However, they are generally reluctant to become involved unless significant attempts have been made to negotiate with the family/Person Responsible.

5.2.11 Note. If a medical decision has been made that provision of medical treatment is medically futile or not in the patient's best interests then VCAT will not appoint a Guardian as there is no decision to be made.

---

**Definitions**

**Advance Care Plan (ACP):** A document that records a patient’s wishes and only comes into effect if a patient loses competence. An advance care plan may record the appointment of a substitute decision-maker, (including a Medical Enduring Power of Attorney- MEPOA), and document medical treatment wishes including resuscitation and life prolonging treatment. These wishes may be documented on a Statement of Choices (SOC) or a Refusal of Treatment Certificate (RTC).
ACP may also contain other written documents which have been signed and dated by the patient that outline their future medical treatment wishes. Appointment of a MEPOA, and completion of a RTC are supported legally by the Medical Treatment Act 1988, and the SOC is supported by common law.

**Advance Care Planning Clinician:** Austin Health have employed staff specifically trained in advance care planning to act as a resource for staff and patients to complete advanced care plans and facilitated conversations between patients, families and relevant staff about patients medical wishes. These staff members are contactable by pager or through the RPC office.

**Best interests:** the best interests of the patient, as defined in section 38 of the Guardianship and Administration Act 1986, is determined by whether the proposed treatment takes the following matters into account:

(a) the wishes of the patient, so far as they can be ascertained; and
(b) the wishes of any nearest relative or any other family members of the patient; and
(c) the consequences to the patient if the treatment is not carried out; and
(d) any alternative treatment available; and
(e) the nature and degree of any significant risks associated with the treatment or any alternative treatment; and
(f) whether the treatment to be carried out is only to promote and maintain the health and well-being of the patient; and
(g) any other matters prescribed by the regulations.

**Capacity:** also referred to as legal capacity. The determination that a patient is competent to make decisions regarding their health, lifestyle, accommodation, legal and financial matters. Medical practitioners are qualified to determine whether a patient is competent to make decisions regarding their health.

**Cardio-Pulmonary Resuscitation:** “The technique of inflation of the lungs and compression of the heart, used in an attempt to revive a person who has suffered a cardiac arrest” (ARC, Guidelines and Policy Statements - Glossary of Terms)

**Competence:** A patient is competent if he/she can receive and understand information about the illness and treatment options, weigh up the benefits, risks and burdens of each choice, understand the consequences and take responsibility for the choices and communicate a decision.

**Full Treatment:** Full treatment includes but is not limited to life supportive treatments, life sustaining measures, surgical procedures, and resuscitation.

**Life Prolonging Treatment:** These are:

a) treatments typically undertaken in the Intensive Care Unit, but are occasionally performed in other areas e.g. Respiratory HDU, CCU, ED. These treatments may include CPR, mechanical ventilation, elective or emergency cardioversion, and physiological support measures such as pacing, first line ACLS drugs and inotropes.

b) ward based treatments that are also life prolonging e.g. enteral feeding, or intravenous antibiotics, blood transfusions, certain medications etc.

**Limitation of Treatment:** Medical situations where a clear decision to limit certain types of treatment has been made. These decisions are made by the doctor and the decision may be based on whether a treatment is likely to be medically beneficial to the patient, or the decision may be made by a fully informed patient (or the MEPOA if the patient is not competent) who has decided to forgo certain treatments. The decision to limit specific treatments does not affect other care, including provision of appropriate palliative care.
**Non-Indicated Medical Treatment:** are treatment/s considered by a senior clinician to offer no reasonable chance of a successful outcome or to restore organ function. These treatments are either in a setting of the elderly, and/or those with multiple medical problems and/or terminal conditions. They are often burdensome and simply prolong the natural course of the disease process, often at times prolonging suffering.

**Person Responsible:** is an ordered list of people as identified under Part 4A, Section 37 of the Guardian and Administration Act 1986 who in relation to a patient who has lost legal capacity to make their own medical treatment decisions, can be asked to consent to treatment on behalf of the patient (refer to list Section 1 this Policy)

**Refusal of Treatment Certificate:** A competent patient has the power to refuse medical treatment for a known condition under the Medical Treatment Act 1988 (MTA, 1988). A MEPOA also refuse treatment for a known condition A Refusal of Treatment Certificate should be signed by the patient (or MEPOA if the patient is incompetent) detailing the exact nature of the type/s of medical treatment they do not want and then be signed by the doctor who must first establishes that the patient is making an informed decision about their treatment.

The original certificate if completed at Austin Health should be filed under the Legal Divider of the medical record and an electronic alert is placed on Medtrak, if the RTC is completed on Non-Austin Health paperwork then a copy of this document must be placed in the history. A copy of the RTC must be forwarded to the Chief Executive Officer, and a final copy forwarded within seven (7) days to the Victorian Civil and Administrative Tribunal.

**Resuscitation:** Are the initial efforts to reverse and stabilise an acute deterioration in a patient’s vital signs. Interventions include chest compressions, mechanical ventilation, cardioversion, pacing and vasoactive/sympathomimetic medications and/or intravenous fluids. Patients excluded from chest compressions may still be considered for mechanical ventilation and or other resuscitative measures.

**Symptom Management:** the provision of medical treatments that are aimed to manage symptoms causing distress, pain and discomfort as a result of the patient’s terminal illness.

**Author/Contributors:**

Karen Detering, Bill Silvester, Deborah Goosen, Jodie Renton

**Legislation/References/Supporting Documents:**

Medical Treatment Act 1988
Guardianship and Administration Act 1986
Limitation of Medical Treatment Policy, 1999
Mental Health Act, 1986
(Informd) Consent (to Diagnosis & Treatment) Policy
Respecting Patient Choices Policy

**Authorised/Endorsed by:**

2009 Clinical Outcome Review Committee
Medical and Surgical Units, Medical Outcome Review Committee
Surgical Audit Review Committee

**Disclaimer:** This Document has been developed for Austin Health use and has been specifically designed for Austin Health circumstances. Printed versions can only be considered up-to-date for a period of one month from the printing date after which, the latest version should be downloaded from the Intranet.