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.

H J N Andreyev

CORRECTION

doi: 10.1136/gut.2005.083063corr1

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′-AAGGCACTCTTGCCTA-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.