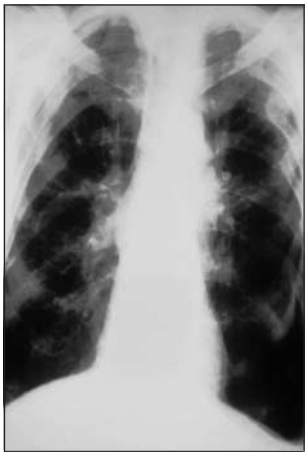
## Treating acute COPD at home is as good and cheaper



SCOTT CAMAZINE/SPL

Hospital at home schemes are safe, effective, and cheaper than inpatient care in hospitals for treating many patients with acute exacerbation of chronic obstructive pulmonary disease (COPD), and free up hospital beds. A systematic review by Ram and colleagues (p 315) identified seven randomised controlled trials (with 754 patients) comparing hospital at home schemes with inpatient treatment. Mortality and hospital readmission were similar in the two groups of patients. Two studies that compared costs showed that hospital at home care was substantially cheaper than inpatient care.

## POEM*

### CRP is a weak predictor of coronary heart disease

**Question** Is C reactive protein a good predictor of coronary heart disease?

**Synopsis** C reactive protein is increasingly recommended as a screening test for coronary heart disease (CHD). This large study included healthy men (n = 8888) and women (n = 9681) born between 1907 and 1935 in Reykjavik, Iceland. Patients were recruited between 1967 and 1991 and followed up until 1995, at which point 2459 participants had had a major coronary event. A group of 3969 control patients were selected from those who had not had an event and were matched by sex, year of recruitment, and age. Logistic regression was used to estimate the odds ratios for the relation between raised C reactive protein and CHD and adjusted for age, sex, CHD risk factors, and socioeconomic status. Although the patients did not specifically report it, the authors feel that the routine use of aspirin or statins was uncommon in this population during the study period. It turned out that C reactive protein was not a very strong predictor, with an odds ratio of 1.45, compared with 1.30 for erythrocyte sedimentation rate, 2.35 for total cholesterol, 1.87 for smoking, and 1.50 for raised systolic blood pressure. An update of a meta-analysis of 22 previous prospective studies found similar and homogeneous results.

**Bottom line** C reactive protein is a moderately accurate independent predictor of coronary heart disease. Its role as a screening tool has not been firmly established.

**Level of evidence** 3b (see www.infopoems.com/levels.html). Individual case control study

Danesh J, Wheeler JG, Hirschfield GM, et al. C-reactive protein and other circulating markers of inflammation in the prediction of coronary heart disease. *N Engl J Med* 2004;350:1387-97.



* Patient-Oriented Evidence that Matters. See editorial (*BMJ* 2002;325:983)

## *Editor's choice*

## All doctors have a personal horror story

Most doctors have at some time borne the broken look of Marlon Brando's Colonel Kurtz in *Apocalypse Now*, dehumanised by the Vietnam War. For me, "the horror" was over 10 years ago as a preregistration doctor in surgery at St James's Hospital, Leeds, about the time the European Working Time Directive was conceived by people with time to think. I began a weekend shift at 8 am on Saturday morning, an endless ward round of patients I'd never seen before with illnesses I little understood. I finished at 9 pm on Monday after non-stop calls—mostly straightforward but many bewilderingly complex—a couple of cheese sandwiches, a few cans of soft drinks, and three hours of broken sleep on a two seater sofa.

At some point on Sunday evening my fellow junior doctors and I cracked. Overworked, sleepless in surgery, every incident and comment greeted with unstoppable mirth, professionalism replaced by inane amusement at our predicament. By Monday evening we were catatonic Brandos. Sharing this rite of passage with senior colleagues attracted little sympathy: "In my day we had it much worse; whole weeks on call without a break." "The experience will be good for you." But was the experience any good for patients? Was it really any good for any of the doctors who lived it then and live it now? Too much mistreatment of doctors and patients has been excused by what is deemed good for us.

This week, the working time directive should mean fewer doctors in training work more than 58 hours a week (p 310). Rhona MacDonald describes how organisers of health care have had to innovate by rethinking out of hours cover and switching to competency based training (p 301). New medical schools have opened in England to supply enough doctors to compensate some far off day for this reduction in working hours (p 327). What hope that doctors in training will see real benefit? MacDonald, a passionate Scot, argues that those already exploited—doctors from poorer countries and non career grades—will be further exploited for doctors in training to benefit. This well meaning legislation—legislation that doctors know to be inapplicable without major reform of the medical workforce and medical training—is proving hard to implement, as our European round up shows (p 310).

Richard Smith, another passionate Scot—by choice, not by birth—left the *BMJ* last week (p 309). He devoted 25 years of inexhaustible energy to this publication—13 years as one of its greatest editors—one eye on blue skies the other on fine detail, working at full tilt to the end as he promised, in defiance of any working time directive. He leaves behind a young team—plus some wise heads—dedicated to building on his considerable achievements. The *BMJ* will miss his genius and his gusto. But as he once told me: "Nobody is bigger than the *BMJ*, not even me."

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