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A recent review of end-of-life care recommended phasing out the Liverpool Care Pathway despite finding that, when properly used, it is a model of good practice

An ethical defence of the Liverpool Care Pathway

In this article...

- Why the LCP was the subject of an independent review
- What the review recommended
- Why the LCP may still be appropriate for use

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Abstract Wrigley A (2014) An ethical defence of the Liverpool Care Pathway. *Nursing Times;* 110: 40, 20-21.
Palliative care in the UK has been ranked as the best in the world. However, the Liverpool Care Pathway was criticised and phased out. This article looks at the LCP's aims, assesses the problems and how these should be tackled. Many of these problems stemmed not from the LCP itself, but its improper use. Better training on the pathway and on communication with patients and relatives could ensure it is used correctly.

The Liverpool Care Pathway for the Dying Patient (LCP) received a great deal of media interest recently and was the subject of the independent Neuberger Review (NR) (Neuberger, 2013). In a recent paper (Wrigley, 2014), I argued that the review's recommendation that the LCP be phased out was too extreme. My reasons were based around responses to concerns raised in the NR, all of which had a common theme – there were no compelling reasons to abandon what was and remains one of the best examples of palliative care practice in the world. Understandably, the palliative care community has raised concerns at losing this key piece of practice guidance.

The criticisms raised in the NR are based on reports of poor patient care, which cannot be ignored. My criticisms are not that the NR highlighted poor practice but that it made some poor inferences from this evidence base; these are out of step with the incidents' causes and led to unwarranted conclusions that the LCP itself was at fault. The concerns raised by the NR are based largely on misconceptions about or improper implementation of the pathway.

The aim of the LCP

Many concerns about end-of-life care outlined in the NR arose from misconceptions about the LCP. The pathway was developed out of a desire to transfer best practice in care of the dying from specialist hospices to general hospitals. There is widespread agreement that before the LCP, poor care and suffering were the norm for patients dying in hospitals (Mills et al, 1994). The central role of the LCP is to:

- Highlight areas of importance;
- Provide general advice on approaches to care delivery;
- Offer guidance on the expected outcome of using these approaches.

Understanding this is crucial if the LCP is to be used correctly. It is a framework, not a prescriptive set of rules; it is intended to support health professionals rather than be a substitute for clinical judgement or ethical decision making.

As a framework, the LCP allows care to be tailored to individual needs, which is exactly what the NR calls for with individual patient plans. These needs are:

- Physical;
- Psychological;
- Social;
- Spiritual.

In other words, the LCP is designed to help people achieve a "good death".

Improper use of the LCP

The goals of care are expressed in the LCP as desired outcomes for patients and their relatives/carers, not processes to be

5 key points

1. The UK has been recognised as offering some of the best palliative care in the world
2. The Liverpool Care Pathway is a framework for good practice, not a prescriptive set of rules for every patient
3. Adequate training is essential to ensure the LCP is used as it was intended
4. It is vital that practitioners communicate the reasons for their actions with a patient's family and carers
5. The five Priorities for Care and the LCP can be implemented together and, if done so correctly, can result in excellent care

Neuberger review: examined LCP use

BOX 1. FIVE PRIORITIES FOR CARE

When it is thought that a person may die within the next few days or hours:

- This possibility is recognised and communicated clearly, decisions are made and actions taken in accordance with the person's needs and wishes; these are reviewed and revised regularly
- Sensitive communication takes place between staff, the dying person and those identified as important to them
- The dying person and those identified as important to them are involved in decisions about treatment and care to the extent that the dying person wants
- The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible
- An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion

Source: Leadership Alliance for the Care of the Dying (2014)

applied; it does not provide tick boxes or a rigid set of guidelines that must be followed in every case. The use of the LCP must, therefore, be supplemented with an awareness of ethical decision making and good communication of these decisions (Thorns and Garrard, 2003).

Treating the pathway as a one-size-fits-all guide – failing to engage in good, ethical decision making, and not effectively communicating the combined clinical and ethical reasoning to colleagues, patients and their relatives – constitutes a failure to implement the LCP as it was intended. This view of the LCP is exactly what appears to be at the heart of concerns raised by the NR.

Specific issues

Specific complaints have been levelled against the LCP.

Hydration: One of the more disturbing complaints was that the LCP indicates that food and water should be denied to patients who are dying, irrespective of their desires, causing distress to them and their relatives. Hydration was seen as being particularly important because the refusal to provide parenteral or enteral hydration for those who can no longer take fluids by mouth has been seen as intentionally hastening death and leading to a painful death.

The LCP does not recommend a blanket refusal of hydration or not relieving thirst. However, it does not recommend always providing parenteral or enteral hydration – there are clinical reasons for withdrawing or not providing this, one of which is that it can exacerbate conditions caused by excess fluids.

It is natural to assume hydration is essential, so its withdrawal in favour of other forms of thirst control may seem counterintuitive. However, this highlights a failure of communication rather than a problem with the LCP. Such problems can arise because of a failure to follow guidance offered by the LCP on:

- Assessing hydration;
- Patient care and comfort;
- Communicating with families.

Medication: a major concern was that the LCP encouraged a deliberate hastening of death through the use of drugs such as morphine. Again, the role of morphine in pain relief was misunderstood. This concern was acute when families found relatives had been fitted with a syringe driver without having been warned. The LCP recommends relatives are involved in decisions to administer morphine and that it is vital to involve them when a syringe driver is to be fitted; again, it appears that staff ignored LCP guidance. The result was poor communication about a very sensitive issue.

Addressing the issues

The NR's recommendation that we prioritise improving end-of-life care is to be welcomed. If the aim is to provide high-quality care in patients' last days or hours and reassure them that they will receive this, better training and understanding, with continued research into end-of-life care, would be better than abandoning the LCP. The response to a problem is often to call for better training but here it is within a meaningful context. We have guidance on how to make good, ethical decisions and how to provide good end-of-life care but that guidance has not been taken up or followed correctly in some settings.

The UK has been ranked as having the world's best overall palliative care (The Economist, 2010). Even the NR acknowledges in its conclusion that:

> *"[I]n the right hands, the Liverpool Care Pathway can provide a model of good practice for the last days or hours of life for many patients... But it is clear that, in the wrong hands, the LCP has been used as an excuse for poor quality care"* (Neuberger, 2013).

To recommend on these grounds that the LCP is phased out makes little sense. One might say that morphine should be phased out as an analgesic because some people use it incorrectly. In accepting the review's call to phase out the LCP, we have lost a high-quality approach to care because it can be misapplied by those who have not been properly trained in its use.

Although there is no good ethical or clinical reason to abandon the LCP, its reputation has been damaged considerably. The negative impressions have been emphasised in the media; palliative care doctors have said "negative press regarding the LCP has caused additional distress for relatives at an already distressing time" (Chinthapalli, 2013). This suggests a name change might be sensible, but to abandon the most highly developed and successful approach to end-of-life care on the grounds that it has been misunderstood and misapplied is to the detriment of both patients and health professionals.

The Leadership Alliance for the Care of Dying People (2014) has said it is to replace the LCP with its five Priorities for Care (Box 1). Its main concern was that the LCP was associated with "standardised treatment and care carried out, irrespective of whether that was right for the particular person". The LACDP has not recommended a single set of support materials, preferring to allow organisations to "work it out for themselves". It therefore seems plausible that, providing they follow the Priorities for Care, using LCP guidance as intended would be largely consistent with providing high-quality end-of-life care. **NT**

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