The new end-of-life guidelines are lethal

The troubling Liverpool Care Pathway for dying patients needs replacing, but not with Nice's plan

PATRICK PULLICINO

As one of the first doctors to raise concerns about the Liverpool Care Pathway (LCP) pushing elderly NHS patients to premature death, I am naturally interested in the new National Institute for Health and Care Excellence (Nice) guidelines that will replace it.

The LCP represented "the best quality of care possible" for the dying as defined by palliative medicine physicians. It is therefore unsurprising that the new guidelines are very similar to the LCP and perpetrate the features that made it so dangerous. Additions have made the new guidelines, if anything, worse than the LCP. The authors had the Neuberger Report on the LCP to draw on, but have not taken on board some of its main recommendations.

Diagnosis of who was imminently dying was the core problem of the LCP and is no better in the Nice document. It includes a cookbook list of features that may suggest someone is dying but is totally inadequate to make a diagnosis and is not evidence-based. So we are back at the LCP in terms of the risk of putting patients who are not dying onto inappropriate and potentially lethal treatment.

This is so crucial that no new attempts to set up this sort of pathway should be made until we have research showing it is possible to accurately diagnose impending death. Until then, as Neuberger said, good quality compassionate care should be given without any pathway.

Neuberger left no doubt that LCP practice on hydration and nutrition was inhumane in some cases. Neuberger said that "the default course of action should be that patients be supported with hydration and nutrition unless there is a strong reason not to do so".

The section on hydration in the Nice document is a disaster of misinformation, distortion and ambiguity, with at least one major error. It says that "death is unlikely to be hastened by not having clinically assisted hydration". This is completely untrue. Not giving hydration is certain to kill someone if they can't take hydration by mouth. And there is no mention of nutrition in the document.

The Neuberger report was unambiguous about the seriousness of the duty to provide hydration and nutrition yet Nice has even reduced the meagre provisions of the LCP. Neuberger said that failure to support oral hydration and nutrition when still possible and desired should be regarded as professional misconduct.

Dehydration was a central mechanism of the deaths on the LCP. Despite the removal of the LCP, I still frequently witness severely dehydrated elderly patients on hospital wards. Unless it becomes standard, and monitored by the Care Quality Commission, that hospitals are obliged to give nutrition and hydration adequate for patients' physiological needs at all times and regardless of prognosis, end-of-life care is going to remain lethal.

One of the most dangerous aspects of the LCP was "anticipatory prescribing" where the physician wrote up sedatives and narcotic medication ahead of time. Nurses were empowered to use preset LCP criteria (eg, pain, agitation) as a justification for increasing the dose. The result was a rapid increase of medication and a quick death for many LCP patients.

The Neuberger report said that it is essential to have a senior responsible clinician accountable for all decisions in end-of-life care. The LCP decision-making process was based on the Mental Capacity Act 2005 designation of a "Decision Maker" and "Best Interest" meeting. The Decision Maker who takes end-of-life decisions could be a nurse or other member of the support team. The Decision Maker is helped by a meeting of all staff and relatives at a "Best Interest" meeting, but the relatives do not have privileged input into decisions.

That effectively usurped the role of the responsible senior clinician and undermined centuries-old evidence-based medical care. The new Nice guidelines continue to use these provisions. Consultants must be restored to full care of, and responsibility for, their patients.

The reality is that LCP was in operation for so long that it has changed accepted practice in the NHS and even after it was removed, similar practices continued under different names. I regularly receive reports from desperate relatives of individuals being treated in an LCP-like fashion who are trying to get active care for relatives who have been determined to be "dying".

Evidence-based medicine is the gold standard for 21st-century health care. The LCP abandoned this and was disastrous not only for the patients but for all medicine. All physicians in general hospitals should use only evidence-based treatments and pathways, and Nice should ensure all pathways meet this standard. Its current proposal certainly does not.

Patrick Pullicino is Professor of Clinical Neuroscience at the University of Kent

COMMENT *on Patrick Pullicino's view at telegraph.co.uk/comment*