an antibiotic was prescribed (2.97; 1.54 to 5.74). Satisfaction was not predicted by any other variable.

Comment

This trial excluded very ill patients but should inform advice to most patients. Selection and non-response bias were not significant³ so despite limitations, these data are likely to provide generalisable estimates of the predictors of duration of illness.

Patients over 12 and those with cough were more likely, and those with shorter illness before consultation less likely, to have prolonged illness. Short duration before consultation was associated with higher temperature and presence of three out of five symptoms and signs. Thus patients with a higher temperature are more likely to present sooner but also get better more quickly.

Satisfaction with the consultation predicted duration of illness independently of potential confounding variables and was more closely related to effective doctor-patient communication than to prescription of antibiotics. This supports both the preliminary analysis³ and evidence from a systematic review.⁵ Doctors should elicit patients' concerns and consider counselling patients—particularly those at risk of prolonged illness—about the natural course of sore throat.

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A dilemma

Entering the minds of the elderly

I was sorting things out pretty well. They had been attending for only a few weeks, but I had managed to reduce their multiple drug regimens and to diagnose and control his atrial fibrillation. Bill and Netty were a delightful couple, always attending together and obviously devoted to one another. Their delight in their new sheltered house and enjoyment of their new town was a pleasure to see.

Now I raised the question of Bill's microscopic haematuria, discovered at the registration medical and present on further samples. "Probably due to your prostatectomy five years ago," I said, "but I'd advise a check at the hospital just to be sure." He seemed hesitant. "It's a small operation—you'll be in and out in a day," I reassured and went on to outline the procedure. Netty beamed her approval. "Well, if you're quite sure, Doctor," Bill said uncertainly. I felt clever and kind.

At cystoscopy no cause of haematuria was found, but a large bladder diverticulum (with suspicious ultrasound echo) could not be visualised. Problems developed a few days later. He developed a urinary infection, acute retention, and renal failure and required urgent admission to hospital. A niece took Netty to her home at which point the extent of her dementia became apparent. The niece was unable to cope with the agitation and the wandering. A few days later, Netty too required admission to hospital, and the unhappy scenario was complete—Bill and Netty separated and both in hospital. As the instigator of this disaster I felt foolish and cruel.

What had gone wrong? I had failed to recognise Netty's dementia and her complete dependence on Bill. Their attendance always together was the clue I had missed. But missing this would not have been disastrous had I sought to involve Bill in the decision to refer him for cystoscopy. Had I done this, he would surely have indicated his concerns and communicated his priorities. I had not stopped to consider that there might be a priority of maintaining their joint independence which far

outweighed the need to diagnose urological cancer in an asymptomatic 85 year old.

Fortunately, all was not lost. The holistic and non-elaborate care of the community hospital came to the rescue and allowed their eventual joint discharge home. Bill now shared his view that he would not contemplate further investigation while his overwhelming priority was to keep Netty at home with him for as long as possible. He would take the risk of undiagnosed advancing cancer.

For a further six months he continued to achieve his aim of caring for Netty. Then he ran into further trouble with renal failure caused by obstructive uropathy. He died a few days after readmission. A large fungating bladder tumour was found at necropsy.

Communicating with the elderly is a difficult skill. All sorts of factors get in the way, not least a paternalistic approach, often misguided, sometimes disastrous. Perhaps even more than with younger patients, we need to find time to seek the ideas and concerns of elderly people if we are to meet their needs adequately and sensitively. The priorities of the elderly can be surprisingly different from those of younger patients. The need to preserve and not to put at risk personal or coupled autonomy is sometimes of paramount concern.

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We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.