the mean arterial pressure is reasonable.[3] Measurements of peripheral vascular resistance and cardiac output in our patients confirmed this relation. The diagnosis of electromechanical dissociation in these circumstances is therefore extremely difficult, and resuscitation should not be abandoned until meaningful haemodynamic data have been obtained. Cuff blood pressure is often meaningless in these circumstances, and resuscitation should not be abandoned with this as the sole criterion.

I would also remind others of recent British studies that confirm that age alone is not a prognostic indicator for survival from cardiac arrest.[4,5] It is the nature of the underlying rhythm that is of greatest importance.

A D REDMOND

South Manchester Accident and
Emergency Service,
Wythenshawe Hospital,
Manchester M23 9TL

1 Skinner D. Monitoring resuscitation. *Br Med J* 1989;**298**:1597. (17 June.)
2 Redmond AD, Edwards JD. Haemodynamics during and after cardiac arrest. In: Vincent JL, ed. *Update in intensive care and emergency medicine*. Berlin: Springer, 1989:531-8.
3 Cohn JN. Blood pressure measurement in shock. *JAMA* 1967;**199**:972-6.
4 Bayer AJ, Ang BC, Pathy MSJ. Cardiac arrest in a geriatric unit. *Age Ageing* 1985;**14**:271-6.
5 Gulati RS, Bhan GL, Horan NA. Cardiopulmonary resuscitation of old people. *Lancet* 1983;i:267-9.

Urinary tract infections in men

SIR,—Dr P E Gower stated that the prevalence and incidence of urinary infections among patients with AIDS are unknown.[1] We became interested in this problem after a two year period during which seven of our patients with AIDS were found to have urinary tract infections after investigations for non-specific symptoms such as fever and myalgia; only two had symptoms of a urinary tract infection. In six of these patients the causative organism was *Escherichia coli*; in the other patient it was *Salmonella typhimurium*, which caused both his urinary tract infection and diarrhoea.

We examined the prevalence of bacteriuria in 125 midstream urine samples taken from 85 homosexual male outpatients with HIV infection, none of whom had urinary tract symptoms. Midstream urine samples were also taken from a control group of homosexual men who had been tested within the preceding six months and were negative for HIV antibody. Bacteriuria was present in seven (8%) of the men infected with HIV (four had $>10^5$ and three had $<10^5$ organisms/ml), but in four of them culture of urine at follow up a month later yielded negative results and no treatment was given. The three other patients were treated for persistent asymptomatic bacteriuria (*Streptococcus faecalis* was present in two patients and *E coli* in one). None of the seven patients had AIDS, but four had detectable p24 antigen and a fifth developed pneumocystis pneumonia three months after treatment for persistent bacteriuria. During the nine months of the study no urinary tract infections were found in the 200 patients attending our HIV clinic who did not take part in the study. Bacteriuria was not detected in 36 urine samples from 33 homosexual men who were negative for HIV antibody.

The results suggest that although overt urinary tract infections are uncommon in men with HIV, asymptomatic bacteriuria is more common. In addition, our experience with the seven patients with bacteriuria indicates that a urinary tract infection may cause non-specific symptoms in patients with HIV, and therefore urinary infection should be considered when investigating unexplained illness in such people. These findings do not sustain our original impression but support the results of L P J Marques and colleagues (abstract of the fifth international conference on AIDS, 1989, Montreal) that overt urinary tract infections were uncommon in men infected with HIV.

JAN WELCH
HARRIET PILKINGTON
CAROLINE BRADBEER

St Thomas's Hospital,
London SE1 7EH

1 Gower PE. Urinary tract infections in man. *Br Med J* 1989;**298**:1595-6. (17 June.)

Pictorial fetal movement charts

SIR,—Dr M I Shafi and colleagues[1] have not matched the simplicity of the "count to ten" method used by Professor Philpott in South Africa (personal communication). His patients are multiracial and mostly poor and uneducated. Each pregnant woman gets a small bag. She fills it with ten little stones in the morning and then removes a stone for each movement felt during the day.

MICHAEL GANNON

Department of Obstetrics and Gynaecology,
Royal Berkshire Hospital,
Reading, Berkshire RG1 5AN

1 Shafi MI, Dover MS, Dyer CA, Byrne P, Constantine G, Luesley DM. Pictorial fetal movement charts in a multiracial antenatal clinic. *Br Med J* 1989;**298**:1688. (24 June.)

Best documented practice

SIR,—The idea that consensus groups of experts could or should determine benchmarks for best documented practice[1] has a number of possible drawbacks. Clearly, there are some situations in which a known condition can be treated in a number of ways with an easily measurable outcome. Such situations are ideally suited to controlled clinical trials and no one would condone the use of a method of treatment after adequate research has shown the superiority of an alternative. However, the controversial issues likely to be addressed by consensus groups are rarely as staightforward—they require decisions to be made in conditions of uncertainty. Diagnoses are possible or probable rather than certain, features of individual patients may affect their response to treatment, and there may be a number of possible qualitative outcomes that are valued differently by patients or physicians.

This is not an argument for ignoring the views of the acknowledged experts or the evidence of audit and trials, but there are alternatives to simplifying the problem and issuing a policy statement to be applied to the generalised case. Data from audit and epidemiological studies can be used to produce estimates of the probability of disease in an individual patient (for example with Bayes's theorem),[2] clinical trials can be used to determine the likelihood of possible outcomes and their relative values can be obtained by utility analysis,[3] and treatment policies can be compared by decision analysis.[4] By such methods the best practice may be determined for an individual patient, rather than by trying to fit the patient into a group for which there is a predetermined treatment.

Statements of best documented practice must categorise patients into simplified groups and will usually fail to take account of variations in local facilities or expertise as well as largely ignoring the views of the patient. Professor Whitehouse says that cancer "lends itself well to such a process," but this can only be if we are prepared to accept such simplifications; even if only a handful of the possible sources of variation between patients are considered the possible combinations rapidly multiply to unmanageable proportions. To describe the best practice for each combination of patient characteristics, grade, and stage of disease would be cumbersome if not impossible. The place for a consensus group is not to lay down rules to be followed blindly but to determine common definitions, assess trial results, and arrive at "subjective probabilities"[5] when published data are inadequate.

JONATHAN MICHAELS

Department of Surgery,
University College and Middlesex
School of Medicine,
London WC1E 6JJ

1 Whitehouse JMA. Best documented practice. *Br Med J* 1989;**298**:1536-7. (10 June.)
2 Hall GH. The clinical application of Bayes' theorem. *Lancet* 1967;ii:555-7.
3 Llewellyn-Thomas H, Sutherland HJ, Tibshirani R, Ciampi A, Till JE, Boyd NF. The measurement of patients' values in medicine. *Med Decis Making* 1982;2:449-62.
4 Weinstein MC, Fineberg HV. *Clinical decision analysis*. Philadelphia: W B Saunders, 1980.
5 Card WI, Good IJ. The estimation of the implicit utilities of medical consultants. *Medical Biosciences* 1970;6:45-54.

How to appoint a colleague

SIR,—I agree with Dr Petch that there are difficulties in appointing consultant colleagues for several decades: in particular, the lack of opportunity to assess a candidate's clinical ability and commitment.[1] Yes, the spread of testimonials should be widened as he suggests, but in a formal manner. As the appointment must be made within the framework of the equal opportunities legislation it is incorrect to accept any hearsay evidence, especially "casually at a conference dinner."

T M O'CARROLL

Leicester Royal Infirmary,
Leicester LE1 5WW

1 Petch MC. How to appoint a colleague. *Br Med J* 1989;**298**:1365-7. (20 May.)

⁂This correspondence is now closed.—ED, *BMJ*.

NHS review

SIR,—A group of public health physicians has diagnosed the white paper proposals as detrimental to the health of the public.[1] They do so inadvisedly.

The health of the nation depends primarily on its sanitation, the hazards of its environment, its consumption of drugs such as alcohol and nicotine, and its diet. Changes in the efficiency and cost effectiveness of the hospital services (which are the principal concern of the white paper) cannot worsen the health of the nation. Such changes could of course affect the relief of that ill health that has already arisen. But this is a different if still tendentious argument.

Relieved of the burden to administrate large and complicated concerns, health authorities may in future be more and not less receptive to epidemiological argument calling for one particular service or another. They may be able to pay more attention and not less to standards of care, which will have become the responsibility of another agency. The new flexibility given by purchase of services from various providers may be an improvement on the "uniform administrative health structure."

The proposals should be debated and may require modification. To say that they "must be resisted" is to deny any alternative opinion, which is in nobody's interest. To base such a statement on unfounded claims for the health of the nation is careless and inflammatory.

A R BULL

MRC Environmental Epidemiology Unit,
Southampton General Hospital,
Southampton SO9 4XY

1 Kharmi G, Scott L, Baker K, Hargreaves S, Connelly J, Roderick P. NHS review. *Br Med J* 1989;**298**:1454. (27 May.)