

HOW CAN I TELL IF THE LIVERPOOL CARE PATHWAY IS RIGHT TO USE?

PALLIATIVE CARE IS BASED PRIMARILY UPON NEEDS AND NOT PROGNOSIS.

A number of very worried clinicians and relatives have asked us recently about the Liverpool Care Pathway and its appropriate use.

Excellent palliative care is a core component of the care that we should give to all people who suffer from terminal illnesses. It would be wrong for any doctor to deny symptom relief to those who are in pain and suffering towards the end of life. The Liverpool Care Pathway was designed to promote excellent care in the last few days of life. But it has aroused a lot of controversy and concern.

It is clear that, if a decision is made that someone is dying and too much morphine is given, people may become unconscious and even die as a result. People with non-cancer diagnoses may be more likely to die from opiates ([Gomes et al 2011](#)). Deprivation of consciousness is a serious matter and only to be done for very grave reasons. At the recent CMA (UK) Conference in London we were told of a lady sent home by staff saying that she had only 3 hours to live. She recovered substantially and had some excellent time with her family for several weeks once the morphine was withdrawn. We must remember that a painful death is a bad death. But in this lady the morphine had not apparently been needed in the (large) dose given, it nearly shortened her life substantially and would have deprived her of her last weeks at home with her family. That is very wrong and concerns about this are echoed in American literature ([Trescot et al 2008](#)).

So how do we know when to give such medicines? There is a serious issue here. The LCP is recommended for use in the last 72 hours of life. That is a recommendation based upon prognosis. And we know that doctors are poor at prognosis. A decision that someone is dying in the next 72 hours may well not be reliable. If someone is suffering then that suffering should be alleviated. In doing so, we fully acknowledge double effect and accept that, sometimes, life may be shortened as a part of symptom relief. But palliative care has always been needs-based.

If going onto a pathway is based upon prognosis and not need, and clinicians (while following the dosage guidance from the protocol) give treatments that may be based upon prognosis but not need, life may be shortened and consciousness removed at one of the most important times of our lives.

We must remember that many people die quietly and peacefully with tiny doses of morphine or no morphine at all. Oral fluids should not routinely be denied and intravenous or subcutaneous fluids may still be used in the dying phase (as is still seen in in some circumstances in hospice care) if they will improve wellbeing and reduce suffering around death.

Happily, the new [version \(12\) of the LCP](#) contains prompts about on-going nutrition and hydration, and the recommendation in version 11 to provide a syringe driver within 4 hours of a doctor's order is qualified by a statement that a continuous subcutaneous infusion should only be provided if indicated. But the focus on prognosis remains and a likely death within 72 hours is not an adequate reason to sedate someone. There must be a need that requires treatment to justify it.

SO WHAT CAN A NURSE ON THE WARD DO IF THEY FEEL THAT THE WRONG TREATMENT IS BEING GIVEN?



Remember that those who are dying require the best palliative care. But pain relief is only needed for those in pain. As well as the relief of pain and distress, for people who are dying a conversation, good spiritual care and time with family is essential. But if using a pathway means inappropriate sedation, or if fluid withdrawal and over-sedation causes death that would not otherwise occur, that is wrong.

Therefore, palliation is indicated by need and not by prognosis. Perhaps given on-going concerns from families about inappropriate use of sedatives and opiates, the need for symptom relief should once more be seen as a more important indication for palliation than prognosis.

Perhaps the worried nurse should ask;

“I know this patient is dying, but do they require sedation?” and

“What are the needs that mean this patient is sedated, or being denied fluids?”

Finally, if there are doubts, all members of the clinical team, each with equal responsibility to the patient and validity of concern, have the precedence, indeed the duty, to demand a full review to raise those doubts. So, if you have doubts, demand a full review of the patient and raise those doubts. The LCP does in fact require this. “Are we sure that this person is dying?” “Are we clear about the diagnosis?”

REFERENCES

Gomes T et al. Opioid dose and drug-related mortality in patients with non-malignant pain. Arch Intern Med. 2011;171(7):686-691; 691-693

Trescot A et al. Opioids in the Management of Chronic Non-Cancer Pain: An Update of American Society of the Interventional Pain Physicians' (ASIPP) Guidelines. Pain Physician 2008: Opioids Special Issue: 11:S5-S62

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