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If it's time for you to die, this is the right way

The Liverpool Care Pathway is about making death dignified – not hastening it, says **Tom Hughes-Hallett**

Imagine you have just six hours to live. You're wired to monitors, and have tubes all over your body. Nurses and doctors know you're not going to recover, but they still keep changing your drugs and taking blood from your arm. Your spouse is trying to hold your hand and talk to you. But all you can hear is a machine that goes "beep". It's probably the last thing you'll hear.

Ten years ago, that was how too many people reached the end of their lives – in hospital, as a failing body, plumbed into machines, with staff doing their best to cope, but with no guidance on how things could be better. But today the way in which many hospital patients are cared for has improved enormously – and death is being treated as the natural end of life, rather than a failure of medical technology.

Driving these improvements has been the Liverpool Care Pathway for the Dying – a model that takes the philosophy and practice developed by experts in hospices, where Britain leads the world, and sets out detailed guidance for doctors and nurses who care for dying patients in hospital. It ensures that the patient is comfortable, free from pain and distressing symptoms such as breathlessness.

As an organisation that stands up for patients at the end of their lives, and their families, Marie Curie Cancer Care is fully behind the correct use of this pathway in hospitals and care homes. Recent controversial cases – such as the 80-year-old suffering from pneumonia, who was put on the pathway but recovered after her daughter intervened – have understandably provoked anxiety. While debate and criticism are valuable, I believe it is important that we scotch some myths.

While the pathway offers guidance on what to do, it's not a straitjacket – the clinicians provide care to fit the needs of the patient. Use of the pathway neither hastens nor slows death. It asks doctors and nurses to consider whether any monitors and tubes attached to the patient are really benefiting them. If not, it recommends removing them. Clinical staff will also keep explaining what's happening to the patient and their family, and ensure their spiritual and religious needs are met.

The pathway is under a constant review to look at how it can be improved. The latest version, which will be launched next month, provides even greater clarity about the need to communicate with patients and relatives. Of course, the Liverpool Care Pathway is only as good as the team using it. That's why we are in favour of mandatory training with regular updates.

Another important point is that the pathway is strictly for those in the last hours and days of life, and identifying precisely when a patient is dying is not an exact science. Regular reviews of a patient's condition take this into account, and if somebody's condition unexpectedly improves, the pathway is discontinued and the plan of care reviewed.

Marie Curie Cancer Care provides care to 55 per cent of people dying at home, mainly through our nursing service. The Government is steadily changing the culture of the NHS, requiring hospital trusts to think of care for the dying as a core service and to make their needs a priority. But we haven't got there yet. Despite our efforts, and those of other organisations, far too many people – over half – still die in hospital, rather than in their homes.

When properly used, the Liverpool Care Pathway is about a dignified death, not hastening death. I'm determined that Marie Curie will continue to stand up for the dying, challenging the Government and the NHS to provide the best possible care for people at the end of their lives.

Tom Hughes-Hallett is the chief executive of Marie Curie Cancer Care

Comment on Tom Hughes-Hallett's view at
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