Table 1 Proportion of bacterial groups (number of cells hybridising to probe/total number of 4',6-diamidino-2-phenylindole-2HCl-stained cells) as determined by fluorescent in situ hybridisation

Sample		FISH				PCR		
		Erec482	Bac303	Bif164	LAB158	EC1531	Archaea	7αDH
A	1	0.11	0.31	0.04	0.012	ND	–	–
	2	0.24	0.42	0.06	0.019	ND	+	–
	3	0.21	0.97	0.06	0.013	ND	–	–
B	1	0.06	0.09	0.02	0.009	D	–	–
	2	0.15	0.27	0.05	0.041	D	–	–
	3	0.33	0.21	0.01	0.013	D	–	+
C	1	0.15	0.07	0.04	0.008	D	+	–
	2	0.11	0.05	0.04	0.007	ND	+	–
	3	0.28	0.13	0.05	0.049	D	+	–
D	1	0.17	0.33	0.05	0.016	ND	–	+
	2	0.16	0.22	0.02	0.022	D	–	–
	3	0.67	0.32	0.04	0.034	D	–	+
E	1	0.28	0.09	0.04	0.020	ND	–	–
	2	0.15	0.14	0.02	0.005	ND	–	+
	3	0.16	0.23	0.03	0.005	ND	–	+

Bac303, *Bacteroides-Prevotella* group; Bif64, *Bifidobacterium*; D, detected; 7αDH, 7α dehydroxylases; DSR, dissimilatory sulphite reductases; EC1531, *Escherichia coli*; Erec482, *Eubacterium rectale-Clostridium coccoides* group; FISH, fluorescent in situ hybridisation; LAB158, *Lactobacillus* and *Enterococcus* group; ND, not detected; PCR, polymerase chain reaction with primers against archaea; +, detected; –, not detected.

group-specific and species-specific probes, with no trends detected in precolonoscopy and postcolonoscopy samples.

We analysed 96-clone libraries from all three stools per patient (GenBank DQ904637–DQ905931, DQ905933–DQ905956). By using the [–]Libshuff programme,¹⁰ we determined which of the libraries originated from the same source, and whether they were subsets or were derived from different sources. For none of the patients did all three libraries derive from the same source, indicating variation in microflora composition. For patient A, the libraries before and 6–8 weeks afterwards originated from the same source ($\Delta C_{X1,Y3}$ and $\Delta C_{Y1,X3} > 0.009$), and the library before was a subset of the library detected 2–4 weeks afterwards. For patient B, all libraries originated from different sources (all $\Delta C_{X,Y}$ and $\Delta C_{Y,X} < 0.009$). For patient C, the libraries at 2–4 and 6–8 weeks after the procedure originated from the same source ($\Delta C_{X2,Y3}$ and $\Delta C_{Y2,X3} > 0.009$). For patient D, the library generated after 6–8 weeks was a subset of both other libraries ($\Delta C_{Y1,X3}$ and $\Delta C_{Y2,X3} > 0.009$). For patient E, the libraries after the procedure were a subset of the precolonoscopy library ($\Delta C_{Y1,X2}$ and $\Delta C_{Y1,X3} > 0.009$) and the library 2–4 weeks afterwards was a subset of that after 6–8 weeks ($\Delta C_{Y3,X2} > 0.009$).

Our observations with different methods did not agree in many details, probably due to different biases inherent in each method. However, all methods indicated that microbiota composition is disturbed in patients undergoing screening colonoscopy, which might have implications for potential health effects that we do not yet understand. Simple DGGE profiling, with universal and group-specific primer sets, might currently be most efficient for monitoring the complex human microbiota composition over time. There is a clear need for improving our understanding of the dynamics in microbiota composition.

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Competing interests: None.

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BOOK REVIEW

The political economy of healthcare; a clinical perspective

Authored by Julian Tudor Hart. Published by The Policy Press, Bristol, £14.99 (hardback £55), pp 336. ISBN 1-86134-808-8

At last, a coherent alternative to the healthcare agenda promoted by all political parties! A distinguished general practitioner draws on erudite sources and vivid personal experience to analyse British healthcare. The core principle of the National Health Service (NHS), he argues, is an exponentially expanding knowledge base, which has been translated to benefit everyone within a framework of consensus and solidarity (despite the odd greedy doctor or patient). The NHS transformed British hospitals "by distributing medical labour away ... from university cities to provide all ... specialty functions everywhere in Britain". Will profit-driven multinationals (which are substantially more expensive to administer than state-run healthcare) ensure that this continues? No other economy has achieved comprehensive healthcare for so little. Critics of the old NHS

suggest that competition-introducing reforms produced benefit: an increase of 30% in output, 32% in inpatients, 81% throughput per acute bed However, although a number of interventions are lazily used as surrogate measures of health gain, they are, of course nothing of the sort.

Public health and chronic disease are doctors' core business. Few patients are "cured", but proper chronic care—which is unattractive to financiers—prevents many acute crises. In the US "managed care plans compete to recruit well people and discard unprofitable sick people". Specialisation optimises the treatment of the acutely ill, but skilled care becomes extremely costly with prolonged illness. Increased profit (for shareholders) can only come from decreased staffing. This directly leads to dirty hospitals, and studies show that reducing workforce numbers increases mortality.

Many health problems are only soluble collectively. Charges "reduce consultation across the board, regardless of the problem ... selective only for those most likely to be sick". Look at HIV-induced carnage in Africa, where few can afford healthcare. Professionals should be "sceptical producers of health gain, rather than salesmen of process". The more that our technology can do, the more frequent difficult decisions become; the opposite of a factory process which requires fewer decisions, the more it becomes automated.

What is the solution if not consumerism? Well, it cannot value financial productivity above net health gain. In an insightful final chapter, using frightening examples of

compromises that doctors have made with totalitarian regimens, Tudor Hart identifies a return to solidarity as the only solution so that "good health cannot be hoarded by those with more power". Healthcare workers (who generally do not make a living by selling to people what they do not need) must be freed to work independently from the whim of self-serving politicians so that together with their patients, they can define which outcomes are really important and thus dictate how high-quality universal local healthcare, without need for choice, is delivered.

This is a short but hugely challenging book. It has weaknesses. The European Working Time Directive, which has had a greater effect than any politician, is not discussed. It barely deals with how to reconcile long training with quality of life or the integration of team working with the experience-based "art" of medicine. It should be nastier about those ineffective leaders of the medical profession and occasionally, arrows fired against other ideological causes intrude. But if you care about healthcare, read it!

I suppose I ought to confess a conflict of interest. As a student a few moons and a bit ago, I went on my 3-week general practitioner elective to Julian Tudor Hart's practice and Julian rescued me from my despair of the anti-intellectual nature of medical education (*BMJ* 1988;**296**:1326). At that time, he taught me how the intellectual, ideological and practical can fuse together and unknowingly shaped a good deal of my subsequent medical career.

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CORRECTION

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Kim J, Reber HA, Dry SM, *et al.* Unfavourable prognosis associated with K-ras gene mutation in pancreatic cancer surgical margins. *Gut* 2006;**55**:1598–1605.

In the Methods section, under Primers and probes and PCR assay the correct sequences should read:

"Quantitative real-time PCR was performed using the following primers:

K-ras, 5'-GGCCTGCTGAAAATGA-3' (forward) and 5'-AAGGCACTCTGCCTA-3' (reverse); FRET probe, 5'-FAM-AGCT CCAACTACCACAAGTTTATATTC-BHQ-1-3'"

NOTICE OF WITHDRAWAL

N J Kenefick, C J Vaizey, A J Malouf, C S Norton, M Marshall, and M A Kamm. Injectable silicone biomaterial for faecal incontinence due to internal anal sphincter dysfunction. *Gut* 2002;**51**: 225-8.

This is withdrawn after the senior authors discovered significant errors in the original paper during review for the purposes of writing the long term follow-up data on the same series of patients.