LETTERS

Letters are selected from rapid responses posted on thebmj.com. After editing, all letters are published online (www.bmj.com/archive/sevendays) and about half are published in print
To submit a rapid response go to any article on thebmj.com and click "respond to this article"

EBOLA CRISIS

What stops healthcare workers volunteering to fight Ebola?

MSF

The outbreak of Ebola virus disease has caused unprecedented demands on health systems in west Africa, which were already fragile and are now at breaking point. The outbreak will be brought under control only with a massive input of money, infrastructure, and people.[1] Crucial among the personnel needed are healthcare workers. For example, Médecins Sans Frontières (MSF), the most heavily involved charitable organisation, currently has only 276 international staff on the ground in the three worst affected countries—Guinea, Liberia, and Sierra Leone.[2] This is far short of the thousands more that are needed.[3]

So far, in the UK 800 people have volunteered to go to west Africa. Although many more have considered going, the factors that hold people back from signing up have not been assessed. Informal discussions among colleagues, and monitoring of social media such as Twitter and Facebook, have suggested that a range of factors may influence healthcare workers' decisions on going to west Africa. Some of these, such as fear of becoming infected or personal home circumstances, are not easily changed. But there are other factors, which potentially could be dealt with if it were clear that they are important. These might include reassurance about the training to be given, clarity over payment and backfill of posts, and allaying uncertainties over repatriation for anyone who becomes unwell.

To gain a better understanding of the barriers that are preventing UK healthcare workers from volunteering to help control the Ebola virus in west Africa, we have launched a simple, brief online survey. We hope that this will identify any modifiable barriers that policy makers and those recruiting staff could potentially address. This would encourage more healthcare workers to volunteer in west Africa, which should in turn help lead to a swifter end to the epidemic. Bringing the outbreak under control would not only benefit the people of west Africa but also help to protect the UK from imported cases. We encourage all UK healthcare workers to complete our survey, which can be found at www.surveymonkey.com/s/HPRUebola.

Tom Solomon director
tsolomon@liv.ac.uk
Lance Turtle clinical lecturer
Fiona McGill National Institute for Health Research doctoral training fellow
Claire Matata research nurse
Rob Christley reader, Institute of Infection and Global Health, University of Liverpool, Liverpool L69 7BE, UK

Competing interests: None declared.

1 Gulland A. Fifteen countries are at risk of Ebola outbreak, says WHO. *BMJ* 2014;349:g6305. (17 October.)
2 Médecins Sans Frontières. Ebola- MSF staff on the ground. www.doctorswithoutborders.org/our-work/medical-issues/ebola.
3 O'Carroll L. Hundreds of NHS medics volunteer to work in Sierra Leone as Ebola spreads. *Guardian* 2014. www.theguardian.com/world/2014/oct/17/nhs-medics-volunteer-sierra-leone-ebola-nursing-call-up.

Cite this as: *BMJ* 2014;349:g6443

SAFEGUARDING CHILDREN

Primary care needs much better systems to safeguard children

For the past year I have felt that general practitioners are disadvantaged in their ability to help protect vulnerable children from abuse.[1] Other agencies "share concerns" and have lower thresholds for reporting, whereas all the training for GPs seems to focus on "referrals." Not surprisingly, it is often unclear whether something that we see crosses the threshold for referral, which will precipitate action and potentially jeopardise future relations with the family.

The complexities of presentations in our surgeries need to be matched by a sophisticated system for dealing with our concerns. The separation of health visitors from the primary care team in most areas has deprived GPs of the ability to make soft referrals when they have concerns about a family, although this has never helped with the sexual abuse of older children.

We need more effective and proportional systems in primary care if we are to fulfil our role in genuinely protecting vulnerable children.

William J Beeby general practitioner, Parkway Medical Centre, Middlesbrough TS8 0TL, UK
Bill.beeby@nhs.net

Competing interests: None declared.

1 Thomas J, Humphery S. Safeguarding children: a challenge to doctors. *BMJ* 2014;349:g5898. (1 October.)

Cite this as: *BMJ* 2014;349:g6445

New tool to aid detection of child sexual exploitation

Thomas and Humphery highlighted the challenges inherent in safeguarding young people against child sexual exploitation (CSE).[1] Consultations with young people within sexual health services routinely entail detailed exploration of risk and vulnerability, placing sexual health as key services to identify those at risk of CSE.

In response to emerging understanding about the prevalence and nature of CSE,[2] the Department of Health and the Home Office awarded the British Association for Sexual Health and HIV adolescent special interest group, in collaboration with Brook, a grant to develop a tool to help detect CSE among young people attending sexual health services.

The formation of a multiagency advisory group, in partnership with young people, some of whom had experienced CSE, has resulted in the development of a document "Spotting the Signs."[3] Thomas and Humphery suggested that the way in which health professionals communicate with young people might affect what information the young person is willing to provide. Similarly, our consultation with young people specifically identified that a conversational tone was desirable, and this is reflected in Spotting the Signs. This document encourages the use of a national proforma designed to act as a prompt to help identify factors associated with CSE.

After a successful pilot in sexual health clinics, outreach settings, and general practice, Spotting the Signs was launched in April 2014 and has been rolled out in many services across the country. Review of the use of the proforma is to be undertaken in 2015, including its potential applicability in other settings such as emergency departments. The proforma is freely available,[3] and a toolkit and e-learning resource are shortly to be released. These initiatives will help to protect young people now and in the future.

Karen Rogstad consultant in HIV and sexual health, Sheffield Teaching Hospitals Foundation Trust, Royal Hallamshire Hospital, Sheffield, UK
Jane Ashby consultant in sexual health and HIV, Central and North West London NHS Foundation Trust, Archway Clinic, London N19 5SE,UK
jane.ashby2@nhs.net
Dawn Wilkinson consultant in genitourinary and HIV medicine, Imperial College Healthcare NHS Trust, Jefferiss Wing Centre for Sexual Health, St Mary's Hospital, London, UK

On behalf of British Association for Sexual Health and HIV Adolescent Special Interest Group

Competing interests: None declared.

1 Thomas J, Humphery S. Safeguarding children: a challenge to doctors. *BMJ* 2014;349:g5898. (1 October.)
2 Berelowitz S, Clifton J, Firimin C, Gulyurtlu S, Edwards G. If only someone had listened. Children's Commissioner, 2013. www.childrenscommissioner.gov.uk/content/publications/content_743.
3 Rogstad K, Johnston G. Spotting the signs: a national proforma to identify child sexual exploitation in sexual health services. BASHH/Brook, 2014. www.bashh.org/BASHH/News/BASHH/News/News_Items/Spotting_the_Signs_-_CSE_Proforma.aspx.

Cite this as: *BMJ* 2014;349:g6454

OPTIMISM ABOUT PCI

The real reasons behind complex surgical procedures

The further that I read into Whittle and colleagues' editorial on patients' optimism about percutaneous coronary interventions,[1] the more the suspense grew. Imagine my surprise when I found no real reference to the effect of the cardiologist's needs and wants on the frequency of the procedure being offered.

The more powerful person in the therapeutic relationship is the doctor, not the patient, so why are so many patients having procedures with benefits that they poorly understand?

Don't look at the patients to find out why. Instead, examine the doctor's motivation.

In some parts of the world it is as simple as money (fee per procedure). In others it's a more complex aggregation of pride, technical complexity, and the challenge associated with the procedure, not to mention the social and professional plaudits that go along with saving lives every day.

Patients think they are having life saving procedures because medical professionals want them to believe that this is so.

W Grant Howard intensivist, general physician, Hamilton, New Zealand
granthoward@rocketmail.com

Competing interests: None declared.

1 Whittle J, Fyfe R, Iles RD, Wildfong J. Patients are overoptimistic about PCI. *BMJ* 2014;349:g5613. (18 September.)

Cite this as: *BMJ* 2014;349:g6448

OBSERVATIONS, p 21

TWO CARE PACKAGES FOR ENGLAND

Wanted: common understanding of the purpose of care homes

The Poor Law's long shadow

DENIS CLOSON/REX

Illiffe and Manthorpe may be right in asserting that the market in social care has failed but the accompanying photograph caption, "The Poor Law's long shadow," is insightful.[1] Poor laws sought to deal with poverty and the "feckless and the reckless." People needing care today have typically survived into later life but are dependent through dementia and frailty; yes, many will be poor, but few are destitute. Their needs are distinct from traditional social care or healthcare.

Care home bed numbers dwarf those in the NHS, and their funding dominates social care budgets. The Department of Health is polarised into "healthcare" and "social care." In recent years, although social care has sought to prevent care home admissions and health services have tried to prevent hospital admissions from care homes, neither has comprehensively led policy and practice for care homes.

We need a common understanding of the purpose of care homes. Recently we used life trajectories to propose an approach we termed formative care.[2] We need to get beyond the mixed messages of "demographic challenge," "success of ageing," and "morbidity compression" and develop care homes that have a valued place in society. This requires new effective ownership and leadership of care home policy and practice.

Clive Bowman honorary visiting professor, City University, London EC1V 0HB, UK
bowmanclive@gmail.com

Competing interests: None declared.

1 Illiffe S, Manthorpe J. Barker & Burstow's care packages for England. *BMJ* 2014;349:g5879. (29 September.)
2 Bowman C, Meyer J. Formative care: defining the purpose and clinical practice of care for the frail. *J R Soc Med* 2014;107:95-8.

Cite this as: *BMJ* 2014;349:g6308

RESPONSE

Katherine Rich replies to Martin McKee

As the representative of most of the New Zealand food and grocery industry, the New Zealand Food and Grocery Council speaks regularly to commentators, journalists, and bloggers on all issues that concern its members. We try to get fair and balanced messages on issues related to food and grocery overall. We do not pay for media coverage or blogs.

We respect science and expertise, and we work constructively with a wide range of public health advocates.

The opinion piece by Martin McKee was disappointing because it repeated a number of falsehoods printed in New Zealand newspapers that we had taken the trouble to raise with them.[1]

For example, McKee's reference to media commentator Wendyl Nissen is ill informed. When she first published her critical piece, the New Zealand Food and Grocery Council wrote to the newspaper to point out that the personal anecdote she had used to underpin her story was untrue. Rather than remove the story, the newspaper chose to upload a separate personal anecdote from two years earlier about how we had lodged a Press Council complaint about an error ridden story by another journalist who had quoted Nissen's book. McKee was correct to state that Nissen had previously criticised the use of artificial colours. However, if he had done his research thoroughly he would have discovered that the New Zealand Food and Grocery Council had sought and received corrections for a two page newspaper article sourcing her work that contained more than 70 factual errors.

New Zealanders are entitled to make their own choices about food colouring, but it is important that what they read is evidence based, not falsehoods repeated from the internet. Readers of *The BMJ* who are interested in this exchange can find additional information on our website (www.fgc.org.nz).

McKee also references comments made about Doug Sellman, best known as the media spokesman for the anti-alcohol campaign group Alcohol Action NZ.

The New Zealand Food and Grocery Council respects the work of Sellman when he is speaking on topics about which he has expertise. Unfortunately, he regularly steps outside his area of expertise to express opinions that are not underpinned by the same academic weight. The use of emotive language to refer to grocery store owners who sell beer and wine as "drug dealers" and "drug pushers" (one of these attacks was aimed directly at one owner by name for applying for a liquor licence) undermines other comments drawn from his academic expertise.

New Zealand is a country where freedom of speech is strongly defended, so Sellman and other advocates are perfectly free to speak on any topic. But equally, other New Zealanders have the right to express a contrary view if they see fit. The debating of ideas is surely an important part of any democracy.

Katherine Rich chief executive, New Zealand Food and Grocery Council, PO Box 25-420, Wellington 6146, New Zealand katherine.rich@fgc.org.nz

Competing interests: None declared.

1 McKee M. Social media attacks on public health advocates. *BMJ* 2014;349:g6006. (8 October.)

Cite this as: *BMJ* 2014;349:g6447