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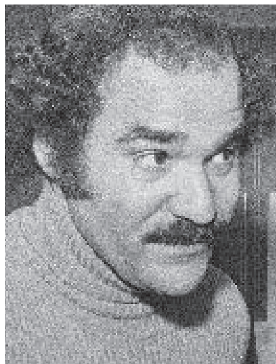

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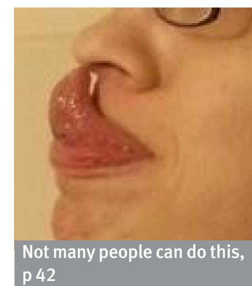

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## PICTURE OF THE WEEK

**The Duma Charity Foundation for Prosthesis in Damascus produces prostheses from found materials, including waste plastics and weapons remnants for people who have lost their limbs due to shelling.**

## RESPONSE OF THE WEEK

'To boost efficiency and cut costs, Indian hospitals ensure that doctors do only the work that physicians can do, and the same goes for nurses and other highly skilled technicians.'

It seems the Indian way would have doctors do what they do best: doctoring. The NHS way, in contrast, ensures our plates are full trying to juggle doctoring alongside auditing, coordinating rotas, organising patient lists, conveying biopsy samples between procedural areas and labs, phlebotomy, typing up our own letters, and sometimes portering patients to and from the wards. Cutting costs by letting go of ancillary staff actually becomes detrimental to efficiency.

Danny J N Wong, ST4 in anaesthetics and intensive care medicine, University Hospital Lewisham, London, UK, in response to "Indian medicine, coming soon to an island near you" (*BMJ* 2014;348:g1740)

## MOST READ

2013 was a horrible year for nursing—nurses are "burnt out," says chief

Change in mental health after smoking cessation: systematic review and meta-analysis

The survival time of chocolates on hospital wards: covert observational study

Neuropathic pain: mechanisms and their clinical implications

Bad medicine: gabapentin and pregabalin

## BMJ.COM POLL

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*BMJ* 2014;348:g352

**This week's poll asks:**

"Should statins be extended to people at low risk of cardiovascular disease?"

*BMJ* 2014;348:g1899

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EDITOR'S CHOICE

# Who are we treating?

**We should take care that choosing to say yes to a course of palliative chemotherapy should not commit patients to a host of outcomes they don't want**

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When we offer palliative chemotherapy to a terminally ill patient, who are we treating, the patient or the doctor? How clearly do we understand the consequences of this treatment decision, and how well do we explain these to the patient and their family?

A study published in the *BMJ* this week indicates that we underestimate the risks of giving palliative chemotherapy in the few months before death. The aim of treatment may be to prolong life by a few weeks, which is what many patients most want, or to manage symptoms and improve quality of life. But the unwanted outcome may be a worse, more medicalised death. Alexi Wright and colleagues found that terminally ill patients who were receiving chemotherapy were more likely to have cardiopulmonary resuscitation, to be mechanically ventilated, and to die in intensive care (p 13). These patients were also less likely to die in their preferred place.

As Michael Rabow comments in his editorial (p 9), the association between palliative chemotherapy and more medicalised death may stem from the patient's determination not to "give up" or from lack of involvement of expert palliative care. But we should take care, he says, that choosing to say yes to a course of palliative chemotherapy should not commit patients to a host of outcomes they don't want.

Meanwhile the controversy over the wider use of statins rumbles on. After controversial new US guidance last year that extended the use of statins to people at low risk of cardiovascular disease (doi: 10.1136/bmj.f6858), the UK National Institute of Health and Care Excellence (NICE) has just published its own draft recommendations (doi: 10.1136/bmj.g1518). These would halve the risk threshold for starting statins in people at low risk of cardiovascular disease—from a 20% risk over 10 years to a 10% risk, as assessed by the QRISK2 tool. This is against a background of falling mortality but rising morbidity from heart disease and widening related health inequalities. The guidance cites the falling cost of generic statins and new evidence of benefits. If you have any views on these draft recommendations, you have until 26 March to make them known to NICE.

Des Spence makes his views abundantly clear (p 41). The evidence supporting the new guidance comes from "a reworked meta-analysis of old disparate cholesterol studies," he says. "Shouldn't we have definitive research before we 'statinise' a whole population?"

John Abramson and colleagues echo this cry. Replying to criticism of their recent *BMJ* article (doi:10.1136/bmj.f6123), they call for a publicly funded randomised controlled trial to compare statins, lifestyle intervention, and both for the prevention of cardiovascular disease in people at low risk.

Abramson's critics are Mark Huffman and colleagues. Their Cochrane review prompted NICE's change of heart and was largely based on the Cholesterol Treatment Trialists' meta-analysis, to which Spence refers. We hope soon to hear from the authors of the meta-analysis, but in the meantime you can read the dialogue between the Cochrane authors and Abramson and colleagues (pp 26, 27).

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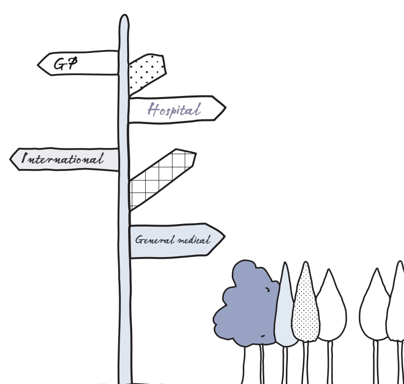


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