Liverpool Care Pathway: a personal and professional view

Sir,

I read with interest the editorial 'The Liverpool Care Pathway: What is the furore in the press about?' (vol 74(1), 2013, p. 4). As a doctor looking after patients in the final stages of their lives virtually on a daily basis and a terminally ill cancer patient, I have strong views on end of life care both personally and professionally.

The majority of the media coverage of the debate has in my view been biased towards negativity and sensationalism. There have clearly been episodes of substandard care reported in the press, but I feel that these cannot just be blamed on the Liverpool Care Pathway itself, which I firmly believe is a fantastic framework to provide excellent care for the dying, particularly in the acute hospital setting.

I think the forthcoming independent review will be useful to investigate cases of poor implementation, but I feel strongly that we, as a profession, should not shy away from using the Liverpool Care Pathway in our practice, merely because of press scaremongering. We need to focus on education, training and support for all staff using the Liverpool Care Pathway to ensure its appropriate use.

I want my end of life care to follow the Liverpool Care Pathway approach when the time comes as, when used properly, it reduces futile medical interventions, promotes comfort and dignity, and supports relatives, all of which are vital factors helping me to achieve that Holy Grail of a good death.

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Revolutionizing problem-based learning with Google Docs

Sir,

During my undergraduate training, problem-based learning was very popular, as it still is today. Through the use of a seven-step approach students are expected to undertake the following when presented with a clinical problem:

Step 1: Identify and clarify unfamiliar terms presented in the scenario; scribe lists those that remain unexplained after discussion

Step 2: Define the problem or problems to be discussed; students may have different views on the issues, but all should be considered; scribe records a list of agreed problems

Step 3: 'Brainstorming' session to discuss the problem(s), suggesting possible explanations on basis of prior knowledge; students draw on each other's knowledge and identify areas of incomplete knowledge; scribe records all discussion

Step 4: Review steps 2 and 3 and arrange explanations into tentative solutions; scribe organizes the explanations and restructures if necessary

Step 5: Formulate learning objectives; group reaches consensus on the learning objectives; tutor ensures learning objectives are focused, achievable, comprehensive, and appropriate

Step 6: Private study (students gather information related to each learning objective)

Step 7: Group shares results of private study (students identify their learning resources and share their results); tutor checks learning and may assess the group (Wood, 2003).

With the ever-increasing presence of mobile devices, medical teaching and learning has certainly changed along the way with such devices being used in lectures, seminars and tutorials.

Google Docs enables individuals to create, share and collaborate on documents online in real time. It also allows for the creation of charts, diagrams and schematics. In medical undergraduate training Google Docs was used during a 1-week preceptorship in a primary care setting with positive findings (George, 2012).

It was William Glasser who once said, 'We Learn...

10% of what we read
20% of what we hear
30% of what we see
50% of what we see and hear
70% of what we discuss
80% of what we experience
And 95% of what we teach others.'

In light of this I suggest that the seventh step should be rebranded:

Step 7: Through Google Docs the group shares results of private study (students identify their learning resources and share their results); tutor checks learning and modifies the documents as needed.

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George D (2012) Using Google Docs to enhance medical student reflection. *Med Educ* **46**: 504–5
Wood DF (2003) Problem based learning. *BMJ* **326**: 328–30