

months, developed an apparent bout of colicky abdominal pain which resolved spontaneously within half an hour. Two days later, his mother observed live threadworms at his anal margin and the family were duly treated with piperazine citrate.

Interestingly, in neither of these cases was pruritis ani a feature, even in retrospect. Accepting that threadworm infestation is relatively common and in many cases probably asymptomatic,⁴ it becomes very difficult to establish a causal relationship to abdominal pain. Nevertheless, one has to question whether such a relationship may exist, what possible biochemical, immunological or other mechanism could explain it, and whether a potentially treatable cause of abdominal pain is occasionally being overlooked. It seems excessively dogmatic to assert that threadworms never cause significant abdominal pain, even when confined to the bowel.

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Effectiveness of anti-smoking advice from doctors who smoke

Sir,

General practitioners who smoke may adversely influence their patients' smoking habits. This is supported by a study which has shown that doctors who smoke deliver less advice to patients on how to stop smoking than doctors who do not smoke,¹ and it is well known that anti-smoking advice given by general practitioners is one of the most important means of helping patients to stop smoking.² However, there is no direct evidence to suggest that doctors who smoke are any less effective in stopping patients smoking than non-smokers.

My general practice trainee year was spent in a group practice in Salisbury where one of the doctors smoked. I conducted a survey of 646 patients and the results indicated that the doctor who smoked had fewer patients who gave up smoking than the doctors who did not

smoke (23% versus 37%, $P < 0.05$). Furthermore, a higher proportion of the patients who chose to consult the smoking doctor were smokers compared with those who consulted the non-smoking doctors (43% versus 37%, $P < 0.01$).

These results must be interpreted with caution because the survey looked at only one practice with a retrospective questionnaire and there was no biochemical validation of the patients' self-reported smoking behaviour.

However, the evidence suggests that doctors who smoke need to be aware that they may, indirectly, be jeopardizing their patients' health and that they must make greater efforts to help their patients to give up smoking.

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'Patient care' and patient benefit

Sir,

The public voice of medicine is fulsome with the term 'patient care'. An impartial observer may feel that its use is axiomatic — what are doctors for but patient care? — but the bland term neatly suggests laudable purpose and is thus a useful rallying-call with which to court public support and even approbation. However, the term is ambiguous. An unhealthy supposition is to equate 'patient care' with quality medicine. More 'patient care' does not equate with better quality practice. The present trend for auditing — of prescribing, referral rates, investigation rates and the like — important though it be, is no substitute for evaluating outcome.

The following case histories illustrate how 'patient care' constitutes the frame rather than the picture.

Case 1. A 40-year-old patient attended the general practitioner with unusual symptoms. The patient was convinced that he had a particular disorder. The general practitioner disagreed and reassured the patient, who returned a fortnight later with the same symptoms. As a further reassurance, the general practitioner refer-

red the patient on to a specialist. The specialist did all the appropriate tests, found no hard evidence of disease but treated with medication 'just in case' — the patient developed an allergic reaction to the drug and died.

Case 2. A 76-year-old lady, irrepressably jocose, had a 20 year history of angina. She was intractably obese and at one of her visits to the doctor for more of her usual angina pills the doctor found her blood pressure raised such that she 'might get a stroke if it's not treated'. Shocked and grateful, she left with her new pills only to return within the month to report that she felt tired and glum (unaccustomed sensations for her). The doctor changed the medication but this, too, did not suit. Another change made no difference. After this, the lady stopped the pills herself and felt better before long. When she returned to confess, the doctor administered a mild rebuke, noted her blood pressure was still raised, repeated the warning about stroke and insisted upon medication — which she fearfully took. Several months on, the lady remarked she had never felt well on her pills and regretted ever having had her blood pressure taken because life had not been worth living since then.

It is hard to see how either doctor could have served his patient worse. Nevertheless, both doctors could claim thoughtful 'patient care'; even to have 'gone by the book'. Such news is likely to confound rather than console patients and relatives, for it suggests the same thing could happen again.

The picture is incomplete without a reference to patient satisfaction which, though a pivotal aspect of practice, is a poor reflection of quality practice. Results accruing from the fashion for auditing patient satisfaction should, therefore, not be overrated or allowed to blur the issue of outcome. Mistaken belief and expectation of what they need can lead patients to be the victims of appeasement — of inessential prescribing, investigation and referral — as case 1 demonstrates. Patient satisfaction will be seen to follow the audit of outcome of medical practice, the latter being the key to a quality health service.

The outcome may be simple and self-evident (for example the results of appendectomy, insertion of a pacemaker or treatment with thyroxine) or less simple and less obvious (for example the result of treatment with antiarthritic drugs, antidepressants, tranquillizers or antihypertensives, the care of the terminally ill or care of the aged). Sometimes it may be impossible to audit outcome but, in truth,