

Incentivising death

It's time we rethought the 'meaningful life' concept developed by the Court of Appeal and which is now seeing its way through our end-of-life care strategy, says **Jacqueline Laing**

The recent revelation that the rolling out of the Liverpool Care Pathway as the NHS National End of Life Care strategy in 2008 had been financially incentivised and implemented with astonishing compliance emerged as a thought-provoking development. Many of us have been warning for years of the financial, political and research interests that there are in institutionalising sedation-and-dehydration regimes, and then, inevitably, medical homicide. Freedom of Information Act requests exposed the millions of pounds that have been paid for the implementation of this national end-of-life care strategy. Much more interestingly, it showed that some hospital trusts had been paid these funds for ensuring that up to two thirds of all deaths were Pathway deaths.

Given that the very livelihood of health professionals was being judged against the new Commissioning for Quality Innovation (CQUIN) 'Gold Standards Framework', professional observance of the pathway was predictable. The revelation of management targets, despite the best efforts of the regime's proponents to play them down, radically alters the debate. Unlike education or housing targets, these ones are potentially homicidal.

Death as a side effect

The Liverpool Care Pathway is undoubtedly intended as a palliative care regime at the end of life. Even its critics would agree that certain aspects may be useful and appropriate. Further, all are well aware that there are occasions when death may be a foreseen side effect of perfectly licit palliation whose primary ends are not homicidal at all. It is well known that treatment may be over-expensive, over-burdensome or simply futile. There is no suggestion of what is known in medical ethics as the error of vitalism – the commitment to excessive or futile treatment or over-burdensome care at the end of life.

The sedation-dehydration aspect of the regime attracts much proper opposition notwithstanding these ethico-legal caveats. Doctors and families have found that those on the Pathway recovered when they intervened to take the patient off it. Many are appalled that they may have participated in a strategy that was effectively unnecessarily lethal in ignorance of a possible misdiagnosis. On top of this,

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many lawyers, journalists and academics have serious concerns about its operation in the context of managerialised and incentivised death targets, rising healthcare costs, the reality of uncertain diagnosis and the pressure placed on healthcare professionals' very livelihood if they are unable to achieve a 'gold standards' death rate.

Utilitarian bioethicism

Add to this the dehumanisation of those regarded as having 'no meaningful life' and 'no best interests' an idea first controversially developed in *Airedale NHS Trust v Bland* [1993] A.C. 789 and the fluctuating concept of human dignity beloved of utilitarian bioethicists and we have yet another worrying background feature that must rationalise putting low-quality 'non-persons' on the Pathway who need not be (see Singer P, *Practical Ethics*, CUP, 1979). To ask whether treatment is futile, over-burdensome or over-expensive is very different to the utilitarian question about whether a person's very life is futile, over-burdensome or over-expensive. Indeed, once institutionalised, the lethal pathway undoubtedly would be used for a multitude of other illicit possibilities given the reality of human vice, mistake and ignorance.

Part of the problem is that where a patient is diagnosed as terminal, the combination of morphine and dehydration are likely to undermine a patient's capacity. Persistent dehydration of any patient, even the healthiest, will kill him. This was the difficulty concerned medical professionals warned of. It introduced an arguably self-fulfilling strategy so that an increasingly incapacitated patient would have to speak on his own behalf in favour of water. As evidence emerged of hospitals, care home and hospices rolling out the programme with staggering efficiency, the Winterbourne scandal with its abuse of the elderly in care homes, came as a reminder that we cannot assume that all that goes on inside institutions answers to the description of 'care', however 'gold standard' the institutional framework. If we invite abuse, managerialise it, targetise it, incentivise it, and punish with job-loss those who do not achieve their key performance indicators, abuse and homicide is what we will get.

The unwillingness of medical professionals to consider the socio-legal background to the programme rightly fosters public and professional outrage. At stake are our very rights to life and autonomy, freedom from inhuman and degrading treatment, and discrimination on the basis of incapacity. All the self-justification and denial in the world will not make the regime less worrying. In an age of austerity, where bed-clearing, employment pressure by way of managerial targets, an ageing population and a dehumanising bioethic prevail, we can say with certainty, for the sake of the vulnerable, it is time for a rethink.



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