LETTERS

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EBOLA CRISIS

A dangerous combination? Ebola, Twitter, and misinformation

The recent Ebola outbreak in west Africa has affected countries deeply in need of foreign aid.[1] People desperately need correct information on how to prevent and treat Ebola. Despite the poverty, the increasing spread of computers, tablets, and smartphones in the region creates an opportunity for the rapid dissemination of information through the internet and social media, but there is no guarantee that this information is correct. After reports that misinformation spread by text messages led to deaths,[2 3] we checked the quality of Ebola related information on Twitter.

We used the Twitter search engine to collect all tweets in English with the terms "Ebola" and "prevention" or "cure" from Guinea, Liberia, and Nigeria during 1 to 7 September 2014. We grouped them into medically correct information, medical misinformation, and other (including tweets of a spiritual nature). Most tweets and retweets contained misinformation, and misinformation had a much larger potential reach than correct information (table).

The most common misinformation was that Ebola might be cured by the plant ewedu or by blood transfusion (unqualified—not just from Ebola survivors). Drinking and washing in salty water were also mentioned. Among these tweets, 248 (44%) were retweeted at least once; 95 of these contained scientifically correct information (38.3%), whereas 146 contained medical misinformation (58.9%; P<0.001). Two of these tweets—"Take ewedu daily to prevent and cure Ebola LUTH doctor urges Nigerians" and "Herbal healers' claim to cure Ebola false"—were retweeted 23 and 24 times, respectively.

While most erroneous tweets were left undisputed, in some cases they were corrected by a Nigerian government agency and this correction spread on Twitter three days later. Public health and government agencies in west Africa should use Twitter to spread correct information and amend misinformation on how to deal with this emergency.

Types of tweets and potential readers (n)

	Medically correct information	Medical misinformation	Other (including tweets of a spiritual nature)
Tweets (%)	203 (36)	313 (55.5)	48 (8.5)
Potential readers	5 596 153	15 039 097	48 308
Retweets*	95	146	7

*x^2 test, P<0.001.

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Competing interests: None declared.

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BARIATRIC SURGERY FOR OBESITY

Eligibility exceeds current NHS capacity to provide service

Arterburn and Courcoulas review bariatric surgery for obesity and metabolic conditions.[1] Based on the 2006 National Institute for Health and Clinical Excellence's (NICE) guidelines and data from the Health Survey for England, around 5.4% of the general adult population in England (2.15 million people) are potentially eligible for bariatric surgery.[2] Those fulfilling the criteria for bariatric surgery are more likely to be women, be retired, have lower educational qualifications, and have lower socioeconomic status.

The number of people eligible for bariatric surgery far exceeds the current capacity of the NHS to provide this service. This implies that the NICE guidelines on bariatric surgery need to be revised so that the eligibility criteria are made more stringent to reduce the number of people eligible, or the capacity of the NHS to deliver bariatric surgery services needs to be considerably increased.

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Competing interests: None declared.

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THE EC AND PHARMACEUTICAL POLICY

Success of the EC's paediatric regulation is established

In his editorial on the European Commission and pharmaceutical policy McKee states, "The goal [of paediatric regulation] was certainly laudable, but its success has been questionable."[1] This statement is referenced by an article written by a consultant to pharmaceutical companies, and former employee of several of them.[2] His opinion is not shared by most other stakeholders, including the European Commission.[3]

During its first five years the regulation has resulted in an increased percentage of clinical trials in children and neonates, 221 changes of paediatric relevance in the product information of authorised medicines, 89 additions of dosage information for children, 77 other modifications to report on new study data, 34% of medicines being authorised by the European Medicines Agency with a paediatric indication from the beginning, 72 new paediatric indications for already authorised products, and 26 new paediatric specific formulations.[4]

Therefore the success of the regulation is established and not questionable. Of course, we should always strive to improve results even when they are good; to do this, cooperation is needed from all stakeholders, including patients, regulators, legislators, and (last but not least) pharmaceutical companies.

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Competing interests: None declared.

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GP SUSPENSION CASE

Was GP's suspension a miscarriage of justice?

A feature of British justice is judgment by peers, but no information is given in the case of Dr Arun Singhal about what experience,

if any, tribunal members had of working in deprived inner city general practice.[1]

Patient A, "not wholly credible as a witness," consulted Dr Singhal with a non-medical problem. She wished to be excused witness duty in court and became angry when a certifying "note" was refused without payment.

She secretly recorded the consultation. Imagine her fury if the opposite had occurred. Do doctors not have a right to confidentiality as do their patients?

She then threatened to commit suicide unless Dr Singhal complied with her wishes. This was not a psychiatric emergency but an attempt to blackmail him. To accede to threats is rarely in a patient's best long term interests and Dr Singhal called her bluff.

It is surprising that Patient A had remained with the practice after publicly describing Dr Singhal as a "fucking joke." Many GPs would regard this as a breakdown in the doctor-patient relationship, but he did not seek her removal. Perhaps he thought they could work through her undoubted personality problems together by being completely honest with her.

Dr Singhal provided testimonials confirming his previous good practice but did not attend the tribunal in person. He may not have recognised that it would regard this incident as serious and he would have been busy looking after his patients.

I had imagined that suspension from the medical list occurred only after a major catastrophic incident or a persistent pattern of dysfunctional clinical behaviour. As a retired GP who worked in a similar practice I have considerable sympathy with Dr Singhal and wonder if a miscarriage of justice has occurred.

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Competing interests: None declared.

1 Dyer C. Tribunal suspends GP after he told patient who was threatening suicide to go ahead. *BMJ* 2014;349:g5804. (23 September.)

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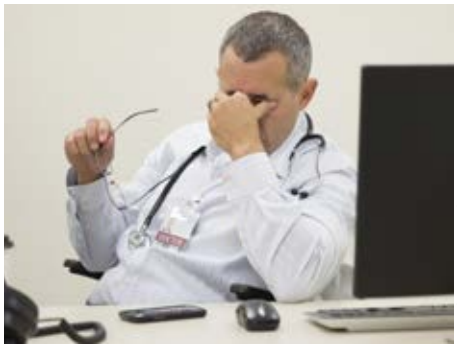
GP EXODUS FROM THE PROFESSION

Proportion of registered doctors leaving UK remains low

Iacobucci's article on comments from the Royal College of General Practitioners highlights the difficulty in drawing simple conclusions from the available data.[1]

The General Medical Council issues certificates of good standing (CGS) on behalf of UK registered doctors to other regulators and employers to confirm that they are not subject to current fitness to practise proceedings. Because these certificates have a three month "shelf life," doctors may need to request several when contemplating working overseas. As such,



JETTA/BLENDIMAGES/CORBIS

the number of doctors leaving the UK cannot be accurately gauged by the number of CGSs issued. Similarly, doctors requesting a CGS do not have to say why they are considering a move.

There has been a 20% increase from 2008 to 2013, but because the numbers are small the overall impact is minimal. The proportion of registered doctors with UK qualifications requesting a CGS has remained consistently low (around 2%) for the past five years.

It is wrong to suggest that there has been a 30% rise in doctors requesting a CGS.[1] This is the figure for the volume of CGS certificates issued, not the number of doctors making the request.

In addition, although a CGS request may indicate an intention to practise abroad, many doctors who request one do not leave, and of those who do, some later return to practise here.

Doctors form part of a global workforce and the UK has benefited from this.

Of course none of this is to deny the pressures on UK doctors and that some of them may be considering working abroad.

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Competing interests: None declared.

1 Iacobucci G. GP leader warns of exodus from the profession. *BMJ* 2014;349:g5828. (23 September.)

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PREVENTING HOSPITAL ADMISSION

Contradiction is inherent in business model for hospitals

One problem that Oliver did not highlight in his discussion of preventing hospital admission was the apparent contradiction inherent in the business model of hospitals.[1]

The fundamental aim of businesses is to increase their share of the market (to enhance profits) and to expand the market. Thus, for a government to insist that a market based organisation seeks to shrink its share of a shrinking market is a breach of any director's fiduciary duty.

It seems to me that those who sought the rigours of a market to be unleashed on the NHS must accept that the rise in emergency and other admissions is exactly what they were likely to get.

Perhaps the long derided skill of healthcare policy analysis should be reinvented in the health service, something public health departments used to do.

Because the public service model aims ultimately to improve health so that admissions are less frequent, the problem is unlikely to be solved until a public service approach is once more in fashion.

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Competing interests: None declared.

1 Oliver D. Preventing hospital admission: we need evidence based policy rather than "policy based evidence." *BMJ* 2014;349:g5538. (23 September.)

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ORGAN DONATION

No more "harvesting" of organs

I was shocked that the word "harvest" for organ donation from deceased donors was used in *The BMJ*.[1]

The word ordinarily refers to gathering an agricultural crop with the use of a sharp implement. Because of its propensity to cause distress to the families of donors (and those who care for them), some journals have banned the use of this word. The *American Journal of Transplantation* took the lead many years ago, and its instructions to authors make this clear.[2]

Organ donation professionals around the world do not use the word, and some professional societies provide detailed recommendations about its use and advice about sensitive language in organ donation in general.[3]

Unfortunately, other health professionals and journalists seem to be unaware that the term has upsetting connotations,[4] so it is still used in medical journals.

I call on the editors of *The BMJ* and my fellow clinicians to stop using the word. Several sensitive and descriptive alternatives, such as "organ removal" or "organ donation," do not carry the negative connotations of "organ harvest."

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Competing interests: I am the clinical director of Organ Donation New Zealand, the national agency for deceased donation in New Zealand, and a member of the death and organ donation committee of the Australian and New Zealand Intensive Care Society.

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Cite this as: *BMJ* 2014;349:g6174