could not be reliably predicted from the international normalised ratio obtained over that period. Despite the small reduction in the warfarin dose on day 6 the international normalised ratio might have been expected to continue to rise over the following days even if the patient had not been exposed to accumulating concentrations of amiodarone.

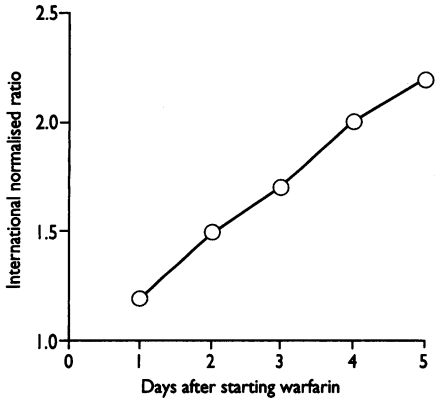

Fig 1—*Changes in international normalised ratio after start of treatment with warfarin*

An alternative lesson of this case is that, in the absence of an appropriate loading regimen, the international normalised ratio should be monitored beyond the usual five to six days because of the delay in reaching a steady state effect.

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Continuing rise in emergency admissions

Visiting elderly patients at home immediately after discharge reduces emergency readmissions

EDITOR,—Simon Capewell suggests various reasons for the rising tide of emergency admissions to hospital, including increased multiple readmissions and decreased support for elderly people in the community.[1] We wish to draw attention to our research into readmission and support on discharge for elderly people.

We evaluated a community based hospital discharge scheme for people aged over 75 and followed up 903 patients for 18 months in a randomised controlled trial; half of the patients received care under this scheme and half received standard discharge care.[2] The scheme consisted of support from a care attendant on the day of discharge and for a maximum of 12 hours a week for two weeks after each discharge for every patient discharged home (a total of three hours' care was given on average). The care attendants' remit was to provide personal care and help and encouragement with rehabilitation and to ensure necessary continuing support. The scheme aimed to provide a safety net for patients, including those assessed as not needing care, and to check gaps in provision or failure to implement services. The care attendants also reported providing emotional support to over half of the patients. This age group of patients has a high readmission rate, with half being readmitted at least once within a year. Those receiving care under the discharge scheme had significantly fewer multiple readmissions (7% *v* 14% were readmitted twice or more within 18 months).[3] This significantly reduced patients' average number of days in hospital over the subsequent 18 months, particularly for the half who lived alone (17 days *v* 31 days). The scheme was costed at £66 000 per 250 000 population, with short term savings of £287 000 (1985-6 values) and much higher long term savings. Early readmission rates (within three months) were significantly higher for those initially admitted as emergencies (26%, compared with 12% after planned admission), but those receiving care under the discharge scheme were significantly less likely to be readmitted as an emergency.[3]

In the three months after discharge the patients' median functional and cognitive ability improved significantly (equivalent to their being 5-10 years younger), the greatest improvement being for patients with heart disease. This suggests an average loss of at least this amount over the period relating to the admission and shows the patients' relative frailty at discharge and the potential for rehabilitation.

This study shows that providing at least one home visit immediately after discharge in addition to the care provided after formal assessment would benefit patients over 75 and be cost effective to health and social services. Similar schemes are being implemented in the North Thames region.[4]

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GPs' low morale is contributing factor

EDITOR,—Simon Capewell describes the diverse and numerous factors associated with the continuing rise in emergency admissions.[1] He fails, however, to mention one of the most important underlying reasons why general practitioners may have a lower threshold than previously for admitting patients to hospital—namely, their low morale.

Out of hours work has been identified by general practitioners in a succession of surveys as one of the more potent causes of perceived stress.[2-4] The necessary follow up home visits are time consuming, but, in addition, keeping ill patients out of hospital requires doctors to absorb worries about the responsibility and management of the clinical condition, the concerns of the patient and carers, and the fears of litigation if all does not go well. This is emotionally draining work on top of a far busier and more exacting daily workload for general practitioners than a decade ago. If individual general practitioners' morale is low it is not surprising that they take the easier management option and have a lower threshold for sending sick patients to hospital rather than monitor and treat them at home.

A continuing rise in emergency admissions is only one area where the consequences of general practitioners' declining morale is proving costly.

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Reduce time from referral by GP to first outpatient attendance

EDITOR,—The fact that elective admissions are increasing at a lower rate per year than emergency admissions[1] suggests that part of the solution is to increase elective admissions, day case procedures, and outpatient appointments in order to reduce what will otherwise probably become arguably inappropriate "emergency" admissions. Patients admitted as emergencies while awaiting admission or an outpatient consultation are likely to receive treatment that is more expensive in staff time and less efficiently delivered than would be the case if it was delivered in the way planned. It may be less effective, but this is not clear. When out of hours teams deliver medical care that would otherwise be provided in normal hours this must reduce the service to other patients whose problems are undoubted emergencies.

As a general practitioner, I think that the most obvious factor to concentrate on is the length of the cycle from referral by a general practitioner to the first outpatient attendance. Locally this seems to be about eight weeks, and the advice from at least one specialist medical department is that if this is too long then the patient should be admitted as a (general) medical emergency. I cannot see any part of the administrative process of organising an outpatient appointment that could not be run as well on a six week cycle as on an eight week cycle. The effects of this change would include a reduction in extra calls to general practitioners (often by relatives out of hours, and not to the patient's own general practitioner, which is a situation well known to encourage admission). We cannot ignore patients' expectations in the health service. Citizens are unwilling to wait eight weeks and will generate more work if we do not react to this.

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