EDITOR'S CHOICE

Who are we treating?

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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 just published in the *BMJ* 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 (doi:10.1136/bmj.g1219). These patients were also less likely to die in their preferred place.

As Michael Rabow comments in his editorial (doi:10.1136/bmj.g1529), 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 (doi:10.1136/bmj.g1899). 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 correspondence between the Cochrane authors and Abramson and colleagues (doi:10.1136/bmj.g1520; doi:10.1136/bmj.g1523).

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