31 August 2015

Legal & Social Issues Committee Parliament House
Spring Street,
Melbourne VIC. 3002
Email: lsic@parliament.vic.gov.au

Submission: Inquiry into End of Life Choices

Thank you for the opportunity to make a submission to the Inquiry into End of Life Choices.

Cancer Council Victoria (CCV) is a non-profit cancer charity organisation involved in cancer research, patient support, cancer prevention and advocacy. The state-wide Cancer Information and Support Service at CCV has provided support and evidence-based information to those affected by cancer, their families and friends for 25 years.

End of life choices are complex, and present a wide range of legal, health and practical considerations for patients, their family and caregivers, and health professionals. As such, CCV supports the broad terms of reference of the Inquiry.

We recognise that there is already a range of laws in Victoria that allow and support people to make informed decisions regarding their own end of life care and choices. Our submission discusses improvements required to clarify the law (to improve understanding and application) and to strengthen protection of patients’ choices.

We welcome the opportunity to contribute to the Inquiry into End of Life Choices. If you have any questions about this submission or would like to discuss this issue further please do not hesitate to contact Dr Deborah Lawson, legal policy advisor, McCabe Centre for Law and Cancer, Cancer Council Victoria on [redacted] or email [redacted].

Yours sincerely,

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Chief Executive Officer
Cancer Council Victoria
Cancer Council Victoria Submission

to Legal and Social Issues Committee, Parliament of Victoria

Inquiry into end of life choices

Cancer Council Victoria (CCV) thanks the Standing Committee on Legal and Social Issues for the opportunity to provide a submission to the Inquiry into End of Life Choices.

End of life choices are complex, and present a wide range of legal, health and practical considerations for patients, their family and caregivers, and health professionals. As such, CCV supports the broad terms of reference of the Inquiry.

There is already a range of laws in Victoria that allow and support people to make informed decisions regarding their own end of life choices. These are discussed in our submission with an emphasis on improvements required to clarify the law (to improve understanding and application) and to strengthen protection of patients’ choices.

Scope of this submission

This submission focuses on issues associated with the end of life choices for persons with cancer. In particular, the submission discusses:

a) the existing legal framework for assisting decision-making at the end of life (including medical practitioner and community understanding of the law relating to end of life choices); and

b) current palliative care practice in Victoria, in the context of the influential role of palliative care at the end of life for many Victorians with cancer.

The submission concludes with recommendations regarding legislative and policy changes to better meet the needs of people affected by cancer in exercising their choices regarding the end of life and palliative care.

Voluntary assisted dying

We acknowledge that voluntary assisted dying or ‘dying with dignity’ falls within the Committee’s terms of reference. While outside the scope of this submission, CCV supports a discussion relating to voluntary assisted dying that is informed by empirical evidence and the learning from other jurisdictions where there is voluntary assisted dying legislation.

End of life care for Victorians with cancer

Many Victorians with cancer are faced with the prospect of making decisions in respect of their end of life care. Understandably, this is a very challenging time, and cancer patients frequently require the support of a range of networks including carers, family,
friends and health professionals in order to enable them to make informed decisions about their end of life care and their death.

In 2013, 11,009 Victorians died of cancer and nearly 30,000 were diagnosed with the disease\(^1\). Cancer accounts for approximately one-third of deaths in Victoria\(^2\). It is estimated that by 2024-2028, deaths from cancer will increase to over 14,000 per year largely due to the growth and ageing of the Victorian population\(^3\).

As such, the issues faced by persons affected by cancer and health professionals working in the field provide an important context for a discussion about the legal and policy framework relating to end of life choices.

**Current law relating to end of life choices**

*Advance care planning*

Advance care planning is the process by which a person considers, discusses and documents their future healthcare and medical treatment wishes (including end-of-life choices), usually with their loved ones and health professionals, in preparation for when they may not be able to make or communicate decisions.

The law facilitates advance care planning in two ways, through:

a) **Advance care directives**: which document decisions about the medical care a patient would or would not want in the future, if they become unable to make their own decisions. While directives usually record decisions about refusing life-sustaining treatments, they are not restricted to end of life decision-making\(^4\).

b) **Substitute decision-making**: which provides the means for a substitute to make decisions in relation to healthcare and other matters when a person is no longer competent to make their own decisions; and

Ideally the development of advance care directives and the appointment of substitute decision-makers occur together, through exploration and discussion of values and desired outcomes, between the person concerned, their loved ones and relevant health professionals\(^5\). As well as being a beneficial process generally, this increases the likelihood that patients’ recorded wishes will be understood and adhered to\(^6\).

In Australia, laws relating to advance care planning can differ greatly between states and territories, which can lead to confusion and different outcomes for patients.

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\(^2\) Ibid.

\(^3\) Ibid.


\(^6\) Ibid.
depending on which jurisdiction they are in\textsuperscript{7}. In particular, the legal regulation of advance care directives differs from state to state; the variability in name, form, scope and legislative prescription of advance care directives across Australia makes it difficult for jurisdictions to recognise directives made in other states and territories. Further, the legal framework for substitute decision-making differs significantly from state to state.

Advance care planning and end of life decision-making can be confusing processes, even within Victoria alone, due to the range of possible substitute decision-makers (with varying levels of authority) \textsuperscript{8} as well as the unclear legal status of advance care directives at common law\textsuperscript{9}.

**Advance care directives in Victoria**

**Refusal of Treatment certificates**

The *Medical Treatment Act 1988* (Vic) (‘MTA 1988’) provides a statutory right for a patient or their agent to make a Refusal of Treatment certificate in respect of medical treatment generally or treatment of a particular kind, for a current condition only (sections 5 and 5A). Similar legislation in other Australian jurisdictions provides for advance refusal and consent to medical treatment and allows directions about treatment for future conditions, and not just a current condition\textsuperscript{10}.

Anecdotally, CCV is aware that there is very low completion of Refusal of Treatment certificates under the *MTA 1988*, even among palliative care patients who have ‘current conditions’ in respect of which they could complete a certificate to refuse life-sustaining treatment. In a submission to the Victorian Law Reform Commission’s (‘the VLRC’) *Guardianship Information Paper*, the Office of the Public Advocate expressed its suspicion ‘that many Refusal of Treatment certificates lodged at VCAT are incomplete or inappropriately completed (by, for instance, containing references to conditions that are not current)’\textsuperscript{11}.

**Broader advance care directives**

Section 4 of the *MTA 1988* states that the Act does not affect any right of a person under any other law to refuse medical treatment. However, it is not clear whether a broader common law advance care directive (for example a directive that encompassed treatments a person would or would not want in respect of potential future conditions or circumstances) would be recognised in Victoria because the courts have not yet had the opportunity to confirm their approach in the context of Victoria’s statutory scheme.

Advance care directives have been recognised at common law in NSW, where the Supreme Court confirmed that ‘[i]f an advance care directive is made by a capable adult, and is clear and unambiguous, and extends to the situation at hand, it must be

\textsuperscript{7} Stewart, C. (2011)
\textsuperscript{9} Ibid.
\textsuperscript{10} *Powers of Attorney Act 1998* (Qld) s35 and *Guardianship and Administration Act 1990* (WA) ss 110P–110R.
respected’ and that ‘[i]t would be a battery to administer medical treatment to the person of a kind prohibited by the advance care directive’\textsuperscript{12}.

The current uncertainty in Victoria can leave carers and health professionals in difficult circumstances when a patient who lacks capacity has made an advance care directive other than the statutory Refusal of Treatment certificate. As noted by the VLRC in its Guardianship report:

\begin{quote}
[t]he ability of a guardian or other substitute decision-maker, to provide legally effective consent to medical treatment that is contrary to the wishes expressed by a person in a common law advance directive is unclear. ... there have not been any cases concerning the relationship between common law advance directives about medical treatment and a statutory substitute decision-making regime such as that created by the G&A Act. Consequently, it is unclear whether a common law advance directive is binding on a substitute decision maker or is merely one of the matters that must be taken account in determining the best interests of the patient. ... If common law advance directives are not legally binding then a substitute decision maker under the G&A Act would only need to consider it as part of the best interests evaluation which requires the person responsible to take a number of factors into account including ‘the wishes of the patient, so far as they can be ascertained’ (s38(1)(a))\textsuperscript{13}.
\end{quote}

**Substitute decision-makers in Victoria**

There is a wide range of possible substitute decision-makers in Victoria who may be appointed to make decisions on behalf of people who have lost capacity to communicate or make their own decisions.

Some substitute decision-makers (those appointed as medical powers of attorney or plenary guardians) have the authority to refuse medical treatment on behalf of a patient, while others (persons responsible who are not plenary guardians and do not hold medical power of attorney) can only provide consent – or withhold consent - to treatment. This complexity is aptly described by Willmott et al. in the following way:

\begin{quote}
The provision of treatment requires consent or some other authorisation. Accordingly, the withholding of consent by a person responsible is capable of preventing that treatment being instituted. ... However, once consent or authorisation is obtained and treatment instituted, further consent or authorisation may not be required. In this case, a person responsible who does not wish for treatment to continue will not be in a position to prevent that treatment continuing if there is already in place lawful justification for treating. To require that treatment be withdrawn, it would be necessary to have a power to refuse treatment and require that it be stopped. Accordingly, a medical professional will need to be aware of how a power to withhold consent may operate differently where treatment is being withdrawn as opposed to
\end{quote}


Carers, guardians, people with powers of attorney and health professionals need to be aware of the authority that each substitute decision-maker has, in order to ensure that treatment decisions are made with lawful and appropriate consents or refusals.

Another complexity in the Victorian scheme for refusing life-sustaining treatment is that the *MTA 1988* excludes palliative care from the definition of ‘medical treatment’ for the purposes of the Act. Palliative care is defined in the *MTA 1988* as the provision of reasonable medical procedures for the relief of pain, suffering and discomfort or the reasonable provision of food and water. The exclusion has the effect that agents cannot refuse food or water on behalf of a patient. Notably however, the Supreme Court of Victoria has ruled that artificial feeding does not fall within the definition of palliative care, and constitutes medical treatment that can be refused under the Act\(^\text{15}\).

Uncertainty about who has the power to make which decisions in respect of a patient who lacks capacity can result in delay when life and death decisions need to be made and additional distress and anguish for carers and health professionals at what is often an already distressing time. The right to refuse treatment – including feeding – needs to be more clearly defined in Victoria, particularly in respect of patients who are not competent to make decisions for themselves.

**Medical practitioner understanding of the law relating to end of life choices**

A recent survey of specialists in Queensland, NSW and Victoria from all fields relevant to end of life decision-making is instructive in gaining a sense of the level of engagement and understanding of medical professionals of the legal framework relevant to end of life decisions\(^\text{16}\).

Importantly, the results of the survey suggested that while doctors recognise the general importance of the law governing the end of life, ‘they do not see it as an overriding factor for decision making, with half the participants considering that the law can lead to inappropriate treatment decisions, and almost two thirds seeing medical and family consensus as more important than law’\(^\text{17}\).

Additionally, and perhaps contributing to this sentiment, the survey found ‘critical gaps and differences in knowledge across specialties’ and that ‘even those with high knowledge levels are twice as likely to agree as to disagree that the law is too complex’\(^\text{18}\). The complexity of the legislative framework governing end of life decision making as a barrier to understanding and knowledge was observed previously by some of the authors of the survey and its report\(^\text{19}\).

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\(^{15}\) *Gardner; re BWV* [2003] VSC 173.


\(^{17}\) Ibid, 638.

\(^{18}\) Ibid.

Suggestions have also been made that, in addition to legal complexity, there are two broad sources of confusion in respect of medical practitioners’ understanding of the law relating to end of life decisions. The first is that the distinction in Victoria between withholding consent and refusing treatment is a ‘long standing and entrenched source of confusion and leads to a number of undesirable outcomes’\(^\text{20}\). The Office of the Public Advocate has previously noted that ‘even skilled practitioners are unable to distinguish withholding consent to treatment and refusing treatment’\(^\text{21}\). The second is that substitute decision-making about healthcare sits ‘awkwardly’ across two statutes – the MTA 1988 (Vic) and the Guardianship and Administration Act 1986 (Vic)\(^\text{22}\).

As such, it is argued that ‘the current state of the law is no doubt a barrier for doctors seeking to know it’\(^\text{23}\). This is seen as a serious shortcoming, given the role of medical professionals in end of life decision-making. The authors argue that ‘better knowledge of the law should increase respect for patient autonomy, through complying with advance directives and seeking consent from authorised substitute decision makers’\(^\text{24}\).

**Community understanding of the law relating to end of life choices**

There is limited evidence of the level of community understanding of the law relating to end of life choices. In 2012 Cancer Council Victoria’s McCabe Centre for Law and Cancer consulted with key stakeholders, including people affected by cancer and their carers’, in relation to community and health professional understanding of the legal framework governing decision-making at the end-of-life. Many patients and carers indicated that they needed more information and education about rights and responsibilities of decision-makers at the end-of-life. Of concern was that many had not heard of advance care planning prior to the consultation\(^\text{25}\).

Patients report a desire to be more involved in decision-making\(^\text{26}\) and a number of government inquiries have identified the need for the community to be better informed about law relating to the end of life and guardianship\(^\text{27}\). To this end, CCV is currently partnering with the Queensland University of Technology, the University of Queensland, Cancer Council New South Wales and Cancer Council Queensland on an Australian Research Council linkage grant (LP140100883) on *Enhancing Community*...

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\(^{20}\) Ibid 790.


\(^{22}\) Willmott et al. (2011).

\(^{23}\) Parker, M. et al. (2015), at 638.

\(^{24}\) Ibid, 639.


Understanding and Engagement with Law at the End of Life. Supporting patients and their substitute decision-makers to understand and assert their legal rights and comply with their legal duties will enable better participation in end of life care decisions and help avoid known adverse outcomes at the end of life such as unwanted burdensome treatment or dying in pain.\(^{28}\)

**Palliative care in Victoria**

**Palliative care policy and practice**

We believe that an assessment of palliative care practice is a necessary part of a comprehensive discussion of end of life choices in Victoria. Palliative care is one of the choices frequently provided to persons facing end of life choices and can also influence the circumstances in which other end of life choices are made.

**What is palliative care?**

Palliative care is coordinated care that is provided by a multidisciplinary team of specialist doctors, nurses, allied health, social workers, spiritual care workers and volunteers. It provides support for persons with a terminal illness and works to maintain quality of life in a way that is meaningful to the individual. This is achieved “through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”\(^{29}\). Palliative care also provides support to families and carers.

Persons affected by cancer comprise the majority of palliative care patients in Australia.\(^{30}\)

**Palliative care and cancer**

Cancer patients have a range of options available to them regarding their medical care towards the end of life. These options are dependent on the prevailing circumstances and can include treatment to reduce or maintain tumour size (such as chemotherapy or radiation therapy) delivered by a treating physician (such as a medical oncologist) with support from a multi-disciplinary team. These services are provided in either an inpatient or outpatient hospital setting, depending on the circumstances of the patient.

Palliative care for the management and relief of pain and suffering remains the primary medical practice adopted for end of life care and may be provided alongside chemotherapy or radiation therapy if required. Palliative care can be received via public or private inpatient palliative care, community palliative care, consultant palliative care, day hospices, or state-wide palliative care services. These services are


\(^{29}\) WHO *Definition of Palliative Care*, [http://www.who.int/cancer/palliative/definition/en/](http://www.who.int/cancer/palliative/definition/en/)

often provided concurrently, such as inpatient care to stabilise symptoms with support from community palliative care to ensure optimal transition back home\textsuperscript{31}.

Care in these instances is primarily overseen by a palliative care physician with a dedicated and expert support team including palliative care nurse practitioners, nurses, general practitioners, allied health, social workers and personal and spiritual care support.

In some instances, the care for the relief of pain and suffering for a terminally ill cancer patient may be provided by the treating cancer physician who may or may not have undertaken training in palliative medicine.

Due to the multidisciplinary nature of cancer care, cancer patients will interact with a range of health professionals throughout their cancer experience. In order to achieve end of life care that comprehensively addresses the needs of terminal cancer patients, it is important for the patient’s multidisciplinary treating team to recognise the important role of palliative care and support the earlier integration of palliative care into the person’s care team. This recommendation is supported by cancer clinical guidelines, such as the Optimal Care Pathways.\textsuperscript{32} The Optimal Care Pathways promote early referral to palliative care services, acknowledging that palliative care can improve quality of life and in some instances prolong life.

Yet barriers exist to the early integration of palliative care for cancer patients. Barriers are identified at the patient, clinician and service levels, some of which intersect.

**Barriers to early integration of palliative care**

**Barriers for patients and families**

Barriers to early integration of palliative care at the patient level include: limited understanding of the care and treatment options available; feeling a sense of “giving up” if referral to palliative care services is accepted; patient and/or family preferences to maintain curative treatment; and denial of disease state leading to a refusal of referral\textsuperscript{33}. For families and carers the fear of losing a loved one may also mean referral to palliative care is not considered.

**Barriers for clinicians**

Australian research suggests that cancer clinicians support early integration of palliative care and consider that patients may benefit from palliative care services whilst still receiving active treatment\textsuperscript{34}. However, there are discrepancies between attitudes and practice in respect of early referral to palliative care. In one study of palliative care referral practices, 71% of cancer clinician respondents agreed that early referral is


beneficial and 92% agreed that a patient might benefit from palliative care whilst still receiving cancer therapy; however, just one-quarter of respondents referred more than 80% of their patients with advanced cancer to palliative care. The literature suggests a number of common reasons for the reticence in making referrals to palliative care, including: cancer clinicians’ perceptions of their own ability to manage patient symptoms; a sense that referring to palliative care is ‘abandoning’ the patient; lack of awareness about palliative care practice; lack of skills, training and experience to recognise when to refer to palliative care; uncertain patient prognosis; difficulty in discussing end of life care with a patient and family; lack of palliative care services to which to refer patients; and the absence of physical symptoms in the patient.

Patient and clinician barriers are inextricably linked. For example, if clinicians were more confident in starting discussions with their patients about end of life care, many patients would be provided the opportunity to better understand their end of life care choices.

Service level barriers

In early 2015 CCV consulted with more than 170 cancer clinicians on priorities for the next Victorian Cancer Action Plan. Barriers to early integration of palliative care were discussed as part of these consultations. Barriers at the service level were those most frequently identified by the clinicians consulted.

A key service level barrier identified was insufficient community and consultant palliative care services to meet demand, resulting in patients and families not receiving adequate palliative care upon discharge from hospital. Regional and rural patients are particularly vulnerable to receiving inadequate palliative care due to a lack of services. Clinicians called for the expansion of a 24-hour, seven-day a week consulting service, and saw particular value in having consultants’ positions in acute hospitals to support better integration of palliative care, particularly through attendance at oncology outpatient clinics and at tumour stream multi-disciplinary meetings.

The demand for palliative care in Victoria is expected to grow by at least 4.6% each year. As mentioned above, between 2024-2028, deaths from cancer are projected to increase to over 14,000 per year, which will increase the demand for palliative services.

The care pathway of cancer patients can be complex, as patients and their families interact with various clinicians and support services, including palliative care. Inadequate integration of these services can result in delays in access and fragmentation in continuity of care.

Cancer clinicians’ views on enhancing palliative care in Victoria

Through CCV’s 2015 consultations with cancer clinicians on priorities for the Victorian Cancer Action Plan, the following priorities for improved access to palliative care were identified:

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35 Ibid.
36 Ibid.
37 Love and Liversage (2014).
38 Department of Health, Victorian Integrated non-admitted Health Minimum Data Set (VINAH), 2010/11.
Building community capacity to integrate palliative care services earlier in patient care

Building community capacity to integrate palliative care services earlier in patient care requires effective approaches to service delivery and workforce capacity that build upon and support specialist care. In addition to identifying opportunities for the Palliative Care Consortia to build sector capacity, suggestions include better utilisation of nurse practitioners, strengthening support for General Practitioners, particularly in regional areas, and making better use of volunteers.

It is important that Victorians have access to palliative care services in a timely and appropriate manner to support informed decision making regarding end of life care. In this way, effective palliative care will work to improve and support the circumstances in which end of life choices are made and implemented.

Improved access to palliative care services

Expansion of palliative care consultancy services would improve patient quality of life and end of life care, increasing the likelihood that more people will die in their place of choice and fewer people present to emergency departments at the end of life. Ideally, this would include access to 24-hour, seven days per week consulting services and improved community-based liaison services. Gaps in community palliative care services hamper the ability of inpatient palliative care services to facilitate complex care discharges to home, and also to implement the safe and timely transfer of patients to home with handover to community services. Clinicians also identified that community palliative care services are not able to meet current demands due to a lack of beds. This is compounded by a lack of consultants and training registrars with available hours to work in the community, with general practitioners, and with patients in their homes.

The use of new and emerging technologies such as telemedicine might overcome some of the barriers to access to palliative care for regional and rural patients. Use of these technologies to provide bedside palliative care consultations are currently being piloted in Victoria.

Advance care planning

Advance care planning is an important tool to support patients, families and health professionals in decision-making relating to end of life care; it has the potential to reduce anxiety and to improve quality of life and care at the end of life. Ideally, advance care planning occurs before a referral to palliative care.

The clinicians consulted identified ongoing integration of advance care planning into standard medical care as integral to supporting end of life care for cancer patients. Clinicians supported the Victorian Government’s advance care planning strategy and acknowledged that there is still considerable effort required to achieve integration. Uptake of advance care planning varies across Victorian health services and uptake

40 Ibid.
within community palliative care services has remained constant at 50% since 2012\(^{41}\). Recent research by Monash University and the Alfred Hospital revealed that for 64 per cent of patient charts reviewed in metropolitan health services the first record of end-of-life conversations occurred in the last 24 hours of life\(^{42}\).

**Palliative care research and identifying gaps**

Greater investment in palliative care research is required as part of a Victorian cancer research strategy, including development of monitoring mechanisms in palliative care services to report performance data. There is evidence to suggest that particular cohorts have unmet palliative care needs that need to be addressed including Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities and low socio economic groups.

**Recommendations**

Cancer Council Victoria makes the following recommendations:

**Advance care planning: recommendations for legislative reform**

1. That the Refusal of Treatment certificate scheme be replaced with broader statutory advance care directives (in prescribed form) that can be made in respect of future as well as current conditions and provide for advance consent in addition to advance refusal. This recommendation aligns with the recommendations of the Victorian Law Reform Commission’s (VLRC’s) 2011 *Final Report on Victoria’s guardianship legislation*\(^{43}\).

2. That legislation governing advance care directives should also clarify the relationship between substitute decision-makers and advance care directives. In this respect, CCV supports the VLRC recommendation that the legislation provide people with the following advance care planning options:

   a. Appointing an enduring personal guardian without instructions or conditions in relation to how they exercise their authority; or
   b. Appointing an enduring personal guardian with an advance care directive (‘instructional directive’) that includes limitations, conditions or instructions about the exercise of their authority; or
   c. Making a standalone advance care directive (‘instructional directive’)\(^{44}\).

   An advance care directive (‘instructional directive’) should be able to provide binding instructions or advisory instructions about health matters.\(^{45}\)

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\(^{42}\) Ibid, p 29.


\(^{44}\) Ibid.

\(^{45}\) Ibid, 221.
3. That Victoria’s legislative framework governing guardianship and medical treatment is simplified into one primary Act in order to simplify the legislative framework and engender greater understanding amongst health practitioners and their patients as to the parameters within which treatment may be administered or withheld.

4. That the right to refuse treatment – including feeding - be more clearly defined in Victorian legislation, particularly in respect of patients who are not competent to make decisions for themselves. Legislative reform in this manner will work to alleviate uncertainty about who has the power to make which decisions in respect of a patient when they lack capacity.

Advance care planning: recommendations for practice

5. That the Victorian Government continues to invest in better integration of advance care planning into health services to maximise patient participation in end of life care choices. Building the capacity of the health sector to better integrate advance care planning into medical (including cancer) care requires leadership from all levels of the health service system, as well as state-wide organisations that have a role in palliative care, including not-for-profits, and the Victorian Government.

6. Continuation of the Advance care planning strategy multi-level approach to strengthen the knowledge and capacity of the community, health professionals, and administrators to understand the importance of advance planning and to integrate advance care planning into standard practice.

7. That the Victorian Government considers establishing a voluntary register of advance care directives and substitute decision-makers that can be easily accessed by health professionals, and which would be particularly useful in emergency situations. This is consistent with recommendations made by the VLRC and in other stakeholder consultations.

8. Investment in targeted and tailored education programs for people affected by cancer, their carers, substitute decision-makers and health professionals on advance care planning options and the legal frameworks, including:
   a. Support for patients, carers and substitute decision-makers to know the resources and tools available to them to make informed decisions regarding end of life care and understand how their choices can be protected;
   b. Support for health professionals to know the legal status of existing tools and resources available to them to support a person’s decision making regarding their end of life care.

Palliative care: recommendations for practice

1. Earlier integration of palliative care
a. Increased support for treating clinicians and team to identify when a referral to palliative care will be beneficial, and to refer to palliative care;
b. Increased support and education for patients and carers to understand the role of palliative care as part of comprehensive care;

2. Greater investment by Government in palliative care services in Victoria, with a particular focus on increased resourcing for community palliative care services.

3. Expansion of a 24-hour, seven-day a week palliative care consulting service to enable better support in acute hospitals, community settings and regional areas.