

ASSISTED DYING **Ray Tallis**

# Assisted dying is not the same as euthanasia

It should be made clear that no attempts are being made to introduce euthanasia through parliament in England and Wales

In a response to *The BMJ* retired general practitioner Philip Hartropp raised a key point about the misleading nature of the leaflet from the campaigning group Care Not Killing circulated in a recent edition of the journal.<sup>1</sup> Hartropp said, “The ‘FACTS’ put forward by Care Not Killing in their leaflet have evidently been chosen to divert the debate away from assisted dying to assisted suicide/euthanasia and away from sensible and evidence based arguments and into the realm of distorting and scaremongering.” He also said that a consultation by the Royal College of General Practitioners in 2013 showed that between 42% and 50% of the college’s membership did not support the college’s current stance of opposition to assisted dying. I would like to expand on his comments and highlight other untruths in the Care Not Killing leaflet.

The leaflet made 12 references to “euthanasia.” It should be made clear that no attempts are being made to introduce euthanasia through parliament in England and Wales. Euthanasia is fundamentally different from what is proposed in Charles Falconer’s Assisted Dying Bill. Under euthanasia laws in the Benelux countries doctors can directly end a patient’s life, at the patient’s request, on the basis of a broad criterion of suffering—not necessarily linked to a terminal illness. In sharp contrast the assisted dying law, as proposed by Falconer and currently legal in the US states of Oregon, Washington, and Vermont, would mean that only mentally competent, terminally ill adults who had a prognosis of less than six months to live would have the choice to take prescribed, life ending drugs. To interchange the terms euthanasia and assisted dying is, to put it simply, wrong.

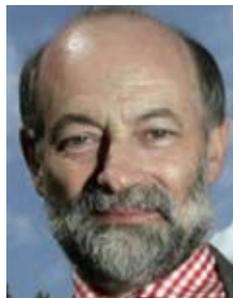
Alison Davis’ story, as described in the leaflet, is a moving one, and her defiance in the face of her conditions is humbling. Again, however, it must be made clear that her eligibility for an assisted death

under the Assisted Dying Bill would have been questionable. One of the many stringent safeguards would be for two doctors to assess the patient independently and reach a consensus on the prognosis and other eligibility criteria. They would have to be confident that the patient had a terminal illness and was likely to die within six months. Although Davis may have satisfied the criteria for an assisted suicide in Switzerland or voluntary euthanasia in the Benelux countries, these laws are categorically not what is being campaigned for in England and Wales.

Professor Andrew Sims correctly states that “assessment of mental capacity can be very difficult.” This is true in a small number of cases and is why the bill contains the provision of referral to a psychiatrist in the case of doubt about capacity. In cases of real doubt, assisted dying should not be undertaken.

Sims also quoted figures from Oregon, where an assisted dying law has been in place since 1997. He stated that the number of cases of assisted dying had risen by 430% over 14 years. The fact is that, after eight years during which the numbers slowly rose while the practice became embedded in end of life care, the annual number of deaths each year from assisted dying has been, consecutively from 2008 to 2013, 60, 59, 65, 71, 85, and 71. The figures have remained reasonably steady over the past six years and went down last year. Further, physician assisted deaths have never accounted for more than 0.25% of all deaths in Oregon.

To stick with Oregon, Professor Rob George stated that 49% of people who had an assisted death in 2012 said they didn’t want to be a burden on family, friends, and caregivers. George failed to point out that the three biggest concerns at the end of life raised by those who had an assisted death were losing autonomy (93%), being less able to engage in activities making life enjoyable



“  
**The Care Not Killing leaflet and the people quoted in it are deliberately trying to cloud the debate on assisted dying with misleading falsehoods, irrelevant statistics, and unnecessary scaremongering**

”

This article is an edited version of a response that was published on [bmj.com](http://bmj.com) on 29 April 2014. To see the original response and other responses in the same thread, visit <http://www.bmj.com/content/347/bmj.f7149?tab=responses>

(89%), and loss of dignity (72%). His point that “only 28% cited insufficient pain management” serves to further highlight that palliative care, no matter how good it is, cannot always alleviate suffering. “Suffering” is a term that goes far beyond pain control alone.

Sims also raised concerns about coercion. Research from Oregon has shown that patients requesting assisted dying were “strong and vivid personalities characterized by determination and inflexibility.” Furthermore, if we are worried about coercion, then surely we would want upfront safeguards to ensure that dying people were making an informed decision, in consultation with healthcare professionals? At present the law turns a blind eye to compassionate amateur assistance to die, with motive and consent being investigated after the person has died.

Brendan O’Neill said that major disability rights groups in Britain opposed any change in the law on assisted dying. This is true (although individual patient representative groups are neutral on the issue). However, as Hartropp explained, the stances of representative bodies are often in conflict with the views of their members. Indeed, in a recent poll of over 1000 disabled people 79% expressed support for assisted dying for terminally ill, mentally competent adults, and only 8% said they thought that disability rights groups should be opposed to a change in the law on assisted dying.<sup>2</sup>

In summary, this leaflet, the people quoted in it, and Care Not Killing as an organisation are trying to cloud the debate on assisted dying with misleading falsehoods, irrelevant statistics, and unnecessary scaremongering.

Ray Tallis is retired professor of geriatric medicine, Stockport  
[raymond@rtallis.wanadoo.co.uk](mailto:raymond@rtallis.wanadoo.co.uk)

Competing interests: I am the chairman of Healthcare Professionals for Assisted Dying.

References are in the version on [bmj.com](http://bmj.com).

Cite this as: *BMJ* 2014;348:g3532

● LETTERS, p 19

PRIMARY CARE **Azeem Majeed**

# Statins for primary prevention of cardiovascular disease

Three obstacles are in the way of extending statin treatment to a wider population

Statistics from the Organisation for Economic Co-operation and Development show that the per capita use of statins in the United Kingdom is the highest in Europe and the second highest of all OECD countries.<sup>1</sup> Several factors account for the high use of statins in the UK, including the emphasis on evidence based medicine in the training of UK doctors; the 2004 contract for general practitioners, which introduced financial incentives for the management of long term conditions such as coronary heart disease and diabetes; and the NHS Health Check programme, which aims (among its objectives) to increase the use of statins for the primary prevention of cardiovascular disease in England in people who have a 20% or more 10 year risk of such disease.

The UK National Institute for Health and Care Excellence is now proposing to reduce the threshold for starting statins for the primary prevention of cardiovascular disease from its current threshold of a 20% 10 year risk to a 10% 10 year risk.<sup>2</sup> Although this could have major benefits for population health by substantially increasing the number of people who would be eligible for statins for the primary prevention of cardiovascular disease, three key issues need to be considered if we are to implement this policy successfully.

Firstly, general practices (the main route for assessing cardiovascular risk and prescribing long term statins) are currently under considerable workload and financial pressure. The BMA and the Royal College of General Practitioners have launched public campaigns to make people aware of this pressure and to try to increase the resources going to primary care.<sup>3</sup> (In recent years, the BMA has reported, the proportion of the NHS budget spend going to primary

care has fallen from around 11% to 8%.) In its draft guidance, NICE did not attempt to assess the workload implications of its proposed 10% 10 year risk threshold or how this additional work would be funded. Furthermore, despite already being overstretched and underfunded, general practices will have other major new areas of work to take on, such as hospital admission avoidance schemes, improved care for older patients, longer opening hours, and more rapid access for people with acute medical problems. General practices may not be able to cope with all these additional areas of work and at the same time further expand access to statins unless the government were to increase the funding that general practices receive.

Secondly, patients need to be convinced to take statins, particularly those with lower levels of cardiovascular risk who may perceive themselves as being healthy and who may not be keen on long term drug treatment. Early results from local evaluations of the NHS Health Check programme are not encouraging.<sup>4</sup> Only a minority of patients attended for their NHS Health Check after they received an invitation, and a substantial proportion of patients who did attend and who were found to have a high 10 year cardiovascular risk did not subsequently start treatment with statins.<sup>5</sup> Clearly, much work needs to be done by general practices, local authorities (now responsible for commissioning the NHS Health Check programme), and Public Health England to convince people who think they are healthy to start long term statin treatment. Convincing people to take statins may be even more difficult in those with a 10 year risk of cardiovascular disease of between 10% and 20% if the proposed NICE guidelines are adopted into clinical practice and



“  
In its draft guidance, NICE did not attempt to assess the workload implications of its proposed 10% 10 year risk threshold or how this additional work would be funded



10% becomes the threshold risk level for starting treatment.

Finally, what is the true level of side effects from statins?<sup>6</sup> Millions of people in the UK are taking statins without suffering any major problems. But there are differences in the risk of side effects shown in clinical trials and in data derived from electronic medical records, which generally report a higher incidence of adverse events in people taking statins than has been reported in clinical trials. This discordance between the evidence from clinical trials and from clinical practice needs to be investigated so that doctors and patients are given accurate information about the risks and benefits of long term statin treatment.

Azeem Majeed is a professor of primary care and head of the Department of Primary Care and Public Health, Imperial College London, and a GP principal, London  
a.majeed@imperial.ac.uk

**Competing interests:** I am a GP principal at the practice of Dr Curran & Partners in Clapham, London. Part of the practice's funding is determined by its performance in the primary and secondary prevention of cardiovascular disease. I have received funding to evaluate the NHS Health Check Programme from the Department of Health, the National Institute for Health Research, and the NHS.

**Provenance and peer review:** Not commissioned; not peer reviewed.

This article first appeared as a *BMJ* blog (<http://bit.ly/1m0w93q>)

- 1 OECD. Health at a glance 2013. [www.oecd.org/els/health-systems/health-at-a-glance.htm](http://www.oecd.org/els/health-systems/health-at-a-glance.htm).
- 2 NICE. Lipid modification (update): guideline consultation. [www.nice.org.uk/guidance/index.jsp?action=folder&o=66546](http://www.nice.org.uk/guidance/index.jsp?action=folder&o=66546).
- 3 Iacobucci G. Royal college calls for 11% of NHS budget to reach primary care by 2017. *BMJ* 2014;348:g1748.
- 4 Artac M, Dalton ARH, Majeed A, Car J, Huckvale K, Millett C. Uptake of the NHS Health Check programme in an urban setting. *Fam Pract* 2013;30:426-35.
- 5 Artac A, Dalton ARH, Majeed A, Car J, Millett C. Effectiveness of a national cardiovascular disease risk assessment program (NHS Health Check): results after one year. *Prev Med* 2013;57:129-34.
- 6 Majeed A, Molokhia M. Adverse effects of statins [electronic response to Godlee F. Adverse effects of statins]. *BMJ* 2014. [www.bmj.com/content/348/bmj.g3306/rr/698335](http://www.bmj.com/content/348/bmj.g3306/rr/698335).

Cite this as: *BMJ* 2014;348:g3491