Letters

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Editor's choice

The problem with the Liverpool Care Pathway is that someone felt the need to give it a name. Once it had a name it also developed boxes that needed ticking. Everything really went downhill from there. In nearly 30 years of general practice I've looked after many dying patients, but each individual's needs are different. Perhaps it's because I haven't given what I do a name, that I haven't stopped doing it and am going to continue until I retire, working in the same way. Of course, because there are no boxes, there are no QOF points to it; but, I'm rather pleased about that.

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Proceed with caution

Beales and Tulloch's arguments about anticipatory care of older patients[1] represent the triumph of hope over experience. Anticipatory care for older people in the community has not yet been shown to be clinically or cost-effective in a thorough and less selective overview of the literature.[2] Trials of anticipatory care for older people in US, UK, and Denmark up to 1990 showed a rise in patients' morale, increased referrals to all agencies, reduced duration of in-patient stay (sometimes), increased in-patient rates (mostly respite care), reduction in mortality in some trials, but no improvement in functional ability and an increase in GP workload unless alternative services were provided.[3]

Evidence for the benefits of anticipatory care remains scarce. The UK MRC trial showed little or no benefits for quality of life or health outcomes for older people receiving comprehensive assessment.[4] A systematic review of 15 trials of preventive home visits for older people showed no clear evidence of benefit[5] while the ProAge trial yielded no change in health-risk behaviours in older people.[6] Case management has not reduced hospital admission rates for frail older people and may even cause disruption of established nursing teams and services.

There are signs that effective interventions are being developed but effect sizes in positive trials are often small and may not remain when interventions are transferred to routine practice. GPs should be cautious about committing time and resources to forms of anticipatory care for older patients that are plausible but untested.

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The right to die peacefully

The editorial[1] and accompanying article[2] in the October edition of the *BJGP* highlighted the problems of advance care planning in older people. We detail below the tragic consequences of failure to have these conversations.

A review of case notes of patients registered with a local CCG, who were over 75 years of age and died after spending no more than 1 night in hospital between 1 January 2013 and 31 March 2013, showed that there were 31 such deaths. Of these, eight came from nursing or residential homes and five of these patients were recorded as being unresponsive or had a GCS of 3 when first seen by the ambulance crew. At least six of the patients would have met the Gold Standards Framework prognostic indicators criteria for being on the palliative care register, and in two the family requested admission or resuscitation in case of collapse.

At least four of these cases were pre-alerted to hospital and taken directly into the resuscitation area for multiple investigations and treatments: frail older patients, clearly nearing the end of life, precipitated into hospital where staff feel an obligation to try to preserve life. Most of these patients do not have the mental capacity to understand what is going on around them, and probably find the interventions extremely distressing. The whole process serves only to cause unnecessary suffering.

In some cases the family were not prepared for the patient's demise, and in most the care institutions were not confident in the management of patients nearing the end of life. The ambulance services are put under considerable pressure and without clarity from the carers will understandably default to an active resuscitation mode.

It is a challenge to primary care to champion the rights of older people to die peacefully.

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