

We select the letters for these pages from the rapid responses posted on [bmj.com](http://bmj.com) favouring those received within five days of publication of the article to which they refer. Letters are thus an early selection of rapid responses on a particular topic. Readers should consult the website for the full list of responses and any authors' replies, which usually arrive after our selection.

# LETTERS



© DAMIKA/MEDISCAN

## PROBIOTICS AND DIARRHOEA

### Data are not widely applicable

We caution against extrapolating the results of Hickson et al, which support the benefit of probiotics in antibiotic associated diarrhoea.<sup>1</sup> We are particularly concerned about their conclusion that a probiotic yoghurt drink, given during and after antibiotic treatment, “has the potential to decrease morbidity, healthcare costs, and mortality if used routinely in patients aged over 50.”<sup>1</sup>

The magnitude of the protective effects of the probiotic yoghurt against antibiotic associated diarrhoea and *Clostridium difficile* infection were stark. However, important issues about the study design and conclusions were not considered or given sufficient weighting in the discussion. In particular, the highly selective inclusion and exclusion criteria are crucial in result interpretation. It took over two years to recruit 135 patients out of 1760 screened individuals, and only 113 of these were followed up for evidence of diarrhoea. Put simply, how can data pertaining to less than 7% of a potential target population be extrapolated to routine use?

**Mark H Wilcox** clinical director of pathology, University of Leeds, Leeds LS1 3EX  
[Mark.Wilcox@Leedsth.nhs.uk](mailto:Mark.Wilcox@Leedsth.nhs.uk)

**Jonathan A Sandoe** lecturer

**Competing interests:** MHW has received honorariums for consultancy work, financial support to attend meetings, and research funding from Astra-Zeneca, Bayer, Genzyme, Pfizer, Vicuron, and Wyeth. JAS has received honorariums for consultancy work and financial support to attend meetings from Novartis and Wyeth.

1 Hickson M, D'Souza AL, Muthu N, Rogers TR, Want S, Rajkumar C, et al. Use of probiotic *Lactobacillus* preparation to prevent diarrhoea associated with antibiotics: randomised double blind placebo controlled trial. *BMJ* 2007;335:80-3. (14 July.)

### No high risk antibiotics?

I was astounded to read in the study method that Hickson et al had excluded “high risk” antibiotics (as well as some misclassified low risk antibiotics).<sup>1</sup> To do so is akin to performing a trial of an agent that claims to prevent type 2 diabetes, but excluding obese patients.

Cephalosporins in particular are rapidly losing their usefulness as frontline antimicrobial agents because of their potential to cause *Clostridium difficile* associated diarrhoea. The loss of these highly effective agents cannot be a good thing.

Any therapy that has the potential to reduce the incidence of diarrhoea associated with *C difficile* should be investigated with enthusiasm, but it should be done in a meaningful way. To exclude the very people in whom it is particularly important to prevent such diarrhoea—patients taking high risk antibiotics—makes this trial of academic value only.

**Tom Billyard** Foundation year 2 doctor, University Hospitals Coventry and Warwickshire, Coventry CV2 2DX  
[tbillyard@doctors.org.uk](mailto:tbillyard@doctors.org.uk)

**Competing interests:** None declared.

1 Hickson M, D'Souza AL, Muthu N, Rogers TR, Want S, Rajkumar C, et al. Use of probiotic *Lactobacillus* preparation to prevent diarrhoea associated with antibiotics: randomised double blind placebo controlled trial. *BMJ* 2007;335:80-3. (14 July.)

### No proton pump inhibitors?

Hickson et al have tried to introduce true scientific method in an area chiefly governed by sales tactics and mass advertising, but an important omission is the seeming lack of any data on treatment with proton pump inhibitors.<sup>1</sup> Since the target population had a mean age of 74, one could safely assume a sizeable proportion of those would be taking antisecretory treatment. Given the physiological gastric pH, and its likely bactericidal effect on the cultures tested, it would have been more than useful to include outcome data for patients taking proton pump inhibitors.

**Mario B Konfortov** general practitioner registrar, Burn Brae Medical Group, Hexham, Northumberland NE46 2ED  
[mario\\_konfortov@hotmail.com](mailto:mario_konfortov@hotmail.com)

**Competing interests:** None declared.

1 Hickson M, D'Souza AL, Muthu N, Rogers TR, Want S, Rajkumar C, et al. Use of probiotic *Lactobacillus* preparation to prevent diarrhoea associated with antibiotics: randomised double blind placebo controlled trial. *BMJ* 2007;335:80-3. (14 July.)

## FOLIC ACID FORTIFICATION

### Clarify the neurological risks

The head to head between Wald and Oakley and Hubner et al mainly focused on possible risks of cancer associated with folic acid fortification.<sup>1,2</sup> However, there are also neurological risks from fortification.<sup>3</sup>

It is unwise of Wald and Oakley to dismiss as unscientific so many reports between 1945 and 1950 of the harmful effects of folic acid in the presence of vitamin B12 deficiency, and then to select only the observations that suit their own case.<sup>1</sup> They are incorrect to state only that folic acid allowed the neurological consequences of vitamin B12 deficiency to progress. The earlier authors reported that both blood and nervous system could improve and relapse but to different degrees and at different rates.<sup>3</sup> This is supported by the recent study of 1459 elderly subjects in the United States after fortification showing that in the presence of vitamin B12 deficiency high serum folate concentration was associated with anaemia, macrocytosis, and cognitive impairment, whereas with normal vitamin B12 status high serum folate concentration was associated with apparent protection from cognitive impairment.<sup>4</sup>

Wald and Oakley's extreme view that there is no credible evidence of any adverse health effects from folic acid supplementation or fortification is unsustainable. The protective effect of folic acid fortification on neural tube defects is real but modest (20-43% reduction), and even after fortification young women will still need additional supplementation. Folates and vitamin B12 are important for nervous system function, including methylation and epigenetic mechanisms,<sup>3</sup> and it would be wise to clarify the benefits and risks at all ages, including elderly people, before exposing everyone to excessive folic acid long term.

Edward Reynolds consultant neurologist, Institute of Epileptology, King's College, Denmark Hill Campus, London SE5 6PJ  
reynolds@buckles.u-net.com

**Competing interests:** ER has engaged in studies of folic acid and vitamin B12 in relation to the nervous system during the past 40 years.

- 1 Wald NJ, Oakley GP. Should folic acid fortification be mandatory? Yes. *BMJ* 2007; 334:1252. (16 June.)
- 2 Hubner RA, Hulston RD, Muir KR. Should folic acid fortification be mandatory? No. *BMJ* 2007;334:1253. (16 June.)
- 3 Reynolds E. Vitamin B12, folic acid, and the nervous system. *Lancet Neurol* 2006;5:949-60.
- 4 Morris MS, Jacques PF, Rosenberg IH, Selhub J. Folate and vitamin B-12 status in relation to anemia, macrocytosis, and cognitive impairment in older Americans in the age of folic acid fortification. *Am J Clin Nutr* 2007;85:193-200.

## NHS RESTRUCTURING

### Consider social anthropology

Braithwaite provides a practical strategy for coping with the restructuring of the NHS.<sup>1</sup> NHS organisations are distinguished only by their instability, and the costs of this are high.<sup>2</sup> So why do we do it?

It is a symbolic act for politicians, so what is also of interest now is the symbolism of who is appointed to lead this—and, whatever the personal characteristics of the individual, the symbolism of a surgeon sends out specific messages about doctor led action. From a social anthropological perspective it may also represent the reaffirmation of the order of tribes in health care,<sup>3,4</sup> which increases in importance in forming and maintaining identity for individuals as the organisational identities fail yet again.

Further useful insight from Australia is provided in the notion of “orphan knowledge”—an evocative term for what was originally an observation about knowledge management but has wider application because there are situations where organisations forget things and repeat past mistakes.<sup>5</sup> Do organisations really “unlearn,” or is it because knowledge is forgotten, separated, or isolated within the organisation?

Annabelle L Mark professor of healthcare organisation, Middlesex University Business School, London NW4 4BT  
a.mark@mdx.ac.uk

**Competing interests:** None declared.

- 1 Braithwaite J. How to restructure—proof your health service. *BMJ* 2007;335:99. (14 July.)
- 2 Mark A. *Trust me I'm not a doctor*. London: Middlesex University Business School, 2003. (HRM discussion paper series No 11.)
- 3 Linstead S. The social anthropology of management. *Br J Manage* 1997;8:85-98.
- 4 Maffesoli M. *The time of the tribes: the decline of individualism in mass society* London: Sage, 1996.

- 5 Caddy I. Orphan knowledge: the new challenge for knowledge management. *J Intellect Capital* 2001;2:236-45.

## JOURNALS AND DRUG ADVERTISING

### Medical schools, take the lead

It is not only journal editors who need to take leadership in changing the culture of acceptance of drug advertising<sup>1,2</sup>: medical schools also need to recognise their responsibility. When it comes to teaching about the ethics of marketing there is much to be done: to our knowledge, no British medical school has a policy on pharmaceutical interaction.

Our American counterparts are setting the standard: Yale, Stanford, and many other American medical schools have policies restricting pharmaceutical interaction during medical school.<sup>3</sup> Their policies reflect the value of marketing representatives as a source of evidence.

The BMA's recent annual representatives' meeting signalled the beginnings of a cultural shift in the United Kingdom. The meeting voted almost unanimously in favour of supporting medical schools in not only forming policies but dedicating time in the curriculum for teaching on professional conflicts of interest.

David Biles year 4 medical student, University of Bristol Medical School, Bristol BS2 8DZ  
db2065@bris.ac.uk

Patrick Howlett year 4 medical student

Robert Hughes year 4 medical student

**Competing interests:** None declared.

- 1 Smith R. Should medical journals carry drug advertising? Yes. *BMJ* 2007;335:74. (14 July.)
- 2 Williams G. Should medical journals carry drug advertising? No. *BMJ* 2007;335:75. (14 July.)
- 3 McCarthy M. US campaign tackles drug company influence over doctors. *Lancet* 2007;369:730.

### Beware advertising packages

In post-Soviet Russia, almost all journals depend mostly on advertisements.<sup>1,2</sup> The most prosperous journals bring profits for their owners, and the owners then press the journals to raise more money through advertisements. This does not reduce the pressure on the content of the journal but introduces another—the demand for more profits.

All advertisers have some influence on the content of the journals to support their advertisements. And if one advertiser succeeds in this, it will not lead to complaints from their competitors. Rather

the opposite: competitor advertisers will demand that the journal provides a similar service for them. In Russia these days the publication of advertisements with the supporting “scientific” paper is the usual advertiser's package.

Vasily Vlassov professor, Moscow Medical Academy, Moscow 101000, Russia  
vlassov@cochrane.ru

**Competing interests:** None declared.

- 1 Smith R. Should medical journals carry drug advertising? Yes. *BMJ* 2007;335:74. (14 July.)
- 2 Williams G. Should medical journals carry drug advertising? No. *BMJ* 2007;335:75. (14 July.)

## BEING AT THE HELM FOR PATIENTS

### It's all in the listening

One serious structural problem for communication in medical encounters is the primacy given to diagnosis (and other technical goals).<sup>1</sup> Doctors don't even listen properly to the first thing a patient says before launching into a series of directive questions designed to produce a diagnosis, or a technical update in a review consultation.<sup>2</sup>

So we rarely discover what is really bugging patients, and we rarely take time to make a well structured plan, with adequate safety netting.

The antidote is spectacular investment in the opening and closing of a consultation, together with efforts in the middle to understand the patient's perspective and reflect it back (expressions of empathy). This is well summarised in the “four habits model” of Frankel and Stein<sup>3</sup> (the in-house method of Kaiser Permanente).

It need not take longer. But it will take much remedial training for existing practitioners. For the next generation, it cannot all be achieved in medical school. New doctors must focus on mastering the technical aspects of doctoring. The rounder consultation can really only come once doctors are caring for their own patients—that is, mastering this skill is a postgraduate enterprise.

Malcolm I Thomas managing director, Effective Professional Interactions, Morpeth, Northumberland NE61 1SH  
mithomas@doctors.org.uk

**Competing interests:** MIT is managing director of Effective Professional Interactions, which offers training for consultations with patients.

- 1 Richards T. Who is at the helm on patient journeys? *BMJ* 2007;335:76. (14 July.)
- 2 Beckman HB, Frankel RM. The effect of physician behaviour on the collection of data. *Ann Intern Med* 1984; 101: 692-6
- 3 Frankel RM, Stein T. Getting the most out of the clinical encounter: the four habits model. *Permanente J* 1999;3:79-88.