these excluded patients, analysis of Rasmussen *et al*'s trial by intention to treat would be useful to exclude such a bias.

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1 Garrow J. Does cimetidine cause weight loss? *BMJ* 1993;**306**: 1084. (24 April.)
2 Støa-Birketvedt G. Effect of cimetidine suspension on appetite and weight in overweight subjects. *BMJ* 1993;**306**:1091-3. (24 April.)
3 Pocock SJ. *Clinical trials. A practical approach*. Chichester: Wiley, 1990;216.
4 Rasmussen MH, Anderson T, Breum L, Gøtzsche PC, Hilsted J. Cimetidine suspension as adjuvant to energy restricted diet in treating obesity. *BMJ* 1993;**306**:1093-6. (24 April.)

Patients as friends

EDITOR,—John S Yudkin describes how he became emotionally attached to a patient and how this affected his professional judgment.[1] It is a warning that most of us are given at medical school: sometimes the aphorism "Never make friends with your patient," attributed to Osler, is quoted.

An incident with a patient who had become a friend prompted me to carry out a small survey last year among some of my colleagues. I asked 49 trainers in general practice in my region to answer a questionnaire on the incidence, problems, and rewards of treating patients who are friends. After prompting I got a 100% response, avoiding any respondent bias.

Forty one of the respondents had friends as patients, with an average of about 12 per doctor. The friendships had begun after the doctors had started in practice, and most had been made by personal contact or through the doctors' spouse or children. Twenty three respondents found their friends a rewarding group of patients to treat, but 32 mentioned problems. The commonest cited was feeling always on call; the next most common was difficulties in assessing problems dispassionately, as Yudkin describes.

Particularly difficult for the doctor were giving bad news, dealing with psychiatric problems and problems in relationships, and intimate examinations. Some doctors mentioned a pressure to overinterpret, investigate, treat, and refer. Maintaining confidentiality, especially with the patient's spouse, was particularly difficult. Eleven of the doctors also thought that their friends had falsely high expectations of them. When asked whether they would withdraw from providing medical care for a friend, however, only 13 said that they would.

It seems that most doctors try to maintain the boundaries between professional and personal life. On occasions these boundaries blur and pose particular problems but perhaps give some rewards for the doctor. Possibly general practitioners have more experience of this phenomenon than other doctors, having more contact with their patients and often living in the same community.

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1 Yudkin JS. Defining the limits of empathy. *BMJ* 1993;**306**:1046. (17 April.)

No charge for unique service

EDITOR,—Malcolm Forsythe's analysis of the problems facing specialist, usually small, groups that must begin charging for their services draws attention to their plight.[1] It neglects to underline, however, that many such services have arisen ad hoc out of research involving expertise acquired over many years and that most of the equipment and the space used is often provided by research charities or medical schools, not the NHS.

Our small diagnostic service is the only one in Europe offering analysis of the full range of purine and pyrimidine genetic metabolic disorders, which are recently discovered disorders with a broad range of presentation and often devastating consequences. The Department of Health is now insisting that the three NHS staff—reluctantly provided in 1990—establish a "diagnostic business."

Though the new charging system may make sense in large services, where previously management had little idea of how money was spent, we know exactly where every penny goes. We don't do simple automated assays on instruction; more usually we are approached as a last desperate hope in a difficult case, and we often undertake a large number of studies at our discretion, based on experience. The pay off can sometimes be rewarding, for both the patient and the clinician; in stopping further unnecessary tests and identifying families at risk the service has saved the NHS far more than it has cost. But who is going to order or pay for such tests?

The main problem is that the large contribution of the research staff and their equipment to the diagnostic process is ignored by the Department of Health's reforms. Our research section has justifiably asked how anyone proposes to run a business with only three people and no equipment. It has become increasingly obvious that central funding would be the most cost effective means of running our service as, rightly, research staff see no reason why they should donate time, which should be devoted to research, to subsidise such a blatant business venture. Thus our main criticism of the department's plan is that it splits research from studies of patients, which must necessarily go hand in hand when new aspects of metabolism are being analysed or discovered.

Accordingly, I have advised the Department of Health that I will not be able to instigate charging: the service remains available unless the department closes it down or allows it to be starved of funds. Britain would then lose its only service for diagnosing purine and pyrimidine disorders, and, as Forsythe notes, claims for non-diagnosis or inappropriate treatment might well result.

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1 Forsythe M. Commissioning specialist services. *BMJ* 1993;**306**: 872-3. (3 April.)

Dipstick testing easy and informative

EDITOR,—In their study of the diagnosis of urinary tract infection Irwin Nazareth and Michael King found that few doctors carried out an investigation other than urine culture.[1] Yet many researchers have shown that simple dipstick testing of urine in the surgery for protein, blood, nitrite,[2,3] and leucocyte esterase[4] provides more useful data even than taking a history. For example, the B scores (bayesian probability scores) for the presence and absence of various symptoms that we found in our study[2] were lower than the B scores for the presence and absence of the above constituents of wine (table). The B scores for the presence and absence of leucocyte esterase, calculated from the figures of Ditchburn and Ditchburn,[4] also show greater discriminating power.

B scores for predicting bacteriuria in adult women

	Present	Absent
Symptoms:		
Frequency	1	−3
Nocturia	2	−2
Dysuria	1	−1
Urgency	1	−1
Haematuria	3	0
Offensive urine	2	0
Nausea	−2	0
History:		
Symptoms for ≤9 days	1	−3
Previous intravenous pyelography	2	0
Result of dipstick test:		
Protein	3	−1
Blood	3	−3
Nitrite	11	−2
Leucocyte esterase	2	−5

Why do doctors still not use simple, cheap dipstick testing?

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1 Nazareth I, King M. Decision making by general practitioners in diagnosis and management of lower urinary tract symptoms in women. *BMJ* 1993;**306**:1103-6. (24 April.)
2 Dobbs FF, Fleming DM. A simple scoring system for evaluating symptoms, history and urine dipstick testing in diagnosis of urinary tract infection. *J R Coll Gen Pract* 1987;**37**:100-4.
3 Hiscoke C, Yoxall H, Greig D, Lightfoot NF. Validation of a method for the rapid diagnosis of urinary tract infection suitable for use in general practice. *Br J Gen Pract* 1990;**40**: 403-5.
4 Ditchburn RK, Ditchburn JS. A study of microscopical and chemical tests for the rapid diagnosis of urinary tract infection in general practice. *Br J Gen Pract* 1990;**40**:406-8.

Zidovudine unproved in AIDS dementia

EDITOR,—B G Gazzard pleads for caution in interpreting the preliminary results of the Concorde trial, but the comment that zidovudine can improve cognition in those with AIDS dementia complex is misleading.[1] The study cited dealt with people with AIDS and AIDS related complex who at baseline were functioning in the normal range on the neuropsychological test battery used and did not have AIDS dementia complex (or HIV-1 associated dementia, to use the current terminology).[2] The improvements in cognition seen, therefore, occurred in people who were functioning in the normal range and at worst showed the relatively mild cognitive impairments that are a common feature of symptomatic HIV infection. This suggests that zidovudine has beneficial effects on cognition long before there is evidence of a clinical dementia.

Similar results showing improvements in cognition after treatment with zidovudine have been reported in numerous uncontrolled studies, including one by our group.[3] Zidovudine has also been shown to reverse the abnormalities in cerebral metabolism seen in patients with AIDS.[4] Claims that the use of zidovudine has led to a reduction in the prevalence of HIV-1 associated dementia, however, are difficult to prove: changes in diagnostic criteria over time, selection bias, and changes in the disease itself are probably the main factors.[5] Unfortunately, the long term efficacy of zidovudine in improving cognition is uncertain as most studies have reported after relatively short follow up periods of a few weeks[2] or months.[3] There is little direct evidence of the efficacy over longer periods, but retrospective analysis of the multicentre AIDS cohort study suggests that the neuropsychological benefits of zidovudine last little more than six months (J C McArthur *et al*,