

COMMENT

The Pseudo-Liverpool Care Pathway

Brian Livesley argues that the Liverpool Care Pathway is open to misuse, and that a different approach to palliative care is needed by healthcare professionals

My father-in-law was a frail but intellectually alert 97-year-old man. He had been married for 68 years and lived contentedly with his wife in a northern town. They had steadfastly refused to join us in the South and eventually moved into a residential home. Once there, however, they were both treated very well. They would walk, he with his Zimmer, to enjoy sitting together in the garden. Then came the day when he developed pyrexia and confusion due to a urinary tract infection and he went into hospital.

When I visited, his initial treatment included antibiotics and intravenous fluids and over a few days he improved. Unfortunately, the physiotherapist, who assessed him was not on-duty over the weekend or available afterwards. As a result, he was kept in bed and stayed there for the following Monday, Tuesday and then continually.

His legs naturally and rapidly developed a typical disuse weakness, and as a result he had difficulty standing at the bedside. He was not lifted to a commode or taken to the toilet but left to cope with a 'bottle' in bed. He became stressed by these restrictions and was catheterised. Despite the consultant refusing to see us, the registrar appeared helpful until we asked questions about his progress. Then, it became evident there were no plans—although his wife, the residential home's matron along with her staff, including the gardener, awaited his return.

When next I visited, the single-room at the entrance to the ward had its door open and a young female patient was lying exposed on the bed for all to see despite having been apparently affected by a stroke. The nurses and junior doctors appeared to be 'busy' behind the nearby nurses' station. There was, however, scarcely a second before a loud piercing scream cried for attention.

As I turned quickly into the main part of the ward I saw that my father-in-law's intravenous fluids had been stopped; his urinary catheter unexpectedly removed; and a prominent 'nil by mouth' notice had appeared at his bedside. His scream was due to the pain of attempting to pass concentrated and infected urine while he was left unattended. I went to speak to the ward sister, waited for her to open the conversation, and then asked about the plans for his care. After a few moments, I said if there was anything treatable it needed to be treated—if not, he wanted to go 'home'; a request the whole family would support. I was surprised when she said that we obviously wanted the best for him—but not as surprised as she appeared to be when I as quietly and simply answered her next question: 'But who, who are you?' I then pointed out that I was going to deliver a lecture (Livesley, 2009) in favour of correct palliative care which required some national attention (General Medical Council, 2010).

Fortunately, it did not take long for his bedside 'nil by mouth' notice to be replaced by intravenous fluids, a urinary catheter to be inserted, and then correction of other deficits to relieve his physical discomfort. I say 'fortunately' because the alternative for him was simply ensuring his prompt return to the residential home for more appropriate care and attention, while the hospital would have been reported to the police—because an indictment lies at common law for a breach of duty which is not a mere private injury but an outrage on the moral duties of society. For example, neglect to provide sufficient food, medical aid or other necessities, for a person unable to provide for himself, and for whom the defendant is obliged by duty or contract to provide, where such neglect injures the health of that person, whether the person injured is of extreme old age (*R. v. Instan*, 1893), or of tender years.

When he returned home, the causes of his recurring emotional and physical misery were correctly diagnosed, explained to him and eased by his GP, who also talked to his daughter. He was able to relax and, with his fears assuaged, enjoy relevant and amusing conversations with his daughter and visiting friends over the next few days until, in their presence, he passed away comfortably.

As I now review this sequence of events, having spent 50 years in clinical medicine—I wonder, what are the reasons for his appalling hospital care?

Is the first explanation that stated by a medical student some 40 years ago, namely:

'We come to clinical medicine with humanity, and after three years they have educated it out of us' (Gale and Livesley, 1974).

Is it reasonable to suggest that this is why things have not changed? Today, in endeavouring to keep people alive, has medical and nursing training produced too many high-tech oriented professionals, who are unwilling or inadequately trained to recognise when a patient is dying and requires a different kind of treatment and care in all of the physical, psychological, and social dimensions?

For all their expertise, clinical professionals can be at a loss about what to do and turn a blind eye to patients' difficulties. This paradoxical behaviour is partly the result of the virtual absence today of those life-threatening epidemic diseases that previously gave doctors and nurses experience with dying patients; as well as the easy availability of the diagnostic and therapeutic techniques associated with high technology medicine, among which ignorance about palliative care can be hidden.

Does this inadequacy among doctors and nurses allow a pseudo-form of the Liverpool Care Pathway to be used to remove the 'problem patient' under a 'starvation and dehydration quick-fix'? Is this one of the reasons why there is 'fear and confusion over [the] death pathway' which has been reported recently? Has this really made some patients reluctant to go to hospital to get the treatment they desperately need (Bingham, 2013)? By misuse has the Liverpool Care Pathway become a licence to kill? Certainly, in the September 2012 consensus statement (National End of Life Care Programme,

2012), published over the signed names of the leaders of 22 nationally known groups, the reader can be left with the answer 'no'. When one reads further, however, the matter is not quite as clear since it states:

'In response to a question asked in the House of Lords on 20 June 2012, the Parliamentary Under Secretary of State for Health, Earl Howe, said:

"The Liverpool Care Pathway [LCP] has sometimes been accused of *being a way of withholding treatment, including hydration and nutrition. That is not the case. It is used to prevent dying patients from having the distress of receiving treatment or tests that are not beneficial and that may in fact cause harm rather than good.*" (National End of Life Care Programme, 2012: text enhanced)

This leaves the italicised phrase open to too much interpretation and allows the words 'not beneficial' to be weaselled to mean 'nil by mouth'. I understand that for this reason the consensus statement is to be modified. After all, for conscious patients particularly, starvation and dehydration are terrible ways to die.

So what is the answer? While all bedside professionals are expected to have a basic knowledge of cardiac resuscitation, it is just as essential that they are trained to at least the same degree in palliative care. It needs to be remembered that palliation is not merely an immediate-end-of-life event. It is the time when both doctors and nurses need the ability, humanity and compassion to impart confidence to the dying patient, and their family and friends, by 'being there'. They should correctly make the diagnoses and treat appropriately any reversible clinical conditions—being willing to discuss the situation—while relieving symptoms

and anxieties promptly. They need to do this even as unnecessary treatment and investigations are being discontinued—and allow conscious patients food and fluids as required; while continuing to provide effective palliative care. This is the real Liverpool Care Pathway. Slowly and surely, this should reduce the panic about dying which has heightened the call for legalised euthanasia.

Inducing death by neglect when a person has unrelieved symptoms not only overlooks the important and simple question of why the symptoms remain unrelieved but also exposes wilful and/or negligent clinical staff—as well as their administrators—to the certain risk of criminal charges. **BJHCM**

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