CARE OR NEGLECT? UNDERNEATH THE LCP

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At one of our recent healthcare retreats at Boarbank Hall, a highly experienced palliative care consultant was explaining the importance of teaching people how to use the Liverpool Care Pathway. She recounted how as a young doctor she had seen a dying child left alone in agony in a hospital ward; no one was systematically overseeing the care of those who were nearing the end of their life. The LCP was developed in order to make those looking after the dying aware of all that should be in place for them, physically, socially, emotionally and spiritually. A chaplain in our group raised an objection: in his experience, the LCP was being used as an excuse to abandon those on the point of death, or even those still some distance from it. 'It's merely a piece of paper,' the consultant replied, 'It is only as good as the way it is used.'

A piece of paper is only as good as the way it is used; and the way it is used, I suggest, can only be as good as the people who are using it. If there is a problem with the LCP, as many are arguing, it seems to reflect a far deeper problem with the staff in our hospitals. No one who truly cared for the dying would neglect them on the basis of a document. The question that comes to mind, 'What kind of people care, or fail to care, for their patients?' In short, we are asking about their virtues or their character.

HOW TO THINK ABOUT DECISIONS

The most influential contemporary model of how we make decisions tempts us to ignore the importance of character. According to this, a decision is like a crossroads. You are driving along and you come to a fork: which of two or three roads do you take? The options available can be provided as multiple choice. There is one decisive moment of choice: what has gone before and what will happen after is irrelevant to this. Sometimes your 'conscience' may place a NO ENTRY sign over one of the roads, even if that is the road that your reason would choose. The reasons you can give for your decision must be clear and limited, so that you can tick boxes to specify them; anyone in the same situation could and should have made the same choice. This model has heavily shaped, for example, the interactive case studies available on the GMC website, which are largely concerned with social and regulatory issues rather than narrowly medical ones. My suspicion is that if the same multiple choice formula had been used for judgements that were medical in the strict sense, the weaknesses of the model would become apparent to doctors and nurses.

An internet case study can provide only minimal information about the human beings involved in a decision. The viewers cannot get to know them, and they cannot get to know each other. The 'Fork in the Road' model in fact ignores the importance of the past - of the character and the personal histories of the healthcare professionals or patients. It also constricts the future, by limits the options available. In these ways, it ignores the fact that thinking about what to do is an extended process: we are constantly making tiny decisions, without even being aware that we are doing so, but cumulatively these are of enormous importance for our progress. To take a concrete example: the doctor's 'decisions' about how to treat her patient begin the moment he knocks on the door. If he is instantly made to feel welcome, everything that follows could be different.

A better model for practical thinking is driving along the road. Here you are constantly making micro-decisions as you adjust what you are doing to all the mass of information you are taking in, about the bends, the road surface, the light and the weather, other cars, roads signs, pedestrians, animals, and a thousand other things. You may occasionally consult a map or a tom-tom, but when you do so the new facts are integrated into the great web of background knowledge that guides you. You make most of your decisions without even registering that you are doing so, and what enables you to do this well is that you possess the virtue of good driving - it is engrained into your character through a mixture of natural ability, training and experience. This model takes seriously the way in which we are constantly revising our short-term aims within the overall aim of getting where we want to go - slowing down to avoid a hazard, and so on. Similarly, medical staff, while aiming at the overall goal of the patient's health and comfort, must constantly be guided by his or her changing responses: 'The best thing would be to persuade Mrs Jones to give up smoking, but if I can't do that ...', or, 'Let's see how Mr Phillips reacts to the chemotherapy and then review the situation.' Finally, a fundamental part of driving well is that you want to drive well. Indeed, you want it so deeply that you would normally never mention it: someone who seriously said, 'I have decided not to run over any pedestrians,' should not be given a licence!

To exercise practical wisdom is to engage in a process, not a single action. The process involves at least four elements, all of which require a properly formed character. First, attentiveness to all the relevant facts and principles, which involves sub-conscious as well as conscious noticing. This requires of the nurse or doctor a sound technical knowledge, and a careful capacity to listen: it is worth pondering the fact that research has shown that doctors listen on average for 23 seconds to a patient before interrupting! Secondly, the ability to spot which facts are salient to the judgement in question. For example, a patient may have a reaction to eating certain foods; one doctor will take no notice, another will spot the relevance of it for the diagnosis. The better the healthcare staff know their patients, the better they will become at attending to and noticing what is important.

Thirdly, practical wisdom requires the ability to bring all the considerations together and make a judgement based on them. There is something irreducibly mysterious about this ability. When discussing it in The Grammar of Assent, Blessed John Henry Newman used the example of Napoleon's uncanny ability to make accurate military judgements in the heat of battle. Newman also explored the way in which the reasons for expert judgements are often subtle and inexplicit, and sometimes cannot be identified even in retrospect. The philosopher Hans-Georg Gadamer talks of 'the skilled and practised hand that can recognise problems simply through feeling and touching the affected parts of the patient's body.' Experience plays a very important part in developing good judgement: as Aristotle put it, we ought to listen to what older people think, even if they cannot always explain their reasons, since 'because experience has given them an eye, they see aright.'

Finally, practical wisdom includes the ability to put good judgements into practice. For this, the intellectual gifts of attentiveness, perception and judgement are still not enough: we need a good heart as well as a good mind. St Thomas called love 'the form of the virtues'. He meant by this that the lesser virtues - courage, good sense, even justice - are only what they should be when they are directed by charity. Technical skill can always be abused: physicians make the best poisoners. But true virtue, guided as it is by love, always acts for the sake of what is truly good. It is striking how often during our healthcare weeks people raise the question of compassion, and whether it is disappearing from the NHS.

The Fork in the Road model tends to emphasise regulations: when you get to the point of decision, you follow the rules to tell you which way to go. For the Driving Along model, a few basic laws are very important indeed, so important that we are normally guided by them without even thinking about them. One of the most fundamental of these, an essential part of the practice of medicine, is 'Never take innocent life.' But rules and guidelines are there only to help you carry out your deepest purposes, which in medicine is caring for the patient. The more skilled and the more compassionate you are as a healthcare professional, in other words, the more focused you are on your true goals and the better equipped you are to deal with them, the less you will need to focus your attention even on those rules that are helpful. For you will already have internalised them. They will not feel like rules, but like common sense. On the other hand, bad rules, including rules made for bad purposes (such as bureaucratic 'efficiency'), will be an irritant, because they will cut across the grain of your skilled and compassionate practice. In the worst case, the threat of bad regulations will push healthcare staff into making what they know to be the wrong decisions, medically and morally. This conception of practical wisdom also changes our idea of conscience. Conscience should not be seen as a kind of irrational and externally imposed NO ENTRY sign, which blocks off certain routes, but as a deep moral understanding of what is good and of how to achieve the good, which is fully integrated into your character. It shapes all your micro-decisions in the way that the fundamental desire to drive safely shapes every moment of skilful driving.

What difference does all this make? Take the 'piece of paper' that we started with. It will be used well insofar as the people who use it are motivated by love for the patient. In that case, it can act as a very useful tool for training the inexperienced; or else as a helpful reminder for those who are tired or forgetful of the things that they are already motivated to do; moreover, it can serve to coordinate care when a team of people is involved. But if the medical staff is not motivated by compassion for the patient, and if their practical wisdom has not been developed and honed, then the LCP will be open to abuse. The same is true for every other set of guidelines: it takes good people to use documents well. It is easier to teach students to tick boxes than to form them in the virtues. But they will not learn the true meaning of medicine unless they learn the meaning of love.

EDITORIAL COMMENT

We strongly agree that there have been serious problems with the LCP. Interestingly, some of those least likely to note this have been palliative care physicians. In their skilled and more highly trained hands it is possible that it is misused less often. We think that this is a reminder to all of us who work in medicine to be able to reflect and see the other view. The view that the LCP is all good is clearly false. But the view that it is always bad may also be less than wholly true.