support the practice of optimisation its cost will have to be calculated into the price of operating on these patients. The benefits in survival, reduced morbidity, and shorter hospital stay are striking enough to justify it.

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Managing atrial fibrillation in elderly people

Active management of atrial fibrillation should include elderly people

Chronic atrial fibrillation is the commonest arrhythmia seen in clinical practice. Not only does it cause increased morbidity and mortality among affected individuals; it also adds a significant burden to healthcare costs. The prevalence of atrial fibrillation increases steadily with age (from 0.5% of those aged 50-59 years to 8.8% of those aged 80-89 years), as do the associated risks.[1] Even in the absence of rheumatic heart disease, there is a sixfold increase in thromboembolic phenomena, and atrial fibrillation accounts for up to 36% of all strokes in elderly people.[2] It is the commonest arrhythmia requiring admission to hospital and is the primary diagnosis in 20% of all new outpatient cardiology appointments. As the population ages so these effects will be exacerbated.

Patients who develop atrial fibrillation are likely to present to their general practitioner with palpitations, shortness of breath, and fatigue. The loss of atrial systolic function can reduce cardiac output by up to 50%, especially in those with coincident ventricular impairment.[3] Older patients, who are particularly vulnerable to these effects, may develop exercise intolerance, which is reversible when sinus rhythm is re-established,[4] or may decompensate and develop frank heart failure.

The most effective way of minimising the increased thromboembolic risk and treating symptoms is to return the heart rhythm to sustained sinus rhythm by electrical or chemical cardioversion. Cardioversion is safe, with an estimated risk of thromboembolism of <1%, even among those at highest risk,[5] which compares favourably with that seen in chronic atrial fibrillation. Cardioversion is most effective when delivered soon after the onset of atrial fibrillation because of structural changes in the atria which perpetuate the arrhythmia.[6 7] Moreover, when the arrhythmia has been present for less than 48 hours cardioversion is safe without prior anticoagulation.[8] Early diagnosis and treatment are therefore important, but how can they be achieved? Once the condition has been identified in the community, assessment in hospital is essential since cardioversion remains a secondary care service.

Large series have shown initial success rates for cardioversion of around 75%-91% in patients of all ages. Factors shown to reduce the likelihood of successful cardioversion include increased duration of arrhythmia (over 12 months), increased left atrial diameter (>45 mm), and heart failure of New York Heart Association class II or greater. Most studies found that increased age itself had no independent effect on the success of cardioversion.[9] Restoration and maintenance of sinus rhythm after successful cardioversion may be enhanced by the use of antiarrhythmic therapy,[10] though optimal drug therapy has yet to be determined.

Failing conversion to sustained sinus rhythm, antithrombotic treatment with warfarin reduces the risk of stroke in patients with atrial fibrillation by about 70%.[11] Many physicians do not use anticoagulation in elderly people, perceiving the risk:benefit ratio to be too high, and continue to prescribe aspirin instead,[12] despite its lack of efficacy in this age group.[11] Although anticoagulation in those aged over 75 is associated with greater risk when the international normalised ratio (INR) is maintained at 2.0-4.5, both the BAATAF and SPAF III trials showed that anticoagulation to a lower INR of 1.5-3.0 is both safe and effective in reducing the risk of stroke in this age group.[11] Starting warfarin therapy in the community is logistically difficult, requiring daily visits for blood sampling, frequent communication, and dose adjustments by patients, all of which are more difficult in elderly people. New low dose starting regimens for the outpatient initiation of warfarin, particularly in elderly patients with atrial fibrillation, should help facilitate its more widespread use.[13]

Wide variations exist in the current management of elderly patients with atrial fibrillation.[12] Surveys of use of anticoagulation show consistently that elderly people are less likely to receive anticoagulants than younger ones on the grounds of age alone, even when

BMJ 1999;318:1088–9

the risk:benefit profile seems favourable.[14] Atrial fibrillation in an elderly patient seems to be accepted by many clinicians as a norm and is not treated aggressively. The ideal management of atrial fibrillation is cardioversion to sustained sinus rhythm, which both abolishes the increased thromboembolic risk and obviates the need for anticoagulation, or, failing this, adequate long term anticoagulation, which should be carefully considered in all patients regardless of age. In practice, even though the ideal may be unachievable, many elderly patients with atrial fibrillation remain suboptimally treated.

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Independent inquiries into homicide

Should share common methods and be integrated into new quality systems

Since 1994 an independent inquiry has been required in all cases of homicide by discharged psychiatric patients in England and Wales.[1] Psychiatrists have argued that these inquiries are inefficient, costly, misleading, and potentially unjust, yet their suggestions that they should cease, or be incorporated into other forms of audit,[2] have not been adopted. Inquiries undoubtedly serve some important needs, but their failure to ask a consistent set of questions or develop a common methodology has limited their usefulness.[3] In particular, many inquiries have not recognised the limitations inherent in the study of a single case.

Inquiries are important because they help relatives to find out what happened. Both relatives and the public want to know that everything that should have been done was done: they wish to see addressed the prima facie case that if someone is dead care must have been inadequate. Moroever, there is a widespread view, shared by some psychiatrists, that inquiries provide a way of assessing and improving services. But a lack of focus has limited the benefits.

The departments of health for England and Wales recommended some terms of reference for inquiries. Typically these include: the quality and scope of the patient's health care, social care, and risk assessment; the appropriateness of his or her treatment, care, and supervision; the extent to which care met statutory obligations and complied with health department guidance; the appropriateness of staff training and the adequacy of collaboration between the agencies. Faced with this list, it is hardly surprising that different inquiries have concentrated on different questions.

The methods adopted by different inquiries have also been inconsistent. There is no consensus, for instance, on whether hearings should be in private or in public, on whether witnesses should have legal representation, or even on whether consent needs to be obtained before a patient's medical records are used. There is no agreed size or composition for an inquiry team. Members receive no training, although most only ever do one inquiry, and there is no agreed pool from which they are drawn. Crucially, no attempt has been made to address one of the central questions of social science, a question which the very existence of inquiries raises: What can the study of an individual case tell us?

If they are to continue, independent inquiries should sharpen their focus. They should attempt to answer one question and comment on the performance of services in relation to two others. The question they should attempt to answer is: Was there anything that should have been done, but was not done, which would have reduced the chances of a homicide occurring? This question is preferable to one that many attempt to answer at present: Could the homicide have been prevented? This second question requires an explanation of why (not merely how) the homicide happened—and thus raises the question of whether our actions are determined by chains of cause and effect which operate according to laws and, hence, predictably? This has detained philosophers and social scientists for centuries.[4] Concentrating on "the chances of a homicide occurring" would avoid the necessity for inquiries to defer to Aristotle.

The two questions where inquiries should limit themselves to commenting are: Were the services meeting accepted standards? and Are those standards good enough? Inquiries should address these two questions because failures of service provision need to

BMJ 1999;318:1089–90