Taking into consideration the nature and purpose of this publication, I would like to invite specialists in the field of anaerobic bacteria and probiotic bacteria to evaluate my remarks. Should they confirm my comments and conclusions, I would like to suggest that:

1. The SAMJ should officially revoke the findings and conclusions presented in the paper.

2. In view of the far-reaching consequences of the conclusions published in the paper, the SAMJ should offer a public apology to the parties affected, to be disseminated in the media.

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2. Culture Media. In: Oxoid Manual. 7th ed. Compiled by Bridson EY. Basingstoke, Hampshire: Unipath, 1995: 2-78 - 2-80.
3. Tharmaraj N, Shah NP. Selective enumeration of Lactobacillus delbrueckii spp. Bulgaricus, Streptococcus thermophilus, Lactobacillus acidophilus, bifidobacteria, Lactobacillus casei, Lactobacillus rhamnosus, and propionibacteria. J Dairy Sci; **86:** 2288-2296.
4. Bevilacqua L. Ovidi M, Di Mattia E, Trovatelli LD, Canganella F. Screening of Bifidobacterium strains isolated from human faeces for antagonistic activities against potentially bacterial pathogens. Microbiol Res 2003; **158**: 179-185.
5. Leblond-Bourgey N, Philippe H, Mangin I, Decaris B. 16S rRNA and 16S to 23S internal transcribed spacer sequence analyses reveal inter- and intraspecific Bifidobacterium phylogeny. Int J Syst Bacteriol 1996; **46:** 102-111.

See also editorial (p. 272), the front-page editorial (p. 227) and Editor's Choice (p. 229) The authors of the original article have been offered the opportunity to respond, but were unable to meet the deadline for this issue. — Ed.

Knowing what you can take — the ins and outs of drug-free sport

To the Editor: Last year Elana Meyer was suspended after winning a 10 km road race when the caffeine level in her blood was higher than the acceptable level. Yet in 2004 caffeine has been removed from the list of banned substances! Clearly the field of drugs in sports is changing very rapidly.

For this reason the Discovery Health UCT/MRC Research Unit of Exercise Science and Sports Medicine, in conjunction with the Institute for Drug Free Sport, have put together an informative workshop, which will serve to update everyone on the current list of banned substances and procedures. The workshop will include an overview of drugs in sport, a talk on the latest issues and controversies on drugs in sport, and a presentation on some facts and fallacies related to nutritional aids that supposedly enhance sporting performance.

The speakers include Dr Shuaib Manjra, Director of the South African Institute of Drug Free Sport, who will give an overview of the different classes of banned substances and procedures and explain the protocol for drug testing. Dr Ryan Kohler will discuss the controversies in drug testing and drugs in sport, and a registered dietician, Amanda Claassen, will discuss an evidence-based approach to nutritional sporting performance enhancers.

The workshop, sponsored by the Institute for Drug Free Sport and supported by the SA Sports Medicine Association (SASMA), will take place on 10 May 18h30 in the auditorium of the Sports Science Institute of South Africa. To reserve your place, please phone Pinky Bobo on (021) 650-4561. There will be a R20 donation to the Ziphelele Mbambo Memorial fund, but SASMA members and students can attend for free on presentation of their registration cards.

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Fee for service

To the Editor: Is it not interesting how the unaffordability-of-medical-care debate in the press is led by big business players and not by the patients or the doctors?

The villains of the piece are always the doctors and fee for service.

Is it not strange that in every other field of human endeavour fee for service works, but not in medicine! Could it be that the real problem lies with the third party payer? When I see a patient and charge R100 he gives the third party R120 to pay me — surely if we settled on R110 we would both be happier? Why do we need the intermediary?

The real beneficiaries in a managed care option are the third parties and their shareholders. For both the patient and the doctor the options become more and more restrictive. Is this not why the medical aid industry runs down fee for service and promotes managed care?.

Necessities such as food, clothing and housing are provided by private for profit markets. Or maybe food should also be regulated by a manager with a list of what you may or may not purchase. Food is certainly even more essential than medical care, and certainly has a much bigger effect on the health of the nation.

State interference in the market can only cause more problems, as I see with the minimum benefits that must be covered, some medical aids are only going to cover the benefit 100% if it is provided by a preferred provider! Hello! Who is the preferred provider? Why, the state hospital. What an easy way out for the medical aid industry!

Surely the best managers of the patients' affairs are the

patients themselves. It is time we looked carefully at savings accounts combined with in-hospital insurance and dread disease cover. The place to look is the USA and Singapore, the latter having a compulsory savings account model that has served them very well (the patient is in charge of his own affairs and there are no middlemen).

Milton Friedman, the Nobel prize-winning economist, said there are four types of payer.

1. Someone who spends his own money on himself. He wants the best quality that he can afford at the best possible price.

2. Someone spending his money on somebody else. The price is important but the quality is not, nor does it matter if that is what the recipient wants, which is why children get underwear for Christmas.

3. Someone spending someone else's money on himself. The sky is the limit, only the best will do, and the cost does not matter, e.g. our politicians on the gravy train spending taxpayers' money.

4. Someone spending someone else's money on a third party. The cost and quality do not really matter and if there is a commission involved then the case is even worse. This is where we find medical aids in the worst scenario.

Therefore it is obvious that the first scenario is the best for all. It brings out the best in the seller as he must produce the goods, and the best in the buyer as he is spending his own hard-earned money. This scenario is fee for service.

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Jan Mikulicz-Radecki — father of surgical endoscopy

To the Editor: I refer to the article by Jarek Kowalczyk on Jan Mikulicz-Radecki.[1] I agree that the latter was beyond any doubt one of the finest surgeons in history. So much for the medical side of things. However, the historical facts of his career as presented in the article are questionable. A look into the electronic edition of the Encylopaedia Britannica reveals the following: Johannes von Mikulicz-Radecki was born in Czernowitz, Romania, on 16 May 1850, and he died on 4 June 1905 in Breslau, Germany. He was professor of surgery at the universities of Krakow (1882 - 1887), Königsberg (1887 - 1890) and Breslau (1890 - 1905).

Firstly, Poland did not exist as a state at that time but was part of both Russia and the Austro-Hungarian empire. It is nonsensical to claim that Radecki was denied a post in Germany when he held the position of Head of the Department of Surgery in Breslau, Germany, until his death. Breslau was occupied by Poland in 1945 and renamed Wroclaw, and its inhabitants were among the 12 million Germans expelled from Eastern Germany by Poland. The history of medical and philosophical heroes should reflect historical truth.

Finally, a glance at an atlas will show that Czernowitz is located in the Ukraine, previously Romania, and not in Poland, as the Encyclopaedia also states correctly, yet again revealing the unfortunate misrepresentation of facts by the author in an otherwise fine article about a brilliant pioneer in medicine.

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1. Kowalczyk J. Jan Mikulicz-Radecki (1850 - 1905) — father of surgical endoscopy. S Afr Med J 2003; **93:** 509 - 510.

Jarek Kowalczyk replies: I get the impression that Dr Schaffner has personal feelings related to the history of Germany and Poland, and not to Professor Mikulicz-Radecki's medical achievements.

I would like to explain the following.

1. The catastrophe of World War I (1914 - 1918) was created by Germany. Much of that war took place on Polish soil, causing substantial material damage to many towns and villages and the extermination of people. Germany lost the war, but did not stop her demands of the eastern part of Europe.

2. Twenty-five years later Nazi Germany started World War II. During that war Poland lost about 6.5 million inhabitants — more than 20% of its entire population. About 0.5 million were soldiers killed on the different front lines. However, the remaining 6 million people were civilians exterminated in concentration camps such as Auschwitz, Treblinka, Stuthoff and Majdanek, all of them located in Poland, executed in the streets of the Polish towns or deported to Germany. A number of towns were completely wiped out, e.g. Warsaw, the capital of Poland suffered 80% damage to its buildings, churches and streets.

3. The Potsdam Conference in 1945 (with no Poland taking part in it) created a new order in Europe. On the basis of this approximately 9 million Germans from western Polish and former eastern German land were deported peacefully to the main land of Germany. These are the facts that must be accepted. There is no point in discussing these matters in a medical journal in the year 2004.

Finally, I would like to stress again that the aim of my short article on Jan Mikulicz-Radecki was to present the life and achievements of a great surgeon and not the history of central Europe.