result of ongoing professional development and quality assurance programs in our hospital. However, our results can be considered valid only for highly resourced centres such as ours.

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Anticoagulation

Jo-Anne Wilson and associates[1] claim that anticoagulation clinics provided better oral anticoagulation than family physicians, but these conclusions do not appear to be supported by their study results.

First, and notwithstanding the apparent statistical significance, the difference in the proportion of time that patients' international normalized ratio (INR) values were within the desired range was less (an absolute difference of only 6%, representing a relative difference of 8%) than the authors' predefined minimally clinically important difference (10% absolute, 20% relative). Moreover, with regard to this primary endpoint, patients under the care of family physicians fared far better (76%) than the authors expected they would in the care of specialty clinics (60%).

Second, there is clearly something amiss with the percentages of patients with high-risk INRs (mentioned in the abstract, the Results and Table 2): the difference between 30% and 40% for the sample sizes in this study would not be associated with a p value of 0.005. Indeed, this difference is not significant at all.

Third, selective emphasis on a subgroup that has been defined post hoc (new patients with target INR of 2.0 to 3.0; see Table 3) seems inappropriate. Are the authors implying that anticoagulation clinics are not as effective if the target INR is slightly higher or if the patient has previously received anticoagulants?

Finally, the authors give the impression that all of the measures of patient satisfaction favouring anticoagulation clinics were associated with a p value of 0.001. Again, this is simply not possible: some of the differences reported are not significant, and those that are significant are generally far more modest.

Overall, it appears that the anticoagulation therapy provided by family physicians in this study was clinically similar to that provided in the more expensive specialty clinics.

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Competing interests: None declared.

I very much like the concept of optimizing patient care by choosing the best methods of care on the basis of research findings. Having been a general practitioner for a number of years, as well as acting in the capacity of a specialist, I recognize the differences in expectations placed upon these 2 types of medical practice.

Thus, it would be helpful if Jo-Anne Wilson and associates[1] could comment on what they perceive as the differences in anticoagulation services between the anticoagulation clinics and the family physicians' offices in their study. It would also be helpful to know how the model for anticoagulation monitoring used by family physicians differed from that used in the anticoagulation clinics. For example, who called the patient to convey INR results, and how often were patients seen during the anticoagulation period? In terms of optimizing care, do the authors feel that anticoagulation might be better managed if the physician were able to focus on just that aspect of care, rather than having to address multiple problems during the same visit (as is usually the case for family physicians)? With regard to patient education about anticoagulation, should information be provided by the physician or by other staff (e.g., nurses)? Finally, did the authors review the differences in cost between the 2 types of service?

All of these details might help in optimizing the model of anticoagulation care.

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Competing interests: None declared.

Jo-Anne Wilson and associates[1] suggest that centralized anticoagulation clinics perform better than, and are preferred by patients over, individual family physicians. However, it is not clear what management of anticoagulation by a family physician entails. As I