fellow beings each in various degree of medical need provides endless fascination. The opportunity to explain diagnosis and treatment to the concerned, the bewildered, the frightened, the truculent and the frankly antagonistic is never boring. To communicate, however briefly and at whatever level of understanding, with the confused or demented provides a moment of shared insight, possibly for both participants.

My objection to acute medical takes lies in what happens thereafter. I can anticipate that it will be impossible to transfer my patients to an appropriate specialist ward. I will be required to accept clinical responsibility for medical problems in which I do not claim to be expert, in a clinical environment that I believe to be inappropriate. I know that the moribund or immobile patient may lie unattended for hour after hour because of a lack of nursing staff. I know that my patient is liable to be transferred from ward to ward during his or her admission, because of insufficient medical beds in the hospital. I know that this phenomenon will be referred to as 'sleeping out' or 'outliers' – an administrative euphemism that belies the reality of disrupted continuity of care for frail, distressed patients and their relatives.

In short, when I am on the acute take rota, I feel like the gatekeeper for second-rate and amateur healthcare delivery to some of the most acutely ill patients in the hospital. In these circumstances, it is perhaps understandable that physicians such as myself express a preference for non-acute duties.

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General practitioners with special clinical interests

Editor – We read with interest the recent editorial on general practitioners with special clinical interests (*Clin Med JRCPL*, September/October 2001, pp346–7).

At the Royal Infirmary of Edinburgh we have developed the primary care GP physician role in acute medicine. This post is complementary to the consultant physician input in the medical assessment unit but focuses on the management of those patients with complex needs, primarily the frail elderly.

The GP works closely with the multidisciplinary team to achieve a medical diagnosis and, more importantly, a prompt functional assessment of the patient. This approach permits safe placement in an appropriate care setting, with a significant proportion (at least 30%) returning directly to a primary care setting.

This is only possible with understanding and close liaison with the primary health care team. The close partnership is achieved with sessions in a local general practice providing general medical services both within the surgery and through working for one of the out-of-hours co-operatives. In the practice the skills developed in the acute setting are used both formally and informally and usually relate to elderly patients.

In addition there is a session in medical outpatients, which is designed to accept referrals from local general practitioners and review them promptly. The clinic also provides follow-up of selected patients discharged from medical assessment.

A formal framework of continuing professional development and education is in place via the Royal College of Physicians CME scheme and symposia combined with selected postgraduate general practice meetings, plus active membership of the Society for Acute Medicine (UK) which also promotes the input of general practitioners to acute medicine.

In effect the post blends the models outlined in the document entitled *General practitioners with special interests*[1] with provision of service within and across primary and secondary care.

This post promotes primary care involvement in the emerging specialty of acute medicine, and in crossing the primary–secondary care boundary promotes high quality, seamless patient care.

Our experience leads us to believe that such posts would be a significant addition to existing practice, in line with the philosophy of the document, but as yet few if any comparable posts are established.

This post is an excellent working example of innovative patient care provision which integrates with, rather than substituting for, consultants but provides a more holistic approach to patient care and an opportunity for future general practice diversification in a unique direction.

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Tuberculosis – a missed opportunity?

Congratulations on publishing such an excellent summary of the current problems of tuberculosis (*Clin Med JRCPL*, January/February 2002, pp55–8).

Dr White details the Leicester school outbreak. There is an important possible contributing factor to this outbreak, which has so far not been mentioned, either in this article or in others about it[1].

Unlike most authorities treating tuberculosis and latent tuberculosis infection (also called subclinical infection), and in contravention of current guidelines[2], Leicester has never pursued a policy of giving comprehensive preventative therapy. The grounds for failing to do this have been published but are somewhat tenuous[3].

As an earlier article states, any protection given by BCG in these school children, aged more than 13 would be waning[1]. This is because, as ethnic minority children, they would have received BCG at birth and it is known to provide protection for only 15 years. If a substantial proportion of children at the school had latent tuberculosis infection, a small amount of added infection received through school contact with an infectious case could have tipped a number of students into having the active disease. It is possible that the failure to use preventive therapy in Leicester has been a contributing factor to the biggest outbreak of tuberculosis in at least the last 25 years.

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Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Audit of anticoagulation control: a comparison between the performance of a hospital anticoagulation clinic and the general practice

Withybush General Hospital runs an anticoagulation clinic (AC) and provides laboratory facilities for INR testing for GP surgeries willing to prescribe and monitor warfarin treatment for their own patients. Fifty randomly selected consecutive patients (26 women) attending the hospital AC were compared with a similar sample of 50 patients (22 women) whose INRs have been requested from the general practice. All patients had their anticoagulation initiated beforehand. A retrospective analysis of their last ten appointments for INR check was undertaken. The therapeutic range was according to the guidelines of the British Society for Haematology and was defined as INR values within 0.5 INR units of the target INR[1].

The age of the patients attending the hospital AC was 69.2 ± 12.9 years and 70.3 ± 10.5 years in the general practice group. There was no statistically significant difference between two groups regarding the indication for anticoagulation and mean duration of follow up (171.1 days in the hospital cohort and 145.9 days in GP cohort). Retrospective analysis of 50 patients' records of their last ten appointments with the hospital AC yielded 478 INR measurements, as on 22 occasions the patient failed to turn up. Similar analysis of the records of 50 patients from the general practice cohort yielded 494 INR measurements, as only on 6 occasions no blood samples were sent to the laboratory. 56.9% of hospital AC INR measurements (272 of 478) were in the therapeutic range, 23.8% (114 of 478) below therapeutic range and 19.2% (92 of 478) of measurements were above therapeutic range compared to 54.1% (267 of 494), 25.9% (128 of 494) and 20% (99 of 494) of the INR measurements respectively of the general practice group. There was no statistically significant difference between the two groups at the 95% confidence interval. There was no incidence of bleeding due to over-anticoagulation in any group. Similarly, no statistically significant difference in anticoagulation control was found when patients with atrial fibrillation were compared separately (25 in the hospital AC group and 24 in the general practice group). Retrospective analysis of their last 10 appointments yielded 237 INR measurements in the hospital AC group of which 140 (59.1%) were in the therapeutic range as compared to 238 INR measurements in the general practice group of which 143 (60.1%) were in the therapeutic range.

This study showed that more than half of the INR results obtained in the hospital AC or in the general practice fell within the recommended range. This is in accordance with previous studies, which gave a range of 47% to 53.4%[2–4]. We could not find any statistically significant difference between the hospital AC and the general practice in maintaining the INRs within the range recommended by the British Society for Haematology. We conclude that the control of anticoagulant treatment can be safely devolved to the primary care doctors who are willing to accept the responsibility, more so in patients with atrial fibrillation, where community based control of anticoagulation treatment is safe and effective.

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