An ethical defence of the Liverpool Care Pathway

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▷ Why the LCP was the subject of an independent review
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▷ Why the LCP may still be appropriate for use

The Liverpool Care Pathway (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 largely on 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
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.

**References**


Leadership Alliance for the Care of Dying People (2014) One Chance to Get it Right. tinyurl.com/LACDPOneChance


Wrigley A (2014) Ethics and end-of-life care: the Liverpool Care Pathway and the Neuberger Review. The Journal of Medical Ethics; advance online publication. doi:10.1136/medethics-2013-101780

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