job security. Epidemiologists and surgeons jointly should influence PR departments to combat perpetuation of "surgical journalism" that in fact is nothing more than tacky marketing. We also have to squelch print or electronic journalism that either hypes flawed outcomes or gives the impression that undergoing surgical care is a piece of cake. In particular, PR must come to grips with the fact that single-patient stories and grouped patient data comparisons are not of the same genre. *The minimization of unrealistic lay expectations should be a solemn PR goal, and hospital epidemiology must exert leadership pressure here using institutional political channels.* One element of the healthcare quality improvement zeitgeist is the belief that total quality management concepts apply to every kind of work. Perhaps our PR departments should review a few checklist items: What are the key PR processes? What is the PR chain of command? What are PR's stated objectives? What is the PR department's mission statement? What are the basic ethical guidelines in PR? Who are PR's main customers? What was the PR department's flaw rate last year? What PR process improvement initiatives exist for next year? Any intellectually honest quality improver in health care must admit that what is good for the goose is good for the gander.

At the hospital-media interface, "all's fair in love and war" seems to be dominating the rules of engagement. It is thus imperative that PR staff partner with key doctors in appropriate ways. Who are these key doctors? A simple strategy apparently is being followed at some hospitals already, in which PR departments maintain comprehensive, updated listings of hospital staff expertise areas and past accomplishments. Only a loosely run PR function will be unaware of which staff have made substantial, relevant contributions on multidisciplinary nationwide task forces, testified as experts in court, worked as investigative consultants to other hospitals, chaired academic work groups, authored major papers and book chapters, or otherwise clearly developed perspective and expertise in topics that may stir media activity. Clearly, surgeons must be consulted before PR plays any of the hospital's surgical outcome cards.

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Prevalence of *C difficile*

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Dr. Frederic Barbut and colleagues, from the Saint Antoine Hospital in Paris, recently reported the prevalence and pathogenicity of *Clostridium difficile* in hospitalized patients in a large multicenter study. The presence of *C difficile* was investigated systematically in a case-control study of 3,921 stool samples sent for stool culture. The prevalence of *C difficile* in cases was compared with a group of 229 randomly selected matched controls among hospitalized patients. Serotype and toxigenesis of isolated strains were compared.

The overall prevalence of *C difficile* in the cases was twice the prevalence in the controls (9.7% versus 4.8%) and was approximately four times higher in diarrheal stools as in normally formed stools from controls. The strains isolated from diarrheal stools were more frequently toxigenic than those isolated from normally formed stools. Serogroup D was never toxigenic, and its proportion was statistically greater in controls than in cases. Conversely, serogroup C was isolated only from the cases. *C difficile* was found primarily in older patients (>65 years) who had a disabling condition, who had been on prior antibiotics, and who had been hospitalized for longer than 1 week.

The authors conclude that this study further supports the role of *C difficile* in infectious diarrhea in hospitalized patients and suggest that clinicians should suspect *C difficile* in patients with a diarrheal illness, especially those considered at risk.

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