A lethal power?

Jacqueline Laing addresses concerns about the Liverpool Care Pathway

In 2008, a year after the Mental Capacity Act 2005 came into force, the Liverpool Care Pathway was recommended as the Department of Health's end-of-life care strategy. Only a year later 300 hospitals, 560 care homes and 130 hospices in England had rolled out the programme. Around 130,000 people a year now are reported to die on the Pathway (29% of the annual 450,000). Freedom of Information Act requests performed by one enterprising journalist subsequently revealed financial incentives to hospitals and care homes that implemented the programme (J Bingham, "NHS millions for controversial care pathway", *The Telegraph*, 1 November 2012). Millions of pounds were paid to roll out the regime. The sub-programme, Commissioning for Quality and Innovation (CQUIN), requires that local NHS commissioners remunerate trusts for meeting "Gold Standards" targets in implementing the Pathway. In certain areas, targets are set specifically to increase the numbers of people in their hospital dying on the Pathway. More worryingly, some hospitals had set targets of between a third and two thirds of all the deaths to be Pathway deaths. Certain hospitals doubled the numbers of patients dying on the Pathway in one year. Eighty five per cent of NHS trusts have implemented the programme. Of those, 62% revealed that they had either received, or expect to receive, financial recompense for meeting targets associated with the implementation of the Pathway.

- The Department of Health has recommended LCP as its end-of-life care strategy.
- Families & medical professionals have voiced concern over the regime.

Concerned health professionals insist that there are indeed problems with the regime. Professors Patrick Pullicino (Kent, neurosurgeon), and Mark Glaser (Imperial College, oncologist), and other doctors have suggested that there are both difficulties of diagnosing imminent death with any certainty and grave dangers surrounding the institutionalisation of this relatively recently implemented national end of life regime (P Millard, A Cole, R Bearcroft, G Craig, D Hill & M Knowles, "Deadly one-way street", 8 July 2012, *The Daily Telegraph*). Families and doctors tell of having intervened to take patients off the Pathway then to find that the patient recovered. Many were not told their loved ones were on the Pathway while others fear the programme has a homicidal character not acknowledged by its proponents.

The Pathway was, until recently, widely advertised as a model of good practice in the last hours of life by successive national Department of Health policy frameworks. It is praised by health professionals who formulated or have implemented it. Academic articles abound in which professionals using the programme are shown to find it constructive. Indeed, when a patient is clearly in the last hours of life, it may well be that acts recommended by the strategy are entirely appropriate. The problem arises when they are not indicated, ie on the strength of misdiagnosis, or when the sedation-dehydration regime is implemented to satisfy managerial targets or countless other unjustifiable possibilities.

> "Managerialised death targets are problematic in the context of uncertain diagnosis"

Reversing the burden of proof

Part of the difficulty is that, where a patient is diagnosed as terminal and imminently dying, the combination of morphine and dehydration is likely to undermine a patient's capacity. Persistent dehydration of even the fittest sedated patient will kill him. This was the problem with the Pathway from the very outset. It reversed the burden of proof, on the strength of a diagnosis that is not always certain, so that an increasingly incapacitated patient would have to speak on his own behalf in favour of water. Even assuming he was healthy enough, in an environment in which the Pathway is normal his pleas may not be heard.

Recent revelations of financial incentives and staggering compliance in rolling out the managerial programme radically alter the debate. Diagnostic concerns in the context of arguably self-fulfilling sedation-dehydration regimes and overarching financial and political pressure to implement the Pathway, suggest that the regime may have acquired a lethal power of its own. This lethal character is almost certainly one that exists independently of the best intentions of those who formulated or apply it. Some of history's most important lessons highlight the problems of institutionalising programmes that invite homicide and reverse burdens of proof in ways that undermine the vulnerable.

Controlling death

Critics have been warning for many years of the numerous financial, medical, political and research interests there are in controlling death whether passively or actively (see J Laing "Food and Fluids: Human Law, Human Rights and Human Interests" in *Artificial Nutrition and Hydration* Ed C Tollefsen (Springer, 2002); "Vegetative" State—The Untold Story" 152 NLJ 7045, p 1272; and "Mental Capacity Bill—A threat to the vulnerable" 154 NLJ 7139, p1165).

The independent inquiry sought by Baroness Knight of Collingtree (Hansard, 5 November 2012) and many families, healthcare professionals, journalists, academics and lawyers is both judicious and timely. However useful the Pathway may be in individual cases properly applied, incentivised and managerialised death targets become problematic in the context of uncertain diagnosis, a steadily ageing population, spiralling healthcare costs, and the philosophical dehumanisation of the vulnerable pervasive in contemporary bioethics. The targets themselves constitute improper pressure on healthcare professionals' employment and livelihood. As such, they predictably invite and rationalise grave human rights abuse with tragic consequences for the defenceless incapacitated in hospitals and care homes. NLJ

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