

The Liverpool Care Pathway

Professor Millard, Peter Hargreaves and others' concerns over the use of the Liverpool Care Pathway, recently published in the Daily Telegraph; do not represent the view of the overwhelming majority of physicians who specialise in palliative care.

Although forecasting death is an inexact science, clinical decisions regarding end of life care are no longer made in isolation, and palliative care hospital support teams are available throughout the country to support other specialities in this work. These teams include physicians who also practice in the local hospice or palliative care unit. Clinical decisions on the prescription of analgesics, sedatives and fluids must be made on an individual patient basis.

Modern practice in evidence-based palliative medicine no longer requires that we administer toxic or life threatening doses of analgesics or sedatives to obtain adequate relief of pain and other symptoms. Treatment with subcutaneous or intravenous fluids is occasionally indicated when dehydration causes distressing symptoms, but is futile in patients where poor oral intake is part of a general deterioration that is inevitable in a terminal illness. It is potentially harmful if administered to patients with heart failure leading to congestion of the lungs.

The Liverpool Care Pathway is not a one-way street and when further deterioration does not occur, it is common practice to take the patient off the pathway and re-institute previous treatment. The use of sedative medication is common in the final hours, simply because delirium with agitation is common as dying patients slip into a coma that precedes death. This treatment of distress, using drugs and doses appropriate to the patient, is not the same as the practice of continuous deep sedation until death that has been described as an alternative to euthanasia in the Netherlands.

The care pathway approach is now commonly used to aid the work of many specialities throughout the health service; it does not replace clinical judgement, but acts as a prompt to assist clinical teams ensure that every patient gets adequate attention to every aspect of their care. Clinical pathways are useful in auditing practice and developing services. It is possible to misuse any clinical tool, but our experience of working with colleagues in hospitals and the community is that, with adequate training and support, it is used appropriately.

The Association for Palliative Medicine is an organisation of over a thousand doctors working in palliative care and we strongly support the Department of Health's End of Life Care Strategy, which includes the promotion of the Liverpool Care Pathway together with the resources required to educate doctors and nurses in its proper use. It represents one of the most powerful tools we have to foster the principles of palliative care in hospital and community where the majority of NHS patients die.

Dr Bill Noble

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