ANZSPM

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Legislative Council
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10 July 2020

Dear Mr Tallentire,

ANZSPM submission to the Inquiry into palliative care in Western Australia

Thank you for your letter from 12 June 2020 inviting the Australian and New Zealand Society of Palliative Medicine (ANZSPM) to make a submission on the terms of reference for the Joint Select Committee, that has commenced an inquiry into Palliative Care in Western Australia. We welcome the opportunity to make this submission.

About ANZSPM

ANZSPM is a not-for-profit specialty medical society representing practitioners of Palliative Medicine in Australia and New Zealand. Our members are medical practitioners who provide care for people with a life-limiting illness. Our membership currently includes more than 400 medical practitioners working in Australia, including 42 members based in Western Australia.

ANZSPM facilitates professional development and support for its members, promotes the practice of Palliative Medicine and advocates for those who work in the field of palliative medicine. ANZSPM's activities aim to improve the quality of care for people with a life limiting illness.

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

Background

We respond to this inquiry in the context of ANZSPM's submission to the Joint Select Committee into End of Life Choice in Western Australia[1] and our published position statement on Euthanasia and Physician Assisted Suicide[2]. Our recommendations from the former document are listed below:

1. End of Life Care

Recommendation 1. 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).

Recommendation 2. Remedy shortages in the specialist palliative care workforce (including in the specialist medical, nursing and allied health fields).

Recommendation 3. Enable earlier integration of palliative care specialist clinical services across health care settings.

Recommendation 4. 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.

Recommendation 5. 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 Western Australia.

Recommendation 6. 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 Western Australia.

Recommendation 7. 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.

[1] ANZSPM Submission – WA end of life choice consultation (October 2017), http://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1555468060&sid=

[2] ANZSPM, Position Statement on the Practice of Euthanasia and Physician Assisted Suicide (updated 31 March 2017), http://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1491523669&sid=

2. Advance Care Planning

Recommendation 8. Implement policy directions which support and value advance care planning and patient preference.

Recommendation 9. Ensure staff are trained to communicate and facilitate appropriate and effective Advance Care Planning.

Recommendation 10. Adapt a consistent legal framework so that Advance Care Plans and Directives have appropriate legal standing.

Recommendation 11. Work towards standardising legislative frameworks for ACPs and ACDs across States and Territories.

3. Euthanasia and Physician Assisted Suicide

Recommendation 12. 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).

Recommendation 13. 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.

We note the recommendations of the Joint Select Committee on End of Life Choices Report (the Report) with respect to the same categorisations:

1. **End of life care**

- Recommendation 7 Page 67
  The Minister for Health should facilitate the establishment of an inpatient specialist palliative care hospice providing publicly funded beds in the northern suburbs of Perth.

- Recommendation 8 Page 68
  The Minister for Health should ensure that community palliative care providers, such as Silver Chain, are adequately funded to provide for growing demand.

- Recommendation 9 Page 74
  WA Health should conduct an independent review, from a patient's perspective, of the three models of palliative care in Western Australia: inpatient, consultative and community. The review should examine the benefits and risks of each model and the accessibility of each across the state as well as the admission criteria for hospice care (see Finding 18).

- Recommendation 10 Page 78

WA Health should implement a process to determine the unmet demand for palliative care and establish an ongoing process to measure the delivery of palliative care services with the aim of making those services available to more Western Australians.

- Recommendation 11 Page 79
  To improve understanding of palliative care in Western Australia, WA Health should:
  - establish a consistent definition of palliative care to be adopted by all health professionals;
  - provide comprehensive, accessible and practical information and education services about palliative care to health professionals and the community;
  - encourage knowledge sharing by palliative care specialists with their generalist colleagues; and
  - establish a palliative care information and community hotline.

- Recommendation 12 Page 83
  The Minister for Health should prioritise policy development and improved governance structures for the delivery of palliative care by WA Country Health Services.

- Recommendation13 Page 83
  The Minister for Health should ensure regional palliative care be adequately funded to meet demand.

- Recommendation 14 Page 91
  Once a consistent definition of palliative care has been established by WA Health in accordance with Recommendation 11, the Minister for Heath should appoint an independent reviewer to audit:
  - The level of palliative care activity actually provided in Western Australia's hospitals and compare it against the level of recorded palliative care activity.
  - The actual spend by WA Health on palliative care on a year-by-year and like-for-like basis, across all aspects of palliative care provision, including community service providers, area health services (including WA Country Health Services) and delineating between inpatient, consultancy and community care.

- Recommendation 15 Page 113
  WA Health should provide ongoing professional development for all health professionals – beyond undergraduate training – about the right of a patient to refuse medical treatment. WA Health should also specifically amend the Consent to Treatment Policy to provide comprehensive information in relation to a competent patient's absolute right to refuse medical treatment.

- Recommendation 16 Page 119
  WA Health should provide ongoing professional development – beyond undergraduate training – for all health professionals regarding the absolute right of a competent patient to refuse food and water. Training should also include those working in aged care.

- Recommendation 17 Page 122

WA Health should provide ongoing professional development – beyond undergraduate training – for health professionals about the transition from curative to non-curative end of life care and effective discussions with patients and families about futile treatments WA Health should consider how it might effectively educate the community about end of life decision-making, and implement appropriate health promotion in this area.

- Recommendation 18 Page 130
  WA Health should provide specific guidelines on the use of terminal sedation by health professionals for patients at the end of life. These guidelines should include an agreed name and definition of the treatment. As per any other medical treatment, the requirement for informed consent must be clear. The treatment must be specifically noted in the medical record as 'terminal sedation'.

2. **Advance Care Planning**

- Recommendation 1 Page 52
  The Attorney General, in consultation with the Minister for Health, appoint an expert panel to review the relevant law and health policy and practice – and provide recommendations in relation to the following matters:
  - the establishment of a purpose-built central electronic register for advance health directives that is accessible by health professionals 24 hours per day and a mechanism for reporting to Parliament annually the number of advance health directives in Western Australia.
  - a requirement that health professionals must search the register for a patient's advance health directives, except in cases of emergency where it is not practicable to do so.
  - amendments to the current Western Australian template for advance health directives in order to match, as a minimum, the leading example across Australia, taking into account Finding 7 (see page 48).
  - consider how the increasing numbers of people diagnosed with dementia can have their health care wishes, end of life planning decisions and advance health directives acknowledged and implemented once they have lost capacity

- Recommendation 2 Page 53
  The Attorney General, in consultation with WA Health, and relevant health professional bodies, undertake an immediate and extensive program to educate health professionals about:
  - the nature, purpose and effect of advance health directives and enduring powers of guardianship;
  - how to identify a valid advance health directive; and
  - how to identify the lawful substitute treatment decision-maker.

- Recommendation 3 Page 53
  The Attorney General, in consultation with WA Health, provide greater education for the wider community about:
  - advance health directives;
  - enduring guardians; and
  - the hierarchy of medical treatment decision-makers.

- Recommendation 4 Page 53
  WA Health immediately develop a strategy to ensure that when an AHD is provided by a patient to a hospital, it is easily accessible and stored prominently on the medical record – until there is a central database.

- Recommendation 5 Page 54
  The Minister for Health recommends to the Council of Australian Governments an amendment to the Medicare rebate schedule to include preparation of advance health directives with general practitioners.

- Recommendation 6 Page 54
  The Minister for Health report to Parliament annually on the number of advance health directives held on hospital medical records in Western Australia.

3. **Euthanasia and Physician Assisted Suicide**

- Recommendation 19 Page 199
  The Minister for Health should ensure that any bill to introduce a legislative framework for voluntary assisted dying is introduced by the government.

- Recommendation 20 Page 201
  The Minister for Health should ensure that health professionals are not compelled to participate if any voluntary assisted dying framework is developed for Western Australia.

- Recommendation 21 Page 206
  The Minister for Health establish an expert panel including health and legal practitioners and health consumers to undertake consultation and develop legislation for voluntary assisted dying in Western Australia, and that this report, together with the Framework contained at the end of Chapter 7, be considered by that Panel.

- Recommendation 22 Page 214
  The Minister for Health should ensure that legislation require that death be reasonably foreseeable as a consequence of the condition.

- Recommendation 23 Page 214
  That the Minister for Health ensure the eligibility requirement in the legislation include that the person is experiencing grievous and irremediable suffering related to an advanced and progressive terminal, chronic or neurodegenerative condition that cannot be alleviated in a manner acceptable to the person.

- Recommendation 24 Page 225
  The Western Australian Government develop and introduce legislation for voluntary assisted dying having regard to the recommended framework and following consultation with the Panel established under Recommendation 21.

Review of the Terms of Reference for the Joint Select Committee on Palliative Care in Western Australia

As requested, we provide general and specific comments on the terms of reference below. ANZSPM's comments will relate specifically to Term of Reference 2. The other terms are reasonable; however, we assume that the membership of the current Joint Select Committee will equally represent both sides of the physician assisted suicide debate in order to negate any bias.

Term of Reference 2
That the joint select committee inquire into and report on:

a) **the progress in relation to palliative care, in particular implementation of recommendations of the Joint Select Committee into End of Life Choices;**
b) **the delivery of the services associated with palliative care funding announcements in 2019–2020;**
c) **the delivery of palliative care into regional and remote areas; and**
d) **the progress on ensuring greater equity of access to palliative care services between metropolitan and regional areas.**

General Comments

ANZSPM believes this inquiry is an essential component of the state-wide review and subsequent improvement in end of life care for West Australians. The work of the Joint Select Committee into end of life choices in 2018 considered important areas of end of life care that required attention, and we comment on these below (Term of Reference 2a).

The funding announcements in 2019-20 addressed some, but certainly not all the areas of end of life care requiring support (Term of Reference 2b). We know that ANZSPM members in Western Australia will provide their own submissions to the Joint Select Committee and we support their advocacy for the delivery of better end of life care, especially to the most vulnerable patients and their families. A select committee intended to address the specific gaps in palliative care is therefore welcome in relation to Terms of Reference 2a.

The Report recommended several processes to identify and monitor gaps in the supply and demand of end of life care across all care settings. We welcome the recommendations of the Committee regarding Advance Care Planning, which align with recommendations 8-11 of our End of Life Choices submission.

We note the omission in the Report, and therefore remind the Committee of the end of life care needs in relation to children living and dying with life-limiting illnesses, as well as the needs of their families/ caregivers.

Of the many interventions suggested by the Report, none seemed to directly address specialist palliative care workforce shortages and carer support issues (recommendations 2 & 7 of the ANZSPM End of Life Choice submission). ANZSPM recommends to the Committee two documents highlighting the importance of these issues:

- Palliative Care Service Development Guidelines (https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/02/PalliativeCare-Service-Delivery-2018_web-1.pdf)
- KPMG Palliative Care Economic Report: Investing to Save – The economics of increased investment in palliative care in Australia (https://palliativecare.org.au/kpmg-palliativecare-economic-report)

Although the Palliative Care Service Development Guidelines provide a framework via a population-based approach, this underestimates the need in remote areas. Hence, Western Australia will need to adapt these guidelines to its own demographics, where the needs of those with chronic diseases and variable access to primary care, as well as the needs of its Indigenous Peoples, are significant. The findings of an independent Palliative Care Workforce Survey undertaken in February 2020, on behalf of the Federal Government (https://www.health.gov.au/news/palliative-care-workforce-survey), may also inform this adpataion.

The KPMG Report makes a case for investing in palliative care via evidence-based benefits, namely:

- Reduced health service utilisation
- Improved coordination of the healthcare system
- Improved wellbeing and productivity for carers
- Lower bereavement costs

It supports many of the recommendations from the Committee, i.e. reviewing models of palliative care to deliver system-wide reform, promoting advance care planning, increasing palliative care literacy across the health sector, and investing in palliative care. The report also calls for an expansion of the palliative care workforce.

ANZSPM recommends the Committee consider the East Metropolitan Health Service End of Life and Palliative Care Strategy Implementation Plan 2019-2024 (EOLPCIP) as an example of a thoroughly researched and robust document providing valuable insights into the background, motivations and implementation strategies for palliative care in this region. (Terms of Reference 2c and 2d)

The EOLPCIP identifies three significant gaps in palliative care in its area:

1. Access to care by Indigenous peoples.
2. A practical model of holistic and end of life care of patients with multiple chronic illnesses, e.g. heart failure and kidney disease.
3. Improving the timing and quality of end of life conversations through education.

ANZSPM recommends that the Committee will follow the example of the EOLPCIP steering committee and engage in a coordinated process of rigorous review, implementation and assessment of interventions for palliative care across Western Australia.

Specific Comments

In this section, we specifically address the Term of Reference 2a in conjunction with recommendations from the Report:

2 (a) the progress in relation to palliative care, in particular implementation of recommendations of the Joint Select Committee into End of Life Choices

Recommendation 7 (page 67): The Minister for Health should facilitate the establishment of an inpatient specialist palliative care hospice providing publicly funded beds in the northern suburbs of Perth.

ANZSPM members report that with the Western Australian Government's current funding commitment, Ramsay Health has plans for a 10-bed palliative care unit in the Joondalup Health Campus. There is no public hospice/palliative care unit from Joondalup to Kalamunda, Joondalup to Murdoch, and Joondalup to Claremont. ANZSPM estimates the palliative care need in the area, considering its large ageing population, would be more realistically met with a 20-bed unit.

A new palliative care unit or hospice must deliver the best possible care for patients with life-limiting illnesses. Specialist staff will be required to deliver this service, underpinned by a budget that supports non-PBS listed medications, cost allowances for access to drugs on the private/ non-PBS schedule, and transportation to and from home, radiation oncology, radiology and off-site procedures (e.g. Sir Charles Gairdner Hospital). ANZPSM estimates that a 20-bed palliative care unit will need 2 full-time equivalent (FTE) AHPRA-certified palliative care physicians, 4 nurses with 1 nurse coordinator per shift (3 shifts per day), 1 FTE specialist social worker, and the availability of psychology, pharmacy, physiotherapy and occupational therapist services to see patients.

In Western Australia, in keeping with national and internationally evidence, many people die in metropolitan hospitals and represent a significant number of deaths. The Report does not address the end of life care needs for this hospitalised population. The EOLPCIP estimates that 75% of deaths in hospitals are predictable (i.e. they are not sudden unexpected deaths) and at present, in-hospital palliative care teams are involved in only 20-25% of these predictable or foreseeable deaths. The KPMG Report recommends an increased investment in earlier and more integrated palliative care services in hospitals, as well as improving access to home and community-based palliative care services. These are important recommendations if we are to prevent unnecessary hospital admissions from the community, but also facilitate timely transfers from hospitals to home, hospice and residential aged care facilities.

Recommendation 8 (page 68): The Minister for Health should ensure that community palliative care providers, such as Silver Chain, are adequately funded to provide for growing demand.

National PCOC (Palliative Care Outcomes Collaboration) data shows that the risk of having uncontrolled symptoms is up to four times higher in community palliative care patients compared to those who die in inpatient facilities. Financial support from the government must equate to better quality deaths at home.[3] Services must be funded adequately to provide the staff to support emergency calls (crises in relation to care for pain, dyspnoea and falls) and level 4 home care packages to support caregivers for all palliative care patients who choose to die at home.

[3] Eagar K, Clapham SP & Allingham SF (2018) Palliative care is effective: but hospital symptom outcomes superior. BMJ Supportive & Palliative Care, doi: 10.1136/bmjspcare-2018-001534.

ANZSPM supports the KPMG Report's recommendation to increase funding and timely access to home and community-based palliative care services. The last reports from PCOC for specialist community palliative care services (https://www.uow.edu.au/ahsri/pcoc/reports/) shows that patients in Western Australia have a mean episode length of 28.8 days and a median of 18.0 days with these services, compared to the national episode lengths of 35.8 days and 23.0 days, respectively. These figures reflect a lack of timely involvement with specialist palliative care services, considering the policy timeframe of the last year of life. ANZSPM supports the Report in ensuring that specialist community palliative care and regional palliative care providers are adequately funded to meet growing demand.

The Australian COVID-19 Palliative Care Working Group (ACPCWG), which includes ANZSPM, has been monitoring the effects of COIVD-19. We note that the current COVID-19 pandemic has exposed service delivery gaps in palliative care across Australia. Following the general public being advised to stay at home, there has been an increase in the workload of community palliative care services; a reduction in the regular supportive outpatient services to palliative care patients; and a reduction in inpatient palliative care unit admissions. Palliative care services have also been affected by staffing shortages (due to quarantine, testing and isolation requirements) and needing to protect their older nursing and medical staff who are themselves at risk of contracting COVID-19.

ANZSPM believes that the Western Australian Government, as with other State Governments, should act on the gaps highlighted by the COVID-19 pandemic in order to maintain access to services and continue care for the vulnerable palliative care population. For example, telehealth has enabled palliative care and general practice services to maintain their support for community patients, especially is rural and regional areas, and this should be continued.

We note that the Report does not specifically mention residential aged care facilities (RACFs), except in recommendation 16. The KPMG Report cites data from the Australian Institute of Health & Welfare (AIHW) stating that 36% of deaths occur in RACFs, and hence recommends expanding palliative care services into residential aged care. PCOC has recognised the work of the Metropolitan Ambulatory Palliative Care Community Service (MPaCCS) in achieving inpatient outcomes from a community setting. It is the only service that provides AHPRA-certified specialist palliative care to every residential aged care facility (RACF), all prisons, older adult mental health facilities and smaller community hospitals. This service consists of only 0.6 FTE medical specialist and 4.7 FTE senior clinical nurses. ANZSPM recommends that the Committee supports improvements in the resourcing of specialist palliative care to RACFs, enabling hands-on, direct patient care at all hours of the day/night that will improve end of life care in these facilities and prevent unnecessary hospital admissions.

Recommendation 10 (Page 78): WA Health should implement a process to determine the unmet demand for palliative care and establish an ongoing process to measure the delivery of palliative care services with the aim of making those services available to more Western Australians.

ANZSPM agrees that specialist palliative care support in primary care and other in-hospital teams are required to achieve high-quality end of life care. We have mentioned that the national PCOC data highlights the limited timeframe before death that patients receive specialist palliative care, and only relates to 25% of all deaths in Australia. The extent to which people receive generalist palliative care, including the quality and timing of this care, is unknown. The KPMG Report estimates that 82,000

deaths in Australia would benefit from palliative care each year, but this figure does not include those people who are predominantly receiving palliative care for symptom management and not terminal care. ANZSPM welcomes the determination of the unmet palliative care need for Western Australians and recommends the ongoing work of the AIHW to inform future planning.

Recommendation 11 (Page 79): To improve understanding of palliative care in Western Australia, WA Health should:

- Establish a consistent definition of palliative care to be adopted by all health professionals.

We refer the Committee to our definitions of Palliative Care (World Health Organisation, 2013), End of Life, and End of Life Care (both defined by the Australian Commission on Safety and Quality in Health Care, 2015), as documented in our submission to the Joint Select Committee on End of Life Choices .

ANZSPM members indicate that there has been little improvement in the public and professional understanding of the breadth and depth of specialist palliative care in the health system. Most providers and consumers of healthcare continue to relate palliative care in context of terminal care, or care in the last days of life. This highlights the knowledge gap amongst healthcare professionals and the general public. More importantly, ANZSPM is concerned that some members of the public have the misperception that palliative care is synonymous with euthanasia and physician assisted suicide.

Recommendation 5 (page 34): Provide comprehensive, accessible and practical information and education services about palliative care to health professionals and the community

- Encourage knowledge sharing by palliative care specialists with their generalist colleagues.

Whilst ANZSPM welcomes the educational recommendations of the Report, we recognise that without mandated education associated with competency standards there is a risk that the required skills and knowledge in the healthcare workforce will remain insufficient to meet demands. We also maintain that tertiary education also requires attention, to improve the baseline palliative care knowledge of healthcare professionals as they enter the workplace.

Training pathways that incorporate palliative care placements and rotations should begin in undergraduate healthcare professional education and extend into postgraduate training positions. Innovative funding, educational opportunities and supervision may provide the ability to develop services in rural areas. Collaborations with the Royal Flying Doctor Service, rural training pathways and Aboriginal Medical Services not only allow for greater integration of palliative care across the State, but also create a network of support and potential sustainability in terms of workforce development.

In order to increase the education and support to non-specialist palliative care clinicians in Western Australia, the specialist palliative care workforce will need an increase in their numbers or find extra time in their working schedules. Although the COVID-19 pandemic has not drastically affected Western Australia, the potential direct and indirect effects of this pandemic in the future will require

a well-prepared healthcare workforce to deal with a surge in demand for end of life care. Hence the Report's attention to education is to be commended.

However, in practice specialist palliative care services are likely to become overwhelmed by additional educational activities and supervisory roles during a growing clinical demand for pain management in the context of the opioid crisis; ageing population demands; and attempts by healthcare services to further reduce unnecessary hospital admissions. Hence, workforce development and modelling are important considerations for sustainability.

ANZSPM recognises the decades of education and support that has already been provided to generalist colleagues. We recommend to the Committee the 2019 Australian Healthcare Associates' Summary Policy Paper: Exploratory Analysis of Barriers to Palliative Care (https://www.health.gov.au/resources/collections/exploratory-analysis-of-barriers-to-palliative-care).

Recommendation 6 page 34:

- Establish a palliative care information and community hotline.

Given the shortage of palliative care specialists, as per the Palliative Care Service Development Guidelines (see above), we are aware that dedicated attention to the hotline may not be possible, due to other clinical commitments. ANZSPM therefore recommends an increase in the staffing of the current hotline, i.e. allowing the specialist to only be working on the hotline, and thereby provide better clinical governance, as well as sustainability during times of increased demand.

Recommendation 12 (Page 83): The Minister for Health should prioritise policy development and improved governance structures for the delivery of palliative care by WA Country Health Services.

ANZSPM acknowledges that the Western Australian Country Health Service has seen a boost in funding and employment of palliative care specialists to service each region since the publication of the Report. However, we understand that clinical outcomes have yet to be realised. According to ANZSPM members, the greatest challenge continues to be in the provision of resources to transport patients back to their homes. This is an essential service for Indigenous Australians to return home to country to die. We recognise that the Royal Flying Doctor Service currently provides such a service, but this occurs in an ad hoc manner due to the cost involved. ANZSPM supports Recommendation 12 but would suggest that the Committee review the clinical outcomes from the recent funding and ensure appropriate and sustainable funding, with respect to the transportation of Indigenous Australians to realise their preferred place of death.

Recommendation 13 (page 83): The Minister for Health should ensure regional palliative care be adequately funded to meet demand.

ANZSPM recognises the importance of palliative care services in regional areas and welcomes the recommendation to adequately fund services to meet demand. We recognise that extra funding has

occurred and hope the Committee ensures that palliative care services benefit from this and future allocations of funding.

Recommendations 19-24 (Pages 199-225): In relation to the introduction of Voluntary Assisted Dying into Western Australia.

We refer the Committee to the ANZSPM position statement on Euthanasia and Physician Assisted Suicide.[4] We note that Voluntary Assisted Dying, as seen in Victoria, can involve both euthanasia (when the patient cannot physically take the lethal substance and a doctor administers the substance) and physician assisted suicide (when the patient can take the lethal substance themselves).

Although Voluntary Assisted Dying (VAD) and Physician Assisted Suicide (PAS) are usually synonymous, we will use PAS in relation to Western Australia as the implementation of this legislation has not been decided. VAD will refer only to the Victorian legislation.

We emphasise that the discipline of Palliative Medicine does not include the practices of euthanasia or PAS. Palliative medicine practitioners will continue to deliver high-quality palliative care to people with a life-limiting illness, whether legislative frameworks exist for the provision of PAS or not.

However, it is important that any PAS framework introduced by the Western Australian Government does not conflate palliative medicine, or palliative care, with PAS. We have already delineated the misperceptions and poor knowledge about palliative care in both the general population and amongst healthcare professionals. Many people already conflate palliative care with euthanasia and PAS, and so any continuation of this misperception will adversely affect palliative care services.

ANZSPM re-iterates recommendations 12 and 13 of its submission to the Joint Select Committee on End of Life Choices:

Recommendation 14. 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).

Recommendation 15. 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.

The provision of a safe approach to the end of life choices for all West Australians is based upon the knowledge consumers have about their rights, as well as their access to palliative care. Health literacy and health beliefs are informed by experiences, social networks, culture, education, religion, society, healthcare systems, and their professionals. These are all important factors in informed shared decision-making and highlights the need to understand patients at a deeper level than currently exists. Palliative care endeavours to achieve such an understanding of people, as they move from living with

[4] ANZSPM, Position Statement on the Practice of Euthanasia and Physician Assisted Suicide (updated 31 March 2017), http://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1491523669&sid=

an illness to dying from it. Furthermore, as with Māori in New Zealand, we have much to learn from the Indigenous Peoples of our land in how we support each other in the face of our own mortality.

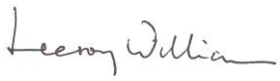
Although the taboos related to palliative care may be difficult to change, the funding to support a viable, evidence-based and valuable healthcare option is essential. ANZSPM acknowledges that optimising palliative care services for the whole population requires an ongoing commitment from the Western Australian Government. We support the efforts being made in the Report and via the Joint Select Committee on Palliative Care in Western Australia.

ANZSPM recognises the desire for PAS in the population, an opportunity to gain control and end suffering at the end of life.[5] However, when palliative care is suboptimal, we are not presenting the population with a credible option to PAS. The introduction and funding of PAS may mean a small percentage of the population will be catered for, but ANZSPM is convinced that it leaves many people without the real option that palliative care can provide. Furthermore, there is evidence that VAD is not without its issues.[6] [7]

In the current climate of COVID-19, we have all been working to prevent unnecessary deaths. For medicine, this has always been a priority and is the same philosophy that underpins palliative care. However, the COVID-19 pandemic has also exacerbated the psychosocial factors that predominately contribute to[8] people requesting euthanasia or PAS and we note that requests for VAD have increased[9] during the pandemic. Subsequently, ANZSPM strongly recommends that palliative care services are optimised, especially in the context of Western Australia developing a legislative framework for PAS.

We welcome further participation in this inquiry and look forward to the Joint Select Committee's findings.

Yours sincerely,



A/Prof Leeroy William
President

Emma Law
Acting Chief Executive Officer

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6 McDougall R, Hayes B, Sellars M, et al. 'This is uncharted water for all of us': challenges anticipated by hospital clinicians when voluntary assisted dying becomes legal in Victoria. Australian Health Review : a Publication of the Australian Hospital Association. 2020 Jun;44(3):399-404. DOI: 10.1071/ah19108.

[7] Moore B, Hempton C, Kendal E. Victoria's Voluntary Assisted Dying Act: navigating the section 8 gag clause. The Medical Journal of Australia. 2020 Jan 20;212(2):67-8.

[8] Hendry M, Pasterfield D, Lewis R, et al. Why do we want the right to die? A systematic review of the international literature on the views of patients, carers and the public on assisted dying. Palliat Med. 2012; 27: 13–26.

[9] https://www.smh.com.au/national/requests-to-die-surge-as-virus-fears-push-terminally-ill-to-make-plans-20200528-p54xbc.html