Radcliffe Hospital and Oxfordshire Health Authorities decided to collaborate in producing their own card. This is now in wide use throughout the county, having replaced the national card not only at the Oxford Radcliffe Hospital but also, more importantly in numerical terms, in all general practice surgeries and community pharmacies. It has also been offered to the other trusts in the county to use if they wish.

The card was approved by the Royal Pharmaceutical Society before the substitution was made. The Department of Health was also given notice of our intentions and raised no objection.

A further concern arose about the need for guidance as to when the card should and should not be issued. A double sided, A4 sized advice sheet was therefore produced, using the best available evidence, and sent to all general practitioners and community pharmacists with the first batch of the new steroid cards. Part of its intention is to rationalise the issuing of the steroid cards. They are not, for instance, recommended for patients receiving low doses of inhaled corticosteroids, in whom there is no increased risk from chickenpox.

The same guidance sheet also includes locally tailored advice as to what should be done if a patient at risk who is receiving corticosteroids does come into contact with chickenpox or shingles.

JOHN REYNOLDS
Clinical lecturer in clinical pharmacology
University of Oxford,
Oxford OX3 9DU

TOM JONES
Primary care medical adviser
JULIE MADDEN
Pharmaceutical adviser
Oxfordshire Health,
Oxford OX3 7LG

SARAH SCHOFIELD
Formulary pharmacist
Oxford Radcliffe Hospital,
Oxford OX3 9DU

1 Feher MD, Simms JP, Lant AF. History of chickenpox and steroid cards: a new warning? *BMJ* 1996;312:542-3. (2 March.)

Doctors Reform Society in Australia defends its reputation

EDITOR,—Events since the publication of Simon Chapman's Focus article from Sydney have shown the shallow analysis of his report.[1] His attempt to tarnish the Doctors Reform Society by saying that it is obedient to a political party requires a response.

The society has always been concerned with a better health system and is jealous of its independent reputation and professionalism. In 23 years of medical politics it has stood firm against moves by both the main political parties to whittle away the universality and accessibility of Medicare. All political views are represented among current members of its executive, who are united in their commitment to the best ideals of medicine. The society has a fine reputation in Australia, and I hope that readers will not have been misled.

CON COSTA
National president
Doctors Reform Society,
Box 14, 4 Goulburn Street,
Sydney, NSW 2000,
Australia

1 Chapman S. Health versus personality in Australian politics. *BMJ* 1996;312:334. (10 February.)

Evaluation of a primary care anticoagulant clinic

Authors did not present enough data

EDITOR,—Sheena H Macgregor and colleagues' report on the evaluation of a primary care anticoagulant clinic managed by a pharmacist is so lacking in methodological detail and supporting data that it is difficult to see how they can justify many of their conclusions.[1] No description of the study setting or study population is given. The potential for selection bias cannot therefore be determined, and it would be inappropriate to generalise the results beyond this particular general practice.

The authors chose to report only the proportion of the total number of measurements of the international normalised ratio that fell outside the target range, but it would be useful to know how many patients had abnormal ratios at any time during the study: did a small number of "difficult" patients contribute all the abnormal values or did most patients have an abnormal ratio at some time during the study? In addition, the subsequent course of those subjects with abnormal ratios is not reported.

No details are given as to how patients' knowledge was measured other than "by questionnaire," and no data are provided to substantiate the claim that counselling in hospital was unsatisfactory but subsequent counselling in the clinic improved patients' knowledge.

Despite the stated aims of the study, no costings are provided that might allow readers to assess the validity of the financial conclusion reached. The study cannot provide evidence that a pharmacist led clinic reduces the risks of toxicity and failure of treatment: it is not of an appropriate design to do so. Finally, only in the statement on funding does it become apparent that the study may have taken place in a fundholding practice. Given the nature of the study and the current climate of encouraging competition between health care providers, it is arguable that this amounts to a conflict of interest, although none is disclosed.

If the provision of health care in Britain is to improve, policymakers must surely be able to base decisions on evidence of a higher quality than this.

PETER W FOWLIE
MRC training fellow in health services research
University of Dundee,
Ninewells Hospital and Medical School,
Dundee DD1 9SY

1 Macgregor SH, Hamley JG, Dunbar JA, Dodd TRP, Cromarty JA. Evaluation of a primary care anticoagulant clinic managed by a pharmacist. *BMJ* 1996;312:560. (2 March.)

Issue of quality control was not addressed

EDITOR,—Sheena H Macgregor and colleagues conclude that "good therapeutic control" and a "cost effective" anticoagulant service can be provided in the general practice surgery.[1] Near patient testing of the international normalised ratio is certainly an attractive means of providing an anticoagulant monitoring service. The authors' paper fails, however, to address the central issue of quality control and does not quantitate the surgery costs.

Optimal patient care requires that near patient testing services meet the same standards of quality control that are required of accredited laboratories. Calibration of a coagulometer does not ensure that the measurements of the international normalised ratio produced on a day to day basis are either accurate or reproducible. The Joint Working Group on Quality Assurance[2] and the British Committee for Standards in Haematology[3] recommend that near patient testing schemes should be subject to a regular, properly documented, quality control process administered in cooperation with an accredited laboratory. This is particularly important for those portable coagulometers (such as the Biotrack 512 used in the study) that analyse uncitrated blood and consequently cannot be entered into national external quality assurance schemes. Without quality control data, comparison of international normalised ratios produced by different analytical systems, as in this study, cannot be meaningful.

Macgregor and colleagues refer only to the marginal costs of their clinic and do not quantify these. They draw a comparison with the hospital clinic's charge of £35. This is inappropriate, particularly as the hospital clinic has been available to fundholding general practitioners in Dundee free of charge.

Purchasers require detailed information about the quality, acceptability, and cost of different systems for monitoring anticoagulant treatment. The studies necessary to generate useful comparative data require cooperation rather than competition between primary and secondary care. In Dundee one such study involving four general practices and the haematology department is currently in progress.

SURJEET ADLAKHA
Staff grade haematologist
PHILIP G CACHIA
Consultant haematologist
MARTIN J PIPPARD
Professor of haematology
Department of Haematology,
Ninewells Hospital and Medical School,
Dundee DD1 9SY

PETER G DAVEY
Clinical director
Pharmacoeconomic Research Centre,
Ninewells Hospital and Medical School,
Dundee DD1 9SY

BARCLAY M GOUDIE
General practitioner
Westgate Health Centre,
Dundee DD2 4AD

1 Macgregor SH, Hamley JG, Dunbar J A, Dodd TRP, Cromarty J A. Evaluation of a primary care anticoagulant clinic managed by a pharmacist. *BMJ* 1996;312:560. (2 March.)
2 Joint Working Group on Quality Assurance. Appendix: guidelines on the control of near-patient tests and procedures performed on patients by non-pathology staff. In: Wood K, ed. *Standard haematology practice 2*. Oxford: Blackwell Science, 1994:278-9.
3 England JM, Hyde K, Lewis SM, Mackie IJ, Rowan RM. Guidelines for near patient testing: haematology. *Clin Lab Haematol* 1995;17:301-10.

Reporting of results should be standardised

EDITOR,—Sheena H Macgregor and colleagues report that primary care anticoagulant clinics run by a pharmacist achieve substantially better results than previously reported.[1] However, they give no indications of the patients' clinical conditions, no data on adverse events or quality of life, no information on how patients' preference was identified, and unhelpful data on costs.

A further major problem is their decision to report the proportion of measurements of the international normalised ratio that were within the target range as ±10% of the British Society for Haematology's guidelines. (We also have to assume that control was assessed against the desired range for the clinical indications for warfarin, although this is not stated.) This means that patients for whom the recommended reference range is 3.0-4.5 could have had actual values of between 2.7 and 4.95. This is a very wide therapeutic window, and it is therefore not surprising that 84-90% of patients achieved it. This study highlights the need for standardisation in reporting results from anticoagulant clinics.

While such point prevalence data are of value, the percentage of time spent within the target range is a more discriminating assessment of therapeutic quality control.[2] One method of assessing the degree of therapeutic control, which we have reported, is to give the mean (±1 SD) international normalised ratio for the clinic.[3] Such analysis allows direct comparison between different environments—for example, primary care and hospital based clinics—and could be applied to the different therapeutic ref-