Submission to Standing Committee on Legal and Social Issues Inquiry into End-of-Life Choices

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Terms of Reference addressed

This submission responds to the Term of Reference about “Assess practices currently utilized .....to manage end-of-life including the role of palliative care.”

How current medical practices and palliative care assist a person to manage their end-of-life care?

Summary:

While palliative care has developed substantially in our institutions and community over the past two decades, considerable deficits still exist in our capacity to respond to suffering, especially when this is due to unrecognised and undertreated depression, existential angst, family distress, communication breakdown and other psychosocial challenges. Major staffing deficits still exist in psycho-oncology services across our Victorian cancer services and palliative care. Without dedicated funding and educational programs to redress this, remediable suffering at the end of life will persist and be poorly addressed within our Victorian community.
Introduction: Suffering - the nature of the clinical challenge in providing end-of-life care

Advanced cancer and progressive irreversible illnesses cause substantial suffering for patients. This is the major impetus to improve the care of these patients. Many studies have sought to better understand the nature of and causes of this suffering.

1. Suffering can be understood to result from any threat to the wellbeing and vital integrity of a person. This results in highly distressing emotions, often with a sense of loss and helplessness that endures.\(^1\)

2. So severe and overwhelming can this suffering be that its source may seem uncertain, its meaning dire, and it can appear to be beyond control.\(^2\) This predicament may cause a person to feel desperate and seek to urgently re-establish a sense of control.

3. Researchers have identified six common predicaments towards the end of life that constitute the typical factors or pathways that are most likely to lead to suffering. These include: \(^3\)

   1) Inadequate symptom control;
   2) Undiagnosed depression & anxiety;
   3) Unaddressed existential distress;
   4) Unrecognized family distress;
   5) Fatigue, burnout, and demoralization; and
   6) Communication breakdown.

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\(^1\) Chapman & Garvin, 1993
\(^2\) Cassell, 1982, New England J of Medicine
\(^3\) Cherny, Coyle & Foley, 1994
What is most striking from this categorization of clinical problems that patients face is the contribution that arises from psychological, psychosocial and existential factors. Indeed physical pain can invariably be reasonably or well controlled, even if occasionally that region of the body needs to be anaesthetized, but the existential, psychological or spiritual pain that causes suffering is much more challenging to specialist palliative care services, who are consulted in the most difficult of circumstances.

4. It is the contention of this submission that the most deficient part of our Australian, and indeed Victorian, palliative care services is the provision of competent psychosocial care. This care is located within the expertise of psycho-oncology and consultation-liaison psychiatry services. While Australian palliative care services were substantially developed during the last two decades, this growth focused on providing palliative care physician and nursing services, but the provision of psycho-oncology and consultation-liaison psychiatry services have never been appropriately funded. A major developmental and educational need exists within our State of Victoria to establish psycho-oncology and consultation-liaison psychiatry services in our networks of oncology and palliative care services.

What is the evidence for psychosocial services with palliative care and oncology?

5. To convince our Department of Health and Human Services that an unmet need exists which will necessitate the growth of new clinical programs to meet the basic requirements of patients with progressive disease and at the end-of-life, epidemiological evidence is needed to provide proof of this unmet need, this human suffering.

6. While specific studies have not yet been conducted in the state of Victoria, or in Australia for that matter, there are overseas studies that do provide evidence
about the psychosocial distress and suffering found in this population of patients. Let us review these studies first of all.

In one major and recent epidemiological study of over 4000 patients with cancer in Germany, rates of formal psychiatric disorders were obtained by structured psychiatric interviews to demonstrate the nature of this problem.\(^4\)

**Mood disorders** including **depression**

- Current real time rate: 8.5% of cancer patients
- Any one-year rate: 15.6% of cancer patients

**Anxiety disorders**

- Current real time rate: 13.5% of cancer patients
- Any one-year rate: 18.5%

**Somatoform disorders** (e.g. pain syndromes, hypervigilant focus on the body causing impairments)

- Current real time rate: 5.6% of cancer patients
- Any one-year rate: 10.3%

**Substance use disorders** (e.g. alcohol abuse)

- Current real time rate: 5.5% of cancer patients
- Any one-year rate: 9.0%

**Post-Traumatic Stress Disorder**

- Current real time rate: 2.5% of cancer patients
- Any one-year rate: 3.2%

Organic psychiatric disorder (e.g. delirium – acute confusional states)

Current real time rate: 2.9% of cancer patients

Any one-year rate: 4.5%

These rates are substantially higher than community-based rates of mental disorders. Overall, some 32% of cancer patients declared unmet psychosocial needs in this recent study in Germany.

Other studies have confirmed the general ballpark figures of this Meynert et al. study in Germany in 2014. For instance, meta-analytic studies have examined rates of psychiatric disorder across large numbers of observational studies and generated overall rates. Thus Vehling and colleagues (2012) reported that among all cancer patients the average prevalence rate of depressive disorders was 11% (95 percent Confidence Intervals 8.1–15.1) and anxiety disorders 10% (95%CI 6.9–14.8). 

Focusing specifically on palliative care patients, Mitchell and colleagues from around 100 studies reported rates of depression as 16.5% (95% CI 13.1–20.3), Adjustment Disorders (problems coping adaptively) 15% (95% CI 10.1–21.6) and Anxiety Disorders 10% (95% CI 6.8–13.2). Studies find higher rates of psychiatric disorder in palliative care and at the end-of-life because of the threat of death and the many cumulative losses that have taxed the coping and adaptation of these patients.

These rates are typically three times higher than the rates of mental illness in the general community and across the lifespan. Our clinical experience points to very similar rates occurring within our community. Very few of these patients receive comprehensive psychosocial care for these disorders.

7. Given the substantial rates of poor mental health among these patients towards the end of their lives, we might well ask why clinical services are not equipped to

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5 Vehling, Mehnert et al., PPM (2012),
respond to this unmet need? Palliative medicine is indeed a young and recently developed specialty, becoming formally taught in our Victorian medical faculties following the establishment of academic units for palliative medicine by the Victorian Government in 1996. As mentioned, early funding was directed appropriately towards the provision of physician and nursing services, with relative neglect to date of comprehensive psychosocial services.

What is meant by Psycho-oncology and related psychosocial care services?

8. Psycho-oncology is a specialty discipline within cancer care that takes responsibility for two primary psychosocial dimensions of care provision:
   a. The psychosocial response of patients, families and staff to cancer and its treatment at all stages of illness; and
   b. The psychological, social and behavioral factors that influence the development, tumor progression and survival of patients with cancer.

Thus psycho-oncology contributes to cancer prevention, behaviours related to screening and early diagnosis, through to coping with the diagnosis and its treatment, survivorship (when cured) with all of the morbidity of long-term and late side-effects of treatment, recurrence and management of advanced cancer, palliative care, dying and bereavement for the relatives left behind.

Psycho-oncology is responsible for care delivered by a number of disciplines engaged with cancer care, principally social work, psychology and psychiatry, but also including contributions from specialty nursing, allied health disciplines like physiotherapy, occupational therapy, nutrition, music & art therapy, and pastoral care, and from general practice and community-based palliative care services. The complexity and co-ordination of care delivered by this diverse multi-disciplinary group is one of the challenges and barriers to development of the discipline.

Both clinicians and researchers recognise the discipline of psycho-oncology. For instance, it is an integral part of the Clinical Oncology Society of Australia
(COSA). The International Psycho-Oncology Society (IPOS), the international parent body of the discipline, recently celebrated the 30th anniversary of its founding. Nevertheless, as a young specialty (like palliative medicine), it has been the Cinderella in the development of oncology and palliative care services, arguably because of the common stigma that is associated with any form of mental illness, and none less so when patients struggle to cope with advanced illnesses that threaten life such as cancer.

While social workers assist with the many social and family problems that challenge patients, Clinical Psychology and Consultation-Liaison Psychiatry are two disciplines that form the bedrock of delivery of active psychological therapies within Psycho-oncology. Consultation-Liaison Psychiatry is the subspecialty within Psychiatry that cares for the medically ill across our general hospitals, and a subgroup of these clinicians specialize in oncology and palliative care.

It is the thesis of this submission that the time has arrived for Victoria to build Psycho-oncology programs comprehensively to enrich and optimise end of life care.

**Is there worldwide support for the importance of these developments?**

9. The Union for International Cancer Control (UICC) is one body that illustrates recognition of this need. The World Cancer Declaration (2013) was sponsored by the UICC, and it specifically recommended that **effective pain control and distress management services should be universally available by 2025.** Whereas palliative care programs address pain control, psycho-oncology and psychosocial services are needed to address the suffering captured under the rubric of distress.

Historically the notion of vital signs in medicine includes the most basic of observations, such as recording a patient’s temperature, pulse, blood pressure
and respiratory rate. To improve pain control, the palliative care community advocated through the World Health Organization (WHO) to have pain recognised as the 5th vital sign. The psycho-oncology community has followed with advocacy that distress ought be documented whenever present as the 6th vital sign. Echoing this, the formal policy statement of the UICC read,

*Recognition of distress as the 6th vital sign will improve the treatment of cancer patients, improve outcomes for cancer patients, and improve the effectiveness of cancer care systems around the world.*

The State of Victoria has substantial work to do to reach this objective across the next decade.

A clinical model has developed which involves the **formal screening for distress**, lest it pass unrecognised because of the busyness and other challenges of clinical care provision. Indeed, many studies across recent decades had identified that psychiatric disorders such as clinical depression, anxiety and related syndromes of existential distress are missed in routine cancer care, despite the best efforts of cancer surgeons and physicians. Thus in 2014, a major Scottish study of 21,000 cancer patients revealed that 73% of depressed patients were not in receipt of treatment. They pass unrecognised and untreated because of the lack of a formal screening program.

Distress has also been seen as less stigmatized and more easily acknowledged than other states of mental illness such as depression. Hence a program known as “Screening for Distress” has emerged as a pragmatic pathway to first recognise and then alleviate this suffering and improve the quality of our care. Victoria has made recent progress in introducing distress screening.

**Screening for distress programs**

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10. In Victoria, screening for distress has been gradually introduced across 2011-2014 across the Integrated Cancer Services (ICS) program for Victoria. The distress thermometer records a score out of 10 for distress. Scores higher than 7 have shown very good sensitivity and specificity for depressive disorders. Scores >4 point significantly to specific unmet needs that allied health services can be invited to respond to. Oncology nurses in Victoria have taken up responsibility for screening for distress.

11. What has emerged since in Victoria is a substantial lack of services to refer these distressed patients to. While most services have access to social work, negligible psychology and psychiatry services can be found. There are significant inequities across metropolitan and regional zones, with major deficits in the rural sector.

While (at one extreme) Petermac employs some 5 psychiatrists, 5 clinical psychologists and 15 social workers to constitute the core of its psycho-oncology program, most oncology services in the east, west, north and south of our city have none or minimal psychology and psychiatry services; a single and overtaxed social worker is all that is available. Regional and rural programs have even larger deficits. A major developmental task exists to build these programs.

**Why does Victoria have a paucity of psycho-oncology services in its cancer treatment programs?**

12. There are a number of complex reasons to both explain the lack of current services and to recognise the potential barriers to their future development:

These include:

a. Underdevelopment of clinical psychology in Australia, including Medicare funding restrictions upon episodes of care able to be provided.
b. Focus of psychiatric services on inpatient and community mental health programs, to the serious neglect of the medically ill.

c. The relative neglect of psychosocial needs of the medially ill since de-institutionalization of the mentally ill happened in Victoria in the 1990s.

d. Department of Health structures that separate responsibility for mental health and acute health, with resultant neglect of psychosocial needs within acute health.

e. The ever increasing complexity of patient and family need with the development of medicine and its treatments.

f. Separation of service provision across several disciplines, wherein no single discipline has the skill base within its membership to adequately address the diverse needs that patients and families want addressed. Thus social work runs a crisis-response service with no capacity for continuity of care; psychology is located within community mental health or general practice, but not oncology programs, and psychologists cannot prescribe psychotropic medication; psychiatry has the capacity to prescribe medication alongside deliver psychological therapies, but psychiatrists with expertise in caring for the medically ill are in very short supply.

g. Historical gate-keeping mechanisms within general practice in our society, without the discipline of general practice being necessarily able to keep pace with the enormous specialty developments that have occurred in cancer care. This contributes to under-recognition and under-treatment of psychosocial concerns among the complex medically ill.

h. Within oncology services, the complexity of anti-cancer treatments today demand so much focus by these specialists on radiation or chemotherapy and related treatments that time does not permit comprehensive and person-centred care to adequately address psychosocial needs.

i. Patient response is so often to turn to unproven therapies and alternative practitioners across the community, lacking awareness of the strong evidence-based help that is available from the discipline of psycho-oncology. Substantial community capital is expended on unproven therapies out of
human desperation for help, without knowledge of the range of specialist psycho-oncology help that could be available if properly resourced.

j. Lack of university-based educational programs for psycho-oncology. Indeed, training and supervision deficits ought not be surprising given the global absence of psycho-oncology clinical services within the community.

k. Individual disciplines can be inward looking and self-protective rather than patient-centric in their orientation. Disciplines with a stronger foothold may fear loss of territory and employment opportunity, limiting their advocacy for the building of comprehensive services. Yet only by comprehensive multi-disciplinary care, whereby the disciplines of social work, psychology and psychiatry work harmoniously together can the clinical challenges begin to be addressed. Once they begin to work together, these relationships invariably develop well and partner collaboratively to help patients and their families. The unmet clinical need is so huge that competition does not arise.

Are there opportunities that signify that the development of Psycho-oncology and related psychosocial services is possible?

13. Several developments offer confidence that the time is right for government and the Department of Health and Human Services to pursue the statewide building of Psycho-oncology services:

a. The recent provision of some Medicare funding for clinical psychology opens up a fresh opportunity to harness this discipline to provide psychosocial cancer care. This has the potential to blend federal and state funding sources.

b. World-wide recognition by human rights movements that psycho-oncology is a necessary and basic human right in cancer care.8

c. The complementary nature of the expertise that each disciplinary group within psycho-oncology can bring to patient and family care, with strengths

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8 International Psycho-Oncology Society Human Rights Declarations
within psychology to deliver therapies like cognitive-behavioural therapy, within social work to deliver family-centred care, and within psychiatry to provide clinical diagnostic services, pharmacotherapy and other complex therapies, as well as overall leadership and clinical supervision of relevant programs.

d. The broad use of Medicare-funded outpatient and community clinics moderate the cost burden to such developments at a state level. While some inpatient consultation is needed, most psycho-oncology care can be delivered as an outpatient or community-based model.

How might the state of Victoria proceed wisely to build these programs of care provision with cancer and palliative care services?

14. Workforce planning and development is needed to ensure an equitable and properly-funded range of programs to deliver this clinical care. This could be readily established through the creation of a Government-sponsored or Ministerial Task Force, created to guide the Department of Health and Human Services in this developmental agenda. Such a task force would need to be established as a multi-disciplinary advisory body, with appropriate consumer representation, to define the need and workforce profile that is required to be responsive to this unmet need, recommend guidelines for the equitable deployment of such a workforce, and work with the Department of Health to roll out this plan over a short period of time in an equitable and responsible manner.

15. This process recognises: 1) The need for new dollars to be deployed in the service of this unmet health need;

2) The crucial role for the Department of Health to provide leadership and integration across the range of disciplines is also recognised;
3) Ministerial sponsorship of such a developmental process would help to guarantee its success in a relatively short period of time.

Are there important ways that the development of Psycho-oncology Services might impact on the quality of end-of-life care?

16. If we return to the issue of suffering, we recognised at the beginning of this submission that a range of clinical factors and predicaments contributed to this suffering. Each of these factors has a number of influences that determine how much suffering occurs that needs to be ameliorated.

a. We noted that undiagnosed or inadequately treated depression & anxiety are significant problems. They have the capacity to take away hope and reduce a patient’s motivation to adhere to or complete complex medical treatments for cancer and other progressive illness. Depressed patients with cancer have a significantly poorer survival time, with reduced adherence to recommended anti-cancer treatments being 3-times higher among depressed patients. There is a basic human rights issue in ensuring that these patients have access to the proper clinical services able to begin to treat and manage the problem. This is an urgent priority for our Victorian community.

b. Our medical community has had little education about what is and how to address what is technically termed “existential distress.” How does a patient confront uncertainty, deal with death anxiety, cope with the

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development of some loss of control from illness and frailty, stay in touch with the essential meaning and purpose in their life, and thus adapt constructively to their illness, even when this is a progressive and life-threatening one? The growth of palliative care over the last 20-30 years has seen considerable research and understanding of these issues mature, particularly within the discipline of psycho-oncology. Alas, this knowledge has not been translated into the general education of medical students, nurses and allied health practitioners. A discipline such as clinical psychology has a long way to go to be equipped to address these needs within our community. **Major educational agendas exist and need special funding such as dedicated educational units in our universities to accelerate this educational agenda.**

c. We have made greatest progress over the last two decades in the building of the discipline of palliative medicine, with a dedicated training program auspiced by the Chapter of Palliative Medicine within the Royal Australasian College of Physicians. Alas, this does not mean that we don’t meet instances of **inadequate symptom control** among some patients in need. Our programs still need to mature, and only by addressing major deficits such as the absence of adequate psychosocial care can we free up our physicians to focus on and further improve physical treatment approaches overall.

d. **Family distress is a major source of community burden resulting from end-of-life care.** The distress caused by cancer reverberates through the family, who are most commonly the main source of patient caregiving. Loss of workforce capacity and productivity result. This distress can carry over into bereavement and, for up to one fifth of primary caregivers, the morbidity of psychiatric disorders such as depression or prolonged grief disorder continue. Palliative care programs have substantially restricted means to deliver bereavement care, with
most budgets not permitting employment of the most experienced and specialist disciplines to deliver this care.

Preventive models of family support for those families most at risk of poor bereavement outcomes have been researched, but not yet translated into clinical programs per dint of inadequate numbers of service providers.

e. Communication breakdown is a perennial problem across clinical services, and although both research and training programs have begun to address many of the inherent issues, there is a long way to go to achieve the quality of care that our community wants and deserves. The existential burden of cancer contributes greatly to the challenges that exist here. Psycho-oncology has been the leading discipline to conduct research and provide communication skills training, in an effort to begin to redress these issues. The lack of adequate psycho-oncology staffing has been a major limitation in the capacity of these programs to grow appropriately.

f. The final major problem which research has identified as interfering in the quality of end-of-life care is burnout, or compassion fatigue, whereby overstretched services become exhausted, staff defend subconsciously against the personal toll of delivering such care, and our patients and their families suffer as a consequence. Social, family, occupational and health stresses occur in all clinicians at various stages of their lives. Proper training and skill development are crucial to overcome burnout. Fortunately, palliative care services have lower rates of burnout than medical or surgical oncology, intensive care, and other related specialties. Nevertheless, this remains a central challenge for all clinical programs to deliver care of the highest quality. Psycho-oncology services have been important in supporting all members of the multidisciplinary team, running Balint-type groups for physicians and clinicians to debrief about difficult patients and guard against burnout, conducting studies of the
factors contributing to burnout and helping our institutions to reduce its rate of occurrence.

**Does psycho-oncology have a role in assessing and helping patients with cancer or other progressive and life-threatening illnesses who wish to hasten their death?**

17. Many studies of the desire for hastened death, the development of suicidal thinking, despair about the value of life and requests for physician-assisted suicide or euthanasia have highlighted the prominence of depression and related psychiatric disorders in the development of this state of mind. The psycho-oncologist plays a central role in assessing such patients, helping them to recognise any hopelessness or helplessness, any worthlessness, any shame, or any sense of loss of the meaning or purpose of their life. **In the therapeutic stance adopted to begin to help such patients, the psycho-oncologist must be a source of hope, however else the clinical state is treated.** Hope is an indispensible stance, whether the prognosis for length of life is years, months, weeks or only days. As strange as this last statement might seem to a non-clinician, there are always sources of hope, tasks to be discerned and roles to be lived out fully, even in patients who are quite close to their dying.

By being able to deal with existential angst, treat clinical depression, allay discomfort about living with uncertainty, affirm the dignity of a person who has started to doubt their value, reassure patients that they are not a burden, support relatives in sustaining optimal communication and mutual care, maintain the morale of medical care providers, and keep hope present rather than despair in those who are seriously ill, the psycho-oncologist has a substantial, integral and important role to play in care provision.

**The development of psycho-oncology services is vital for Victoria to be able to deliver optimal medical care.**
18. One of the most difficult clinical tasks for all physicians is the development of the clinical experience and medical wisdom to be able to prognosticate reasonably accurately. Research has repeatedly shown that oncologists have a five-fold error rate in accurately assessing the length of a person’s life.¹¹ This is a highly complex task, with many biological, psychological and social factors influencing what the final outcome is.¹² The experience of the psycho-oncologist in understanding the science of prognostication is vital, and becomes one straightforward explanation for why the general psychiatrist, GP, general psychologist or even medical social worker is less able to help the patient with advanced cancer or terminal illness. Many of these clinicians have not been appropriately trained and equipped to understand and recognise when other clinicians may have erred or the patient and family have misunderstood what the prognosis may ultimately prove to be. Unfortunately, this is a reality of modern and highly specialized cancer care. Considerable experience in understanding prognosis allows the psycho-oncologist to recognise when a patient has misunderstood what their oncologist intended and correct this misunderstanding. Correction of misunderstanding restores hope and helps the patient re-focus on living out their life, instead of becoming overwhelmed by grief and losing direction. Many consultations with properly trained psycho-oncologists have this element to the patient assessment, whether the malignancy involves early stage or advanced disease. The complexity of cancer care is one very important reason for why psycho-oncology has needed to develop as a specialty of its own.

Are there challenges for legislators interested in introducing physician-assisted suicide or euthanasia to benefit those wanting autonomous choice

¹¹ Christakis NA. Death Foretold. Univ Chicago Press, 1999
over when and how they die that derive from the insights of psycho-oncology?

19. From what has been covered thus far in this submission, it should have become clear that my motivation in making this submission is about enhancing the quality of care that we deliver as a community in caring for patients and their families with cancer and other progressive, life-threatening diseases, including during end-of-life care. **We have much to still achieve to realize an optimal standard of care provision.**

20. It is conceivable that many who advocate for physician-assisted have witnessed poor quality care to loved ones in their past. Others have limited insight into what psycho-oncology can do, rarely refer if they are clinicians, and out of pity for those perceived to be suffering, want to be able to hasten death via physician-assisted suicide. In my experience, which is informed by extensive international work, clinicians who prescribe barbiturates to their patients to hasten their dying lack skills in restoring hope and improving quality of life in patients facing the end of their life. They focus on the provision of medication to hasten death, should the patient seek this.

I don’t perceive that that the fundamental clinical stances of 1) supporting quality of life and optimal palliative care, and 2) supporting euthanasia are compatible. As a result, the medical community divides and two different standards of care emerge – one that promotes hope, the dignity of the person and affirms living until natural death intervenes, and the second that is neutral about the value of a person, allows them to suicide if they wish, and sees managed death as the solution to many complex and challenging medical problems. Do legislators who advocate for euthanasia understand this dichotomy? Do they consider the potential for a poorer standard of medical care for many, resultant from the wishes of some? Ethicists recognize this as a principle of justice, and legislators have to chose whose needs in this regard are greater.
21. Are legislators concerned for the disabled, those incapacitated, those who might be pressured by a medical community that embraces physician-assisted suicide? Are they concerned about cases of involuntary euthanasia seen in other societies that legalize this practice? Are legislators confident that they can design suitable medical and psychiatric safeguards to protect the vulnerable who become suicidal and suffer mental illness through the bylaws and gate-keeping mechanisms built into such legislation. These are some of the many very difficult issues that government must determine.

I had the opportunity to study the patients that Philip Nitschke cared for in Darwin when euthanasia was legal in Australia. We published together the clinical accounts of these patients in the Lancet in 1998. The legislative gate keeping mechanisms established by the Rights of the Terminally Ill (ROTI) legislation failed to protect the vulnerable. Poor medical care was evident, with inadequate pain control, non-use of radiation therapy, inadequate treatment of depression and suicidal thinking in patients; in short, the abysmal use of palliative care. The experience of observing the poor quality of care delivered during this period of the ROTI legislation convinced me of the legislative challenges of protecting the vulnerable while trying to meet the needs of those desiring voluntary euthanasia.

I for one, across my 40+ years of my medical career, have seen too many mistakes made to hold any confidence that such bylaws can truly protect the vulnerable that governments ought to protect. I also believe that the introduction of legislation for physician-assisted suicide will inadvertently lower the quality of mental health care that we deliver within our society.

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Conclusion

22. To conclude this submission, I return to the vital need for palliative care and the related discipline of psycho-oncology to grow to improve the care that our society delivers at the end-of-life. Moreover, the standard of care is established well before that terminal phase is reached, and it is folly to artificially split such care up into chronic / advanced disease and end-of-life. Continuity of care is a vital principle for patients and their families, and many of the strategies used in patients with early stage and curable cancers also apply to those with progressive disease. Increasingly we salvage people who experience recurrence of their cancer. We also need to strive to salvage those who, for a time, lose hope about life. There is much that can be done to help those afflicted in this way, and my goal is to advance this standard of care and help our profession to ever improve on the quality of the care we deliver.

Psycho-oncology is the specialty that is comprised of multi-disciplinary care delivered by psychiatrists, psychologists and social workers, among others, and is a vital and essential dimension of comprehensive palliative care. Psycho-oncology is lacking from many oncology programs in our Victorian community. Its development is a crucial and urgent need to improve the quality of care that we deliver to patient with cancer and their families, including but not limited to care at the end of life. In this submission, I advocate for the development of psycho-oncology in Victoria.

Recommendations

That a Taskforce be established by the Department of Health and Human Services, comprised of appropriate experts, and commissioned to examine the unmet psychosocial needs of patients receiving oncology and palliative care
services and to advise on the appropriate psycho-oncology workforce to adequately address these unmet needs.

That the Government ensures that appropriate new funding is established to adequately staff psycho-oncology programs equitably across our state and to establish educational units to urgently teach psycho-oncology and lift its workforce across the coming decade.