Conservative management was more effective than invasive management in acute non-Q-wave MI
D Massel
Evidence-Based Medicine 1998;3:177
This is a summary and appraisal of a randomised controlled trial of 920 patients with non-Q-wave myocardial infarction.1
The two groups of patients were invasive—angiography and appropriate revascularisation—or conservative—radionuclide ven-
triculography and thallium stress testing with invasive procedures only when specific criteria were met. It was concluded that there was no difference in the outcome measures of death and non-fatal myocardial infarction at two year follow up for both groups.


PERSONAL VIEW

People should die at home
Cilla Reid

“Does she really need to have this” I heard the plea from behind a curtain of our department. Peeking into the cubicle I found a junior doctor trying to put up a drip and take blood from a cachectic woman who didn’t look as though she would last the hour (indeed she didn’t). Her husband was with her and was her advocate in trying to defend her from unnecessary intervention. I called the doctor out of the cubicle and asked, in private, why this procedure was necessary. The explanation was that the routine tests were being carried out before admission and a drip was being put up for rehydration. Inquiring further into the history I ascertained that the lady was suffering from terminal cancer and was being given palliative care only. She was being cared for at home by her family until that evening, when, feeling they could no longer cope, they sought help from their GP practice, speaking to the deputising doctor who arranged acute admission.

I persuaded the doctor not to investigate the lady and to treat her with analgesia only while we endeavoured to keep her as comfortable as possible. She died in the accident and emergency department shortly afterwards. Fortunately her GP, when contacted, knew her well and was willing to sign the death certificate, avoiding a postmortem examination and having to report her death to the coroner.

In this country 73% of deaths occur in hospital or other communal establishments (including nursing homes) while only 20% die at home. Of the remainder 4% die in hospices and about 3% elsewhere.1 The hospice movement works to improve care of the terminally ill, and by appropriate management of pain, nausea, and other symptoms often succeeds in returning patients to their home and families for their final days. In hospital, on the other hand, we seem reluctant to face up to dying patients and to allow them to die peacefully or with dignity. Thus we routinely carry out unnecessary interventions and investigations, usually instigated by junior doctors with little experience of palliative or terminal care, often in the hostile setting of a busy accident and emergency department.

Surely we can do better.
I know of one trust who has employed round the clock district nurses who will see such patients in their homes. This avoids admissions to precious acute hospital beds while giving both patients and their families appropriate quality care at home. This is at present funded by winter pressure money but would surely be a good innovation all year round.

As a nation we need to accept dying as part of life and as doctors we should see kindly care of the dying patients and their relatives as an integral part of our role. It need not be defeat and we should not reflexly investigate and intervene in the dying patient without considering what action is really justified. This approach requires experience and should not be left in the hands of juniors.

I believe care and support at home in the final hours and days to be more appropriate in many cases than hospital admission. Terminally ill patients should never have to spend their final moments in an accident and emergency department.

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