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 referred 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 accrueing 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 appendicectomy, 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,

there are very few cases to which the question: 'Has the patient benefited from medical intervention?' cannot be met with an answer of 'Yes' or 'No'. A negative answer should not be seen as a disgrace so much as an education; the mistake is not to ask the question.

A single prefix may be the answer: 'Beneficial patient care'. Were this new term to be used with the same frequency as the old, it would not of course have the same public relations appeal — it implies alternatives. However, it is likely to make true quality assessment, each time a doctor treats a patient, habitual; and so prompt, if necessary, beneficial adjustments to future practice.

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Breast self examination

Sir,

David Mant (May *Journal*, p.180) correctly summarizes the consensus of the literature on breast self examination in asserting that there is no evidence that it is effective in reducing mortality from breast cancer. However, there is equally no evidence that it is not effective. Quite simply it has never been practised on the scale and with the reliability necessary to settle the matter. This is because even those women who respond favourably to the offer of appropriate instruction require intensive guidance, supervision and continued reassurance if they are to remain both motivated and confident in their ability to distinguish the normal from the abnormal.[1-3]

However, as Dr Mant says, women are likely to examine their breasts whether or not they are taught breast self examination. There would be much to be said for ensuring that such examination is done so as to achieve an optimal balance of sensitivity and specificity and to limit the anxiety which may be the main outcome of ineffective practice. This is unlikely to be achieved by posters and pamphlets but it might well be achieved in general practices able and willing to invest the necessary resources. Although it may remain formidably difficult to subject the efficacy of breast self examination to formal appraisal, there must surely be some benefit from ensuring that what will inevitably be done is done more effectively.

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Sir,

Dr Mant's editorial (May *Journal*, p.180) seeks to promote critical debate and appraisal of the role of breast self examination in the prevention of breast cancer. There are two complementary, but distinct, issues here: the validity of breast self examination as a screening test, and the importance of the early diagnosis of breast cancer in reducing morbidity and mortality. Whereas the value of breast self examination as a screening test may be in doubt, the importance of early diagnosis of breast cancer is not.

Lundgren points out the differing response of Swedish and British women to the discovery of a palpable breast lesion.[1] Swedish women present with less advanced breast cancer than their British counterparts, which is reflected in a superior mortality to incidence ratio in Swedish women compared with British women (36% and 60% respectively). Furthermore, it must be remembered that much of the morbidity and mortality from breast cancer occurs outside the 50–64 years age group which is targeted for mammography. In the St Helens and Knowsley district in 1987, there were 86 deaths from breast cancer, of which at least 55 (64%) were among women who would not have been within the target population for mammography.

To discourage breast self examination because of its questionable validity as a screening test may well discourage women from presenting early with palpable breast lesions, and lead to an increase in morbidity and mortality. A crucial health promotion role exists for general practitioners in encouraging properly conducted breast self examination and with it increasing the awareness of the potential benefits of early diagnosis of breast cancer. It may yet be shown that at a particular age or in other specific groups, breast self examination is an effective screening procedure, most likely in women over 40 years of age.

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Screening and the new contract

Sir,

The government's proposed new contract states that we are now to screen everyone from the age of 16 years every three years until the age of 74 years, and annually (by home visit) thereafter. This raises the ethical question of whether as responsible general practitioners we should be involved in this activity.

First, as far as I am aware there is no evidence that triennial screening of the young is of any value. Furthermore, actively encouraging the fit young to attend may 'medicalize' health and a paper by Dr Stoate (May *Journal*, p.193) suggests that screening may actually cause psychological harm to healthy volunteers.

Secondly, while there is some evidence that annual screening of over 75 year olds may be of value, there is no comparative evidence to state that one method is better than another (for example, letter followed by a visit if indicated versus selective visits of those not seen in the previous year). One could also postulate that social services screening of the elderly would be of more value than medical screening, since social support is what the elderly usually need. I am not aware of a comparative study being done. Visits to those elderly who already attend surgery will encourage dependence on visiting by the general practitioner.

Finally, the kind of screening proposed has not been shown to fulfil the criteria for screening mentioned by Stoate.

As a doctor I should not be actively involved in something that could damage peoples' health. The contract stipulates that I must. Is there an answer to this dilemma?

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Screening: the case against

Sir,

When I first read the title of Dr Stoate's paper, 'Can health screening damage your health?' (May *Journal*, p.193), I assumed