LETTERS

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Oral anticoagulation monitoring

Sir,

The editorial by Hobbs and Fitzmaurice (August *Journal*)[1] rightly advocates the need for standardized evaluation of anticoagulant control if we are to be able to ensure a high level of clinical efficacy for patients. Their discussion of options, however, does not consider patients' preferences.

Our patients requested a surgery-based clinic, and patients who had previously been poor hospital attendees were encouraged to have regular monitoring.[2]

A survey after the first year revealed that all patients considered the surgery-based clinic to be an improvement. A wide range of reasons were identified (Table 1). Many commented that they preferred surgery-based management to seeing rotational junior doctors as they could build a relationship with the same person over a period of time and receive care from someone who knows their medical problems, current drug therapy, and sensitivity to warfarin dosage changes. Patients admit to feeling more at ease in the surgery than at the hospital and are more likely to ask questions regarding their therapy. Good relationships are established and improved patient awareness is achieved through counselling and education. It is also possible to spend time reinforcing areas of poor understanding and prioritizing the information provided to each patient. Patient awareness is less well achieved where (because of other pressing duties) continuity, knowledge, and commitment is lacking, as is often the case where junior medical staff are involved.

The reduction of waiting times in the surgery clinic compared to the hospital was of prime importance to the elderly and those in full-time employment. Management of any patient group with specific long-term monitoring needs should take the patient's opinion into consideration.

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References

1. Hobbs FDR, Fitzmaurice DA. Where should oral anticoagulation monitoring take place? *Br J Gen Pract* 1997; **47:** 479-481.
2. Macgregor SH, Hamley JG, Dunbar JA, *et al.* Evaluation of a primary care anticoagulant clinic managed by a pharmacist. *BMJ* 1996; **312:** 560.

Sir,

I was fascinated by the editorial by Hobbs and Fitzmaurice (August *Journal*) from the University of Birmingham.[1] In West Lothian, where I practise, oral anticoagulation monitoring 'traditionally' (for at least the past 16 years) has been carried out in general practice. My experience, albeit many years ago in a hospital setting, was that oral anticoagulation monitoring clinics were run by either house officers or senior house officers who had received no special training in this field, and who had no idea what international normalized ratio (INR) was required for an individual patient. As Hobbs and Fitzmaurice suggest, these clinics were unpopular with patients, who had to put a whole morning aside to attend.

Our practice uses a simple system that combines patient convenience with the benefit of INR testing at an approved site, avoiding the problems of near-patient testing. The patient attends the practice nurse when testing is due and the blood is taken. The blood is then sent to our local hospital for testing that day. The result is then phoned back by the hospital and entered on an individual patient sheet; this sheet has the patient's name, date of birth, phone number, reason for anticoagulation, whether the anticoagulation has to be lifelong or for a limited period, and the desirable ratio for the patient. The date and INR are entered, and a doctor is asked to decide what dose the patient should then take and when the INR should be rechecked. The patient then phones to find out the result and what action needs to be taken. All these sheets are kept together in a folder. This allows a member of staff to go through all these patient records easily once a month to check on defaulters.

Our practice of approximately 13 000 patients has 79 patients requiring oral anticoagulation monitoring. All patients have a warning on their computer and written records to alert doctors that these patients are on anticoagulation therapy.

Rodgers states that 78% who responded to their questionnaire in the former Northern Region were already involved in monitoring and that 32% were involved in initiating warfarin anticoagulation.[2] However, Lip, in the same issue, reveals only 7.5% of patients in the Birmingham practices were being monitored by the GP

Table 1. Factors important to patents attending for anticoagulant monitoring.

	Percentage of patients considering issue important
Appointment system available	94%
Can contact staff easily	88%
Can see same person each visit	82%
Clinic visits are short	82%
Time to ask questions	82%
Can be seen at short notice	82%
Can be seen in GP surgery	76%
Clinic near home	76%