1. Do not delay discussion of and referral to palliative care for a patient with serious illness just because they are pursuing disease-directed treatment.

Palliative care provides an added layer of support to patients with life-limiting disease and their families. Symptomatic patients can benefit regardless of their diagnosis, prognosis or disease treatment regimen. Studies show that integrating palliative care with disease-modifying therapies improves pain and symptom control, as well as patient quality of life and family satisfaction. Early access to palliative care has been shown to reduce aggressive therapies at the end of life, prolong life in certain patient populations, and significantly reduce hospital costs.

Supporting Evidence

2. Do not delay conversations around prognosis, wishes, values and end of life planning (including advance care planning) in patients with advanced disease

Advance care planning is a process, which includes choosing a surrogate or alternate decision-maker and communicating values or wishes for medical care. Evidence shows that advance care planning conversations improve patient and family satisfaction with care and concordance between patients’ and families’ wishes, reduce the likelihood of patients receiving hospital care and the number of days spent in hospital, and increase the likelihood of receiving hospice care.

Supporting Evidence
3. Do not use oxygen therapy to treat non-hypoxic dyspnoea in the absence of anxiety or routinely use oxygen therapy at the end of life

Oxygen is frequently used to relieve shortness of breath in patients with advanced illness. However, supplemental oxygen does not benefit patients who are breathless but not hypoxic. Supplemental flow of air is equally as effective as oxygen under these circumstances. The use of a fan for facial air streaming can also be effective.

Supporting Evidence


4. Do not use percutaneous feeding tubes in patients with advanced dementia; instead use oral assisted feeding

Strong evidence exists that artificial nutrition does not prolong life or improve quality of life in patients with advanced dementia. Substantial functional decline and recurrent or progressive medical illnesses may indicate that a patient who is not eating is unlikely to obtain any significant or long-term benefit from artificial nutrition. Feeding tubes are often placed after hospitalization, frequently with concerns for aspirations, and for those who are not eating. Contrary to what many people think, tube feeding does not ensure the patient’s comfort or reduce suffering; it may cause fluid overload, diarrhoea, abdominal pain, local complications, less human interaction and may increase the risk of aspiration. Assistance with oral feeding is an evidence-based approach to provide nutrition for patients with advanced dementia and feeding problems.

Supporting evidence

5. To avoid adverse medication interactions and adverse drug events in cases of polypharmacy, do not prescribe medication without conducting a drug regime review

Older patients disproportionately use more prescription and non-prescription drugs than other populations. Evidence shows that such polypharmacy increases the risk of adverse drug reactions and hospital admissions. Medication review with follow up is therefore recommended for optimising prescribed medication and improving quality of life in older adults with polypharmacy.

Supporting evidence


How was this list created?

Fellows from the Australian and New Zealand Society of Palliative Medicine and Australasian Chapter of Palliative Medicine (ANZSPM/AChPM) convened a working group to produce an EVOLVE list for palliative medicine. The Royal Australasian College of Physicians (RACP) assisted this working group in compiling a list of 15 clinical practices in palliative medicine which may be overused, inappropriate or of limited effectiveness in a given clinical context based on a desktop review of similar work done overseas. This list was then sent out to all ANZSPM and AChPM members, seeking feedback on whether the items fully captured the concerns of clinicians in an Australasian palliative medicine context and if not, whether any items should be omitted and/or new items added. 40 responses to this email were received. Based on these, 3 items were removed leaving a shortlist of 12. An online survey was then sent to all ANZSPM and AChPM members asking respondents to rate each item against three criteria from 1 (lowest) to 5 (highest), and to nominate any additional practices worthy of consideration. The criteria used to rate the practices were strength of evidence, significance in palliative care and whether palliative care physicians could make a difference in influencing the incidence of the practice in question. Based on the 114 responses to this survey, the top 5 were selected.