First randomized trial of Liverpool Care Pathway finds little clinical benefit for dying patients

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The first randomized trial to test the effectiveness of the Liverpool Care Pathway program, developed and implemented widely to support patients as they near death, has found little clinical benefit compared with standard care for cancer patients dying in hospital.

Based on these findings published in *The Lancet*, the authors suggest that any initiative to replace the LCP in England should be "grounded in scientific evidence"* and tested in controlled trials before it is implemented.

"Across health care there is a need to improve care for people who are dying, which has led to widespread uptake of the Liverpool Care Pathway (LCP) before adequate assessment…A decade after widespread uptake…The results of [this,] the only adequately powered study of LCP so far have not shown clinically meaningful differences for patients—the ultimate measure of useful health policy", write David C Currow from Flinders University in Adelaide, Australia and Amy P Abernethy from Duke Clinical Research Institute in the USA in a linked Comment.

The LCP was jointly developed by the Marie Curie Hospice Liverpool and the Royal Liverpool University Hospital in the late 1990s with the aim of rolling out the best practice of hospices to hospitals, to provide uniform, high-quality, dignified care for dying patients in the last days or hours of life. But its effectiveness for improving care for the dying has

not been assessed in a randomised trial until now.

In this study, The Liverpool Care Pathway Italian Cluster Trial Study Group assessed the impact of the Italian version of the LCP (LCP-I) on the quality of care of adult patients dying with cancer and their families in 16 general medicine hospital wards across Italy. Wards and their matched palliative care teams were randomly assigned to be trained in and to use the LCP-I programme, or to follow standard health-care practice.

All patients who died of cancer during the 6 months after implementation of the LCP programme were identified. Bereaved family members were interviewed 2–4 months after their relative's death (119 with relatives cared for in the LCP-I wards and 113 in the control wards), and the quality of end-of-life care assessed using a scale of 0-100. Families also rated key aspects of care including information and decision-making, co-ordination of care, support for families, and control of symptoms such as pain and breathlessness.

No significant differences in the overall quality of care between the wards in which the LCP-I was implemented and the control wards was noted (70.5 vs 63.0 on the scale of 0-100). Additionally, two dimensions assessed—respect, dignity, and kindness and control of breathlessness—also showed some improvement in the LCP-I wards. Crucially, no differences in survival times between patients in LCP-I and control wards were noted.

According to study leader Dr Massimo Costantini from the Research Institute S Maria Nuova of Reggio Emilia in Italy, "Although we found no significant difference in overall quality of care for those on the LCP-I ward, we did see a small improvement. This could indicate that the LCP-I may have the potential to close the gap between hospice care and hospital care as we know families rate quality of hospice care more

highly. While the results of this trial should be interpreted with caution because there were slightly fewer participants than expected, and we observed some variability in implementation of the LCP between the hospitals, this is a robust trial and the findings should be used to inform strategies to care for dying patients. There could be fundamental components of the LCP that might be beneficial, and the next steps are to establish this."

Professor Irene Higginson, co-author of the study and Director of the Cicely Saunders Institute at King's College London, adds, "Our findings demonstrate just how important it is for any initiative that replaces the LCP in England to be grounded in scientific evidence and tested in controlled trials before being rolled out across the board. We must face this challenge head-on and ensure scientific evidence forms the foundations for any new initiative if end-of-life care is to be genuinely improved for patients and their families in England."

Writing in the linked Comment, Currow and Abernethy add, "Looking to the future, there is a need for government and other funders to be far more willing to fund research into health services that can inform policy and for many more senior clinicians to contribute to shaping national clinical policies."

More information: www.thelancet.com/journals/lan … (13)61725-0/abstract

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