



ANZSPM Submission:

INQUIRY INTO AGED CARE, END-OF-LIFE AND
PALLIATIVE CARE AND VOLUNTARY ASSISTED
DYING

APRIL 2019

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1. Introduction

- 1.1 This submission is made by the Australian and New Zealand Society of Palliative Medicine (ANZSPM), the specialty medical society for medical practitioners who provide care for people with a life-limiting illness in Australia and New Zealand. ANZSPM represents practitioners of palliative medicine across Australia and New Zealand, with around 15% of our members based in Queensland.
- 1.2 ANZSPM appreciates the opportunity to make this submission to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the Committee) with respect to its *Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying* (the Inquiry).
- 1.3 In this submission, we comment broadly on the matters raised in the Inquiry Issues Paper, in particular with respect to end-of-life and palliative care and voluntary assisted dying. We have not individually addressed the specific questions identified in the Issues Paper, although many of those questions are indirectly addressed within our general discussion of the issues.
- 1.4 We are aware that submissions are being made by other organisations, individual practitioners and groups of practitioners working directly in and with the sector in Queensland. We recognise that those participants are better placed to comment on specific questions with respect to the systems and practices currently in place in Queensland. Similarly, there are other organisations better placed to comment on the standard of aged care services in Queensland.
- 1.5 We would welcome the opportunity to meet with the Committee to provide additional information that may be of assistance with the Inquiry.

2. Executive Summary

- 2.1 Palliative Medicine exists to improve the quality of care of patients with life-limiting illnesses and their families. It encompasses not just the physical but psychological, social, spiritual and cultural needs of the individual and family unit. Palliative medicine practitioners recognise that care is not just focused on the last stage of life, i.e. dying. The focus is broader and involves the last days, weeks and months of life and focuses on supporting people to live as well as possible.
- 2.2 As a specialist society of medical practitioners working in palliative care, we recognise the increasingly complex nature of end-of-life care (as defined by the Australian Commission on Safety and Quality in Health Care (ACSQHC)¹) and believe that much can be done to improve the delivery of and equity of access to high quality end-of-life care.
- 2.3 Critical factors to enable this are to ensure that all health care practitioners can effectively provide end-of-life care, with appropriate specialist palliative care support; and specialist palliative care services are available for people with more complex needs.

¹ Australian Commission on Safety and Quality in Health Care, National Consensus Statement: Essential elements for safe and high-quality end-of-life care (2015), <https://www.safetyandquality.gov.au/publications/national-consensus-statement-essential-elements-for-safe-high-quality-end-of-life-care/> (accessed 15 April 2019).

- 2.4 The delivery of quality end-of-life care requires a health workforce equipped at recognising progressive life limiting illness, assessing need and tailoring effective and consistent clinical care and support for people and their families through to the last days and hours of a person's dying phase, and for families into bereavement. This care needs to be integrated, nimble and responsive to changing needs, and to be provided in the location of the person's choosing. Clinical care needs to be integrated with other critical social and community services. Investment is needed to further embed holistic, interdisciplinary care to supports all people with life limiting illness in a way that ensures they are delivered, integrated and coordinated throughout the wider health service. This would have substantial knock-on benefits to support the patients' voice in their health care including at end-of-life.
- 2.5 Much of the community debate currently fuelling the discussion about alternative choices highlights inadequacies in the current systems across Australia and New Zealand, including in Queensland. People with life-limiting illness and their carers do not currently have universal access to quality end-of-life care, which may extend over the last days to years of the person's life dependent on need. Legislating for assisted dying in this context presents a risk that decisions will be made by persons who have not been given optimum choices for their end-of-life care.
- 2.6 ANZSPM believes the substantive solution to suffering and loss of dignity as one approaches the dying phase lies in improving both the quality and accessibility care.
- 2.7 ANZSPM's published position on euthanasia and physician assisted dying makes clear that palliative medicine does not include those practices and that ANZSPM does not support the legalisation of euthanasia and/or physician assisted suicide.² This is consistent with the positions of the Australian Medical Association and the World Medical Association.
- 2.8 The discipline of palliative medicine provides support for persons with a life-limiting illness to support them living with their illness. Palliative medicine practitioners will continue to deliver high quality palliative care to persons with a life-limiting illness, whether or not legislative frameworks exist for the provision of euthanasia or assisted dying. However, it must be recognised by the Queensland Government that assisted dying does not form part of palliative medicine and the two must not be conflated.

3. About ANZSPM

- 3.1 ANZSPM is a not-for-profit specialist medical society for medical practitioners who provide care for people with a life limiting illness. ANZSPM aims to improve health outcomes by working with and influencing the system and community around the person with a life-limiting illness.
- 3.2 ANZSPM facilitates professional development, support and advocacy for its members across Australia and New Zealand to promote best practice in palliative medicine.
- 3.3 ANZSPM promotes the discipline and practice of Palliative Medicine in order to improve the quality of care of patients with palliative diagnoses and support their families.
- 3.4 Our members include palliative medicine specialists, doctors training in the specialty of Palliative Medicine, General Practitioners and doctors who are specialists in other disciplines

² ANZSPM Position Statement on Euthanasia and Physician Assisted Suicide (updated 31 March 2017) <http://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1491523669&sid=> (accessed 15 April 2019)

with an interest in palliative medicine such as oncologists, haematologists, intensivists, psychiatrists and geriatricians. ANZSPM currently has 507 members, including 76 members based in Queensland.

- 3.5 ANZSPM is overseen by a Council of members, which includes representation from Australia and New Zealand and also from the Royal Australasian College of Physicians' Australasian Chapter of Palliative Medicine. ANZSPM's day-to-day operations are managed by a small team of staff based in Canberra ACT.

4. ANZSPM comments on the Issues Paper

- 4.1 ANZSPM's members include practitioners of palliative medicine and other medical practitioners with an interest in palliative care across Australia and New Zealand, including those working in Queensland. As such, ANZSPM is well placed to comment on current end-of-life and palliative care practices and to discuss the position our organisation has taken on euthanasia and physician assisted suicide.
- 4.2 Our comments below are focused broadly on the issues set out in the Issues Paper, particularly with respect to end-of-life and palliative care and voluntary assisted dying, rather than on the specific questions set out in the *Issues for consideration* in each part of the paper relating to those issues.

A. Aged Care

- 4.3 ANZSPM does not have specific comments on the standard of aged care services in Queensland, recognising that other organisations are better placed to provide feedback in this area. We do, however, support the Committee's decision to closely monitor the Royal Commission examining the Quality and Safety of Aged Care across Australia and note that ANZSPM is contributing to that process through our affiliate membership and collaborative work with Palliative Care Australia.
- 4.4 Additionally, we would like to note that in the context of aged care services generally, there is often an assumption that residents of aged care facilities are "clinically stable", and as a result access to key health professionals may not be seen as critical. This assumption is flawed because it fails to recognise that the nature of life limiting illnesses, and indeed multimorbidity which underpins the reason most residents require high level residential aged care services, and by nature of these conditions, their clinical and palliative needs can rapidly change over time and in some instances are complex. The scope of practice of health professionals (whether doctors, registered nurses or allied health, depending on the issue at hand) allows them to conduct regular assessment to respond to these changes, including after hours (as needed), and to respond to acute new issues by flexibly and nimbly tailoring management to the new clinical scenarios and support the resident and their families plan proactively for future care taking into account their preferences, values and wishes.

B. End-of-life and palliative care

- 4.5 **End-of-life** is defined by ASCQHC³ as:

³ Australian Commission on Safety and Quality in Health Care, National Consensus Statement: Essential elements for safe and high-quality end-of-life care (2015), <https://www.safetyandquality.gov.au/wp->

The period when a patient is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown.

This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.

4.6 **End-of-life care** is defined by ASCQHC⁴ as:

Includes physical, spiritual and psychosocial assessment, and care and treatment delivered by health professionals and ancillary staff. It also includes support of families and carers, and care of the patient's body after their death. People are 'approaching the end-of-life' when they are likely to die within the next 12 months.

This includes people whose death is imminent (expected within a few hours or days) and those with:

- *advanced, progressive, incurable conditions*
- *general frailty and co-existing conditions that mean that they are expected to die within 12 months*
- *existing conditions, if they are at risk of dying from a sudden acute crisis in their condition*
- *life-threatening acute conditions caused by sudden catastrophic events.*

4.7 **Palliative Care** is defined by the World Health Organisation (2013),⁵ as reflected in the National Palliative Care Strategy 2018,⁶ as:

"...an approach to care that improves the quality of life of patients (adults and children) and their families who are facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual. Palliative care also respects the choice of patients and helps their families to deal with practical issues, including coping with loss and grief throughout the illness and in case of bereavement."

4.8 Palliative Care affirms life and regards dying as a normal process. It improves the quality of life of patients and their families facing the problems associated with life-limiting illness. It aims to prevent and relieve suffering by means of early identification, and assessment and treatment of pain and other problems – physical, psychosocial and spiritual. It is about life, not death.

4.9 ANZSPM embraces the definition of **Palliative Medicine** adopted in Great Britain in 1987:

[content/uploads/2015/05/National-Consensus-Statement-Essential-Elements-for-safe-high-quality-end-of-life-care.pdf](#) (accessed 15 April 2019).

⁴ Ibid.

⁵ The Australian and New Zealand Society of Palliative Medicine Position Statement (2014) on Quality End-of-Life Care – Part 1: *Essential Elements for quality, safety and appropriate clinical care at the end-of-life*, <http://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1393375205&sid=> (accessed 15 April 2019)

⁶ National Palliative Care Strategy 2018, [http://www.health.gov.au/internet/main/publishing.nsf/Content/EF57056BDB047E2FCA257BF000206168/\\$File/12291_PC-Strategy.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/EF57056BDB047E2FCA257BF000206168/$File/12291_PC-Strategy.pdf), p4 (accessed 15 April 2019)

“Palliative Medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life.”

- 4.10 It is a fundamental tenet of Palliative Medicine that it neither hastens death nor prolongs life.
- 4.11 Palliative medical practitioners recognise that care is not just focused on the last stage of life, i.e. dying. The focus is broader and involves the last days, weeks and months of life and focuses on supporting people to live as well as possible.
- 4.12 Good palliative care supports the person (along with his/her carers and health professionals) to be informed about their condition; supports their involvement in shared decision-making and communication of preferences for care; and provides proactive clinical care to address physical, psychological and emotional needs. Support and empowerment for informal caregivers is also critical, which includes the bereavement period.
- 4.13 Responding to the changing needs for a person with a life-limiting illness and their carers’ needs in the hours, days, weeks, months (and even years) leading towards death should be a whole-of-health responsibility. In both cancer and non-malignant disease there is increasing complexity of illness, and many people live with multiple comorbidities all impacting on care and clinical needs.
- 4.14 Significantly, this is often associated with a perception of burden(s) and fears for ongoing care upon a person, their carers and family. This perception can accumulate and often become magnified over time especially if the required support is not forthcoming. It can present as significant psychiatric, psychological, psychosocial and/or existential concerns which can be so overwhelming that the accumulated suffering may cause a person to seek to end their life in an attempt to potentially re-establish a sense of control.
- 4.15 Palliative medicine practitioners, and the many health care professionals who provide the necessary interdisciplinary care, play a key leading role in facilitating end-of-life choice for patients and their carers. It is important for people with advanced disease to make management and treatment choices to reflect their values and changing needs. A system that promotes and embeds standards of care to give this capacity for people and their carers will enhance their quality of life.
- 4.16 Palliative care resourcing in Queensland must be responsive to the growing population and health demographic and recommendations made from the previous inquiry of 2012⁷ remain relevant and should be re-considered in line with 2019 predicted growth figures.

Recommendations – End-of-life and palliative care

- 4.17 ANZSPM members located in Queensland have expressed concern about the adequacy of frontline palliative care resourcing throughout Queensland, particularly in regional, rural and remote areas.

⁷ Government Response to Recommendations, Health and Community Services Committee, *Palliative and community care in Queensland: towards person-centred care* (Report No. 22), <https://cabinet.qld.gov.au/documents/2013/Aug/PalliativeCommCare%20Report/Attachments/Response.pdf> (accessed 15 April 2019)

4.18 A range of recommendations relating to end-of-life and palliative care services are listed below, taking into account specific points of feedback from ANZSPM members located in Queensland:

1. Awareness

- Systematically and consistently promote community awareness, to improve health literacy and understanding, and enculturate dying as a normal part of living. (This will hopefully reduce misconceptions and fears around dying and suffering at the end-of-life as well as fear of opioids, and lack of awareness of the extent of choice and engagement possible in decision-making in end-of-life care).

2. Workforce

- Implement appropriate standardised data collection processes across generalist and specialist services and government/non-government services in order to quantify unmet palliative care needs and service setting preferences.
- Remedy shortages in the specialist palliative care workforce (including in the specialist medical, nursing and allied health fields).
- Ensure funding models recognise the need for essential palliative care services for patients and families 24 hours/7 days per week.

3. New Models of Care and integration of services

- Implement new models of care that pragmatically address current needs in the community and facilities, including earlier end-of-life care.
- Incorporate technologies such as telehealth and electronic patient information systems – essential for linking specialist palliative care services with regional and rural generalist services according to patient flow patterns and extending across hospital and health service boundaries where necessary.
- Enable earlier integration of palliative care specialist clinical services across health care settings.
- Support resourcing of specialist allied health professionals for therapies (such as palliative physiotherapy, occupational therapy, speech therapy, pharmacotherapy and music therapy) in specialist palliative care units, residential aged care facilities and for in-home community patients.

4. Access to care

- Expand palliative care programs across health care settings to ensure equitable, integrated and responsive access to care (including geographically - regional, rural and remote areas; and setting - hospitals, residential aged care and in the community) supporting people's choice of location for end-of-life care and dying, and ability to receive timely high quality care regardless of diagnosis.
- Target at-risk, vulnerable and isolated populations, including those in correctional facilities and residential aged care facilities (with support of specialist nurse practitioners in palliative care).

5. Training

- Mandate training in minimum competencies in end-of-life care management and communication skills for tertiary education and vocational training for all health professionals in Queensland.
- Mandate end-of-life care and communication skills workplace competencies and continued professional development to ensure currency of skills for all clinically based health care professionals in Queensland.
- Support clinical educators within Level 6 Palliative Care Services, to facilitate education of the public about the advantages of early referral to palliative care and clinical education of generalist staff delivering palliative care.

6. Carer support

- Invest in increased carer support including opportunity for quality respite care to address the important issue of the sense of being a burden which is a concern held by many people at the end-of-life.
- Support Palliative Care Queensland to continue to deliver palliative care awareness and advocacy in Queensland.

7. Advance Care Planning

- Implement policy directions which support and value advance care planning and patient preference.
- Ensure staff are trained to communicate and facilitate appropriate and effective Advance Care Planning (ACP).
- Adapt a consistent legal framework so that ACPs and Advance Care Directives (ACD) have appropriate legal standing.
- Work towards standardising legislative frameworks for ACPs and ACDs across States and Territories.
- Recognise the value of dedicated ACP Facilitators.

C. Voluntary assisted dying

4.19 ANZSPM's published position on euthanasia and physician assisted dying is set out in our Position Statement on *The Practice Euthanasia and Physician Assisted Suicide*.⁸ This document was produced following a survey of our members to ensure that the statement is reflective of member views, with the most recent review in late 2016.

4.20 ANZSPM recognises that ultimately decisions to legislate for euthanasia and/or physician assisted suicide are matters for government, having regard to the will of the community. At the

⁸ See note 2 above.

same time, we highlight the importance that such decisions are informed by appropriate research and consultation with the medical community, including palliative medicine practitioners.

4.21 It is also critical that legislators recognise the distinction between assisted dying and the specialty of palliative medicine and that they should not be conflated. It is incumbent on the Queensland government to consider who will be delivering assisted dying services and not to make the assumption that palliative medicine practitioners will take on this additional role that is not part of palliative medicine.

4.22 Key points from the Position Statement that we draw to the Committee's attention to are:

- a. There remain significant inequities in provision of palliative care services, particularly in regional and rural areas where the shortages of Palliative Care Specialists are most evident.
- b. ANZSPM advocates, and its members deliver, excellent quality care for people living with life-limiting illness by proactive assessment, treatment and prevention of physical, psychological, social and spiritual concerns; and support for caregivers.
- c. For people who are requesting assisted dying, particular care is needed to ensure that access to high quality care that addresses symptom control and other issues, including specialist palliative medicine referral is available
- d. According to international best practice, the discipline of Palliative Medicine does not include the practices of euthanasia or physician assisted suicide.
- e. ANZSPM does not support the legalisation of euthanasia or physician assisted suicide, but recognises that ultimately these are matters for government to decide having regard to the will of the community and, critically, informed by appropriate research and consultation with the medical community, including palliative medicine practitioners.

4.23 ANZSPM's position is consistent with that of the World Medical Association (WMA), an international organisation representing physicians which provides ethical guidance to physicians through its Declarations, Resolutions and Statements. These also help to guide National Medical Associations, governments and international organisations throughout the world.

4.24 The WMA's Declaration on Euthanasia⁹ states:

"Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness."

4.25 The WMA Position Statement on Physician-Assisted Suicide likewise states:

⁹ WMA Declaration on Euthanasia (adopted by the 53rd WMA General Assembly and reaffirmed with minor revision by the 194th WMA Council Session, Bali, Indonesia, April 2013) <https://www.wma.net/policies-post/wma-resolution-on-euthanasia/> (accessed 15 April 2019)

“Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However, the right to decline medical treatment is a basic right of the patient and the physician does not act unethically, even if respecting such a wish results in the death of the patient.”¹⁰

- 4.26 These Position Statements strongly urge physicians to refrain from participating in euthanasia even if national law allows it or decriminalises it under certain conditions.
- 4.27 For completeness, we note that the debate around euthanasia and physician assisted dying sometimes makes reference to withdrawal of treatment by a medical practitioner. The basic ethical principles that govern medicine include patient autonomy, beneficence or simply do good, non-maleficence (do no harm), justice and futility. A competent patient is able to decide to stop treatment of any form. Equally, a medical practitioner is able to withdraw a treatment that is deemed to be futile. This results in the disease progressing on its natural course.
- 4.28 It is helpful to remember that for many conditions, patients would never have survived without modern medicine ‘artificially’ keeping them alive. Therefore stopping a treatment is not a decision to actively cause death. Rather, it is a decision to allow a natural death. In contrast, euthanasia and assisted suicide involve actively seeking death and are irreversible decisions. While some members of the public and some advocates for euthanasia may not understand the distinction, as highlighted by the WMA Position Statements above, medical professionals and ethicists are clear that the distinction is absolute.
- 4.29 We acknowledge that, as with the diversity of opinion in the general and medical communities across Australia and New Zealand, there are divergent views on euthanasia and physician assisted suicide within our membership.
- 4.30 We encourage the Queensland government to support the Queensland community in its understanding of the role of palliative care in end-of-life care and to ensure that the Queensland community is well supported by a palliative care workforce that delivers genuine choice in end-of-life care. This is of critical importance prior to any assessment on community sentiment on voluntary assisted dying.
- 4.31 Persons making end-of-life decisions are some of the frailest and most vulnerable patients the medical profession has the privilege to care for.
- 4.32 As noted earlier, the complexity of a life-limiting illness and changing needs of a person with such illness may be associated with a perception of burden and fear for ongoing care upon a person, their carers and family, especially where the required support is not forthcoming. This may result in a person seeking to end their life.
- 4.33 We consider that much of the community debate that is currently fuelling discussion about alternative end-of-life choices, including assisted dying, points to inadequacies in the current systems for end-of-life care across Australia and New Zealand, including in Queensland.

¹⁰ WMA Position Statement on Physician-Assisted Suicide (adopted by the 44th World Medical Assembly in Marbella, Spain, in September 1992 and editorially revised by the 170th WMA Council Session in Divonne-les-Bains, France, in May 2005 and reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015) <https://www.wma.net/policies-post/wma-statement-on-physician-assisted-suicide/> (accessed 15 April 2019)

Legislating for assisted dying in this context presents a risk that decisions will be made by persons who have not been given optimum choices for their end-of-life care.

- 4.34 Legislative processes for assisted dying cannot guarantee protection for persons who may change their minds with the right support and treatment, recognising that such wishes often wax and wane through the course of one's illness. Persons with life-limiting illness may make these decisions with irreversible consequence at their most vulnerable time.
- 4.35 Legislative processes also cannot ensure that no wrongful death has taken place because of misdiagnosis, uncertainties around prognostications or determination of mental capacity, or guarantee that the request for assisted dying was free from coercion (direct or indirect).
- 4.36 Introducing legislation to facilitate assisted dying without first ensuring that people can receive end-of-life care in any clinical setting or location, and ensuring adequate and appropriate care including palliative care, does not provide genuine choice for end-of-life care.
- 4.37 ANZSPM has made submissions on legislation proposing to introduce assisted dying in NSW and Victoria, as well as in New Zealand, and on consultations on end-of-life choices in the ACT and Western Australia, outlining its position on euthanasia and physician assisted suicide and the important distinction between palliative medicine and assisted dying. We have noted that in other jurisdictions many strong recommendations have been made concurrently with recommendations around assisted dying legislation about improving the equity of access to palliative care and quality of care at the end-of-life and we have expressed concern that these have not had the same urgent and proactive action.
- 4.38 We consider that legislating for assisted dying (as in Victoria's case) fails to deal with the pressing need to address current deficits in palliative care, that have far reaching and serious negative impacts on the quality of life and decision-making for people at the end-of-life and their carers.
- 4.39 We are concerned that the legislative proposals being considered or implemented in other jurisdictions diverts attention away from the larger problem of service gaps for the broader population of people currently receiving end-of-life care in Australia, for whom the priority is access to high quality palliative care and support.
- 4.40 In the event that a legislative framework for assisted dying is introduced in Queensland, we note that care must be taken to support both medical practitioners who choose to participate in the framework and those who choose not to participate. Language plays an important part in both legislation and policy in this area. The Issues Paper asks (at Question 37) whether medical practitioners should be **allowed** to hold a conscientious objection against VAD. Framing the question in this way gives the impression that a medical practitioner could be compelled to deliver assisted dying in circumstances where they do not wish to do so, according to their personal or professional medical ethics. It is preferable for the government to approach this as a voluntary choice for practitioners to participate in assisted dying should they wish to, rather than to "allow" practitioners to refuse to participate. Similarly, we note that many practitioners who have a conscientious objection to assisted dying will also find the process of referral to another practitioner or service very difficult, as by doing so they may feel complicit in the process that they object to. We suggest that this needs to be considered whilst respecting the right of the individual to have access to information and services.

4.41 Additionally, there is a large proportion of Queensland that is rural and remote and does not have access to palliative care services. Any assisted dying system needs to respect the ability of a single medical practitioner working in those areas to conscientiously object.

Recommendations – voluntary assisted dying

4.42 We make the following recommendations related to voluntary assisted dying in Queensland:

- Refrain from legislative change to enact Physician Assisted Suicide or Euthanasia and instead, support a more responsive approach to the complex care needs in end-of-life care and dying, for patients and their carers (having regard to the recommendations outlined above).
- Ensure rapid response specialist palliative care models are available to directly support urgent or complex issues, and other care needs in the location of the person's preference, in particular when a person is imminently dying.
- If, despite the recommendations above the Queensland government chooses to pursue a voluntary assisted dying scheme, recognise that assisted dying does not form part of palliative medicine and that a distinct service will be required to implement the scheme.

5. Conclusion

5.1 Palliative Care Specialists have the privileged position of spending our working life listening to, supporting and advising patients and families at the most vulnerable time of their lives.

5.2 We commend the Committee for considering the important issues around provision of aged care, end-of-life and palliative care and ensuring that citizens of Queensland are supported by appropriate levels of care so that they can make informed decisions about their end-of-life care.

5.3 The Committee's work reflects the increasing concerns of the public, health care and specialist palliative care professionals, including ANZSPM members, that our health care systems are failing to adequately manage the complexity of needs and burdens presenting for people at the end-of-life; in terms of access to services, quality of care, health professional competencies and responsiveness to preferences and choices.

5.4 This Inquiry presents an opportunity to facilitate greater consistency in the delivery of palliative care services across Australia having regard to the broader National Palliative Care Strategy.

5.5 To meet increasing public expectations for quality end-of-life care across the health care system focus needs to be on legislative, funding and models of care frameworks within Queensland which directly target improved palliative care provision and engagement, equity and choice in the location of care, and tangibly support informal caregivers.

5.6 There are several areas of action needed to improve end-of-life choices:

- The capacity for people to articulate choice and have this respected requires legislation that facilitates proper planning and preparation for dying. This includes Advance Care Plans (ACPs), Advance Care Directives (ACDs), Enduring Powers of Attorney and Enduring Powers of Guardianship. Ensuring legislation and systems provide that people are communicated to

and respected by health professionals delivering care regarding these issues would strengthen planning and considerably improve the end-of-life care for the growing population in Queensland who are approaching or at the end-of-life. Health care professionals also need ongoing training to be equipped to engage and support conversations about planning for future care, and to respectfully discuss care preferences.

- Significant growth in palliative care services and workforce, and other support services are required to meet the gap in current needs, improve integration and responsiveness; but also address future population needs as those who will need end-of-life care is expanding and their clinical and demographic characteristics are changing. Improvements should support the growing need for expert end-of-life care in all settings of care, especially aged care, and equality of access across Queensland, regardless of place of residence or diagnosis.
- Informal caregivers play a significant role in the support and delivery of care for people with life limiting illness, and there are significant gaps in the practical, financial and emotional support available.

5.7 Finally, ANZSPM calls on the Queensland Government to refrain from legislating for assisted dying and instead, support a more responsive approach to the complex care needs in end-of-life care and dying, for patients and their carers. In particular, ANZSPM calls on the Committee to make recommendations for the Queensland Government to focus its attention on health reform and investment which will immediately strengthen palliative and end-of-life care.