

Comment

The data show that the number of HIV related consultations in Dutch general practice is rather low. However, the increase observed in the number of these consultations during the study period and the differences in the numbers of consultations recorded between practices are remarkable. General practitioners can play an important role in reassuring their concerned patients providing that they can translate the general information about AIDS/HIV to the needs of the individual patients.

Funding: Ministry of Welfare, Health and Culture, after

nomination by the Dutch programme committee for AIDS research.

Conflict of interest: None.

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(Accepted 1 November 1995)

Methods for managing the increased workload in anticoagulant clinics

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Following evidence of clinical benefit in non-rheumatic atrial fibrillation,¹ increasing numbers of patients with cardiac conditions are being referred to outpatient anticoagulant clinics, necessitating review of existing services.² In one anticoagulant clinic in a north London hospital the number of new patients referred increased by 27% and clinic attendances by 77% between 1991 and 1993. Methods for managing this increase have been reported,^{3,4} but we have developed a system which can operate within existing resources by selecting patients requiring consultation with a clinic doctor.

Patients, methods, and results

A weekly anticoagulant clinic was administered by a phlebotomist with the help of two health care assistants, and all patients were seen by the clinic doctors (a consultant haematologist and a registrar) for dosing and counselling. In 1991 a baseline audit of 152 notes and details of anticoagulant control over six months was conducted. As only half of clinic attenders spend more than half the time within therapeutic limits,⁴ 100 patients were required to have an 80% chance of detecting a 20% change in the proportion of patients spending most of the study period within their target range. The first group (group 1) was a 1 in 2 sample of patients attending the clinic for more than six months (n=105), selected alternately from an alphabetical list. Because control of anticoagulation is more variable at the start of treatment,⁵ a second group (group 2) was formed from consecutive new patients (n=47). Control of anticoagulation was audited against the patients' individual international normalised ratio (INR) target ranges. We estimated the time which each patient spent within therapeutic limits during the six months

by calculating the interval between INR tests and dividing it equally between INR results at the beginning and end of each interval.

After the baseline audit the clinic system was modified so that fewer patients were required to see the doctors: new attenders until control had been stabilised, patients whose INR was outside therapeutic limits, those asking to see the doctor, and those who had experienced five key events relating to anticoagulant control (bruising or bleeding; attendance at an accident and emergency department; admission to hospital; starting, stopping, or changing any medicines; notification of dental treatment or surgery due within two months). Health care assistants were trained to ask each patient about the five key events at each visit (excluding first attendance), to record the answers on the revised treatment card, and to refer to the doctors any patients who said they had experienced any of the events. All other patients had their doses determined by the doctors without consultation.

In 1993 seven months after these changes were implemented we repeated the audit. Owing to an increase in the number of patients attending clinic, the second sample consisted of 206 patients: 122 patients in group 1 and 84 in group 2. The second audit included four patients in group 1 and 37 in group 2 from the first audit.

Table 1 shows the outcomes of both the baseline audit and the second audit. Although there was a 50% reduction in the number of patients seeing a clinic doctor, the second audit showed that the median proportion of time spent within therapeutic limits remained unchanged.

Comment

This audit suggests that a simple screening system and a revised treatment card is a suitable method for managing the increasing numbers of patients without incurring additional costs, such as buying computer dosing systems³ or by shifting anticoagulant services to primary care.² The quality of clinical practice was maintained (even among patients with cardiac conditions) despite the reduction in the number of patients having a medical consultation.

Funding: Royal College of Physicians.

Conflict of interest: None.

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(Accepted 23 November 1995)

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BMJ 1996;312:286

Table 1—Results in anticoagulant clinic before and after introduction of a system of screening patients so that only some saw the doctor

	Baseline audit		Second audit	
	Group 1	Group 2	Group 1	Group 2
No of patients	105	47	122	84
No with cardiac conditions	82	11	79	37
Interval between appointments (days)	33	13	38	14
% Of time in target range:				
All patients	50 (33-75)	40 (17-62)	57 (38-72)	45 (25-60)
Cardiac patients	54 (33-75)	33 (10-50)	54 (36-74)	43 (22-62)
No (%) spending \geq 50% of time in therapeutic range	61 (58)	20 (42)	73 (60)	41 (49)