LETTERS

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EBOLA AND ETHICS

Complexities in responding to the Ebola epidemic

JOHN MOORE/STAFF/GETTY

I disagree with Gericke in his editorial on Ebola and ethics.[1] Because there was no vaccine, health workers at the front line were desperate for an effective response, so the focus on specific treatments was highly appropriate. If an effective treatment had been found, people would have seen hospitals as places to be cured rather than places to die. This would have brought infected patients out of their homes and into isolation, slowing the epidemic.

The $100m (£67m; €93m) contingency fund proposed after the 2009 flu epidemic to allow rapid responses to future pandemic threats was not followed up because of lack of interest. But because of the Ebola virus epidemic and spurred by criticism, WHO is now trying to raise it again.[2]

To claim "If only a fraction of the World Bank estimate had been spent on health system preparedness before the current epidemic" ignores a reality that international aid donors have long recognised. Underdeveloped African countries need two or three decades before they can sustain basic health systems.[3] Health services are almost always near the bottom of their budget priorities. Long term improvement in basic health services will not be possible if countries are not willing, or able, to provide attractive salaries and service conditions for health workers (to prevent brain drain) and to maintain the modern facilities that have been donated to them.

Regrettably, as has been seen during this epidemic, much international health aid has never reached the grass roots level of the health services in these countries but has disappeared unaccounted for en route, as shown by recent audits.[4 5]

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1 Gericke CA. Ebola and ethics: autopsy of a failure. *BMJ* 2015;350:h2105. (23 April.)

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Ebola risk at health facilities

Gericke outlines how the current focus on access to experimental drugs for Ebola virus disease has directed attention away from infection control and the strengthening of health systems.[1] Since the first recognised outbreaks of Ebola in 1976,[2 3] it has been clear that health facilities with weak infection control procedures amplify outbreaks by infecting healthcare staff and patients.

The outstanding ethical failure in the ongoing outbreak—a joint failure by WHO, the US Centers for Disease Control and Prevention, ministries of health, and non-governmental organisations—has been not to warn people that attending a health facility puts them at risk of contracting Ebola. WHO and others responding to the outbreak have not recognised and reported the number of patients who probably acquired Ebola in the healthcare setting, which is in sharp contrast to WHO's weekly reports of infected health staff.[4]

Silence about the risks to patients breaches the World Medical Association's Declaration of Lisbon on the Rights of the Patient.

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1 Gericke CA. Ebola and ethics: autopsy of a failure. *BMJ* 2015;350:h2105. (23 April.)

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MSF Ebola treatment centres were far from perfect

As a consultant working as Ebola virus disease technical adviser for a UN agency and an international non-governmental organisation in Guinea from 15 September 2014 to 15 March 2015, I am unclear what evidence the "consensus" on the "exception" of the charity Médecins Sans Frontières (MSF) is based on.[1] Who evaluated MSF's Ebola treatment centres?

Only two treatment centres existed in Guinea until 14 October 2014, both run by MSF. Centres that I visited were mostly, at least in Guinea, designed in a way that was at best technically unsound, and at worst ethically unacceptable. Patients with suspected Ebola were gathered in one tent for testing, keeping symptomatic patients of unknown Ebola status together for hours or days; health staff wore personal protective equipment in these tents. There was no physical separation of beds—just one metre's distance from the centre of one bed to the next. The verbal justification that MSF repeatedly gave was that patients with "wet" and "dry" symptoms were separated and that the probability of being a case was taken into account when separating patients into different tents. Infection between people with suspected disease could not be excluded, yet negative patients were not followed up as contacts after they left the centres.

We had to wait for the Centre de Traitement des Soignants built by the French army for patients with suspected disease to be separated in disposable tents, which cost about €200 (£142; $223) each, and for negative patients to be followed up for 21 days.

Mortality from Ebola in Guinea remained unacceptably high. It took Paul Farmer's questioning for attention to be paid to the unacceptable rehydration protocol in MSF run centres.[2]

MSF did its best, but as with any other NGO, its standards of care should be evaluated by international and national agencies.

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1 Delamothe T. Towards a better epidemic [Editor's Choice]. *BMJ* 2015;350:h2419. (7 May.)

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SAFETY OF NEW ORAL ANTICOAGULANTS

Effective antidotes for new anticoagulants

Sarrazin and Rose discuss the safety profiles of the anticoagulants rivaroxaban and dabigatran but do not include the most recent developments in reversing their effects.[1]

Idarucizumab is a monoclonal antibody that can immediately reverse the effects of dabigatran.[2] Clinical trials have demonstrated an immediate, complete, and sustained reversal of the anticoagulant effect of dabigatran after administration of idarucizumab, with no prothrombotic effect.[2 3] After successful clinical trials a market authorisation was submitted for approval to the European Medicines Agency (EMA) and US Food and Drug Administration (FDA) in March.[4] Idarucizumab is likely to be the first of several effective antidotes for newer

anticoagulants. Others are in various different stages of clinical development.

The anticoagulant effect of warfarin can be rapidly corrected by administering prothrombin complex in acute haemorrhage situations. Until now one of the major longstanding concerns about newer anticoagulants has been the lack of rapid and effective reversal agents. The development of agents such as idarucizumab may be a "game changer" in the transition towards the use of newer anticoagulants.

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1 Sarrazin MSV, Rose A. Safety of new oral anticoagulants. *BMJ* 2015;350:h1679. (24 April.)

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WHISTLEBLOWING IN THE NHS

Non-clinical hospital managers should be regulated

Regulation 5 of the Care Quality Commission sets out "Fit and proper persons" standards for hospital directors,[1] but no such standards exist for the vast cohort of senior and middle managers, who are not board members. So what sanctions might exist for hospital managers who repeatedly ignore issues about patient safety?[2]

Concerns about patient welfare are usually first raised with departmental managers, who are often non-clinical. If non-clinical managers were bound by a professional accountable body to act always in the best interests of patients, they would be more likely to listen and act. Doctors and nurses would be able to refer relevant hospital managers to an accountable body if the reformed NHS whistleblowing system ignored patient safety.

This regulatory change for hospital managers is long overdue and would give increased confidence to all who care for patients.

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2 Holt K. Whistleblowing in the NHS. *BMJ* 2015;350:h2300. (1 May.)

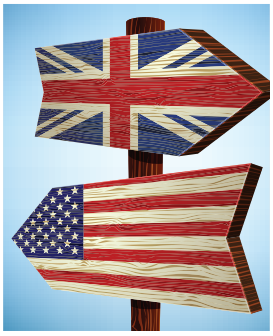
Cite this as: *BMJ* 2015;350:h2769

THE NHS FIVE YEAR FORWARD VIEW

Obstacles to collaborative and affordable healthcare in the UK

The King's Fund article suggests we need to look across the Atlantic for future models of integrated care.[1] Really? We've been here before.

Readers may remember Feachem and colleagues' paper, published 13 years ago, which compared clinical outcomes between Kaiser Permanente and the NHS and suggested that we should ditch the NHS model for the US one.[2] This ideologically motivated paper was quickly demolished, with the NHS showing better outcomes, more equity, and reduced costs.[3] This latest advocacy of restructuring along the lines of accountable care organisations doesn't even aspire to the rigour of that offering, instead arguing that because such organisations have reduced costs in the world's most inefficient, fragmented, and inequitable service we could reduce costs in our immeasurably more efficient NHS by aligning our service with theirs.



The authors should come to east London and talk to GPs and other healthcare workers. We are working together in local networks along with our specialist colleagues and are improving outcomes despite all the pressures we face.[4] We could show them around Barts Health and have a chat about how the private finance initiative is going to bankrupt us, maybe find a consultant who is brave enough to admit that the internal market fosters irrational priorities and is driving up administrative costs. Finally, they could go to a clinical commissioning group meeting dealing with contracting out or saving services that used to belong in the NHS but now, who knows? These are the real obstacles to collaborative, imaginative, and affordable healthcare in the UK that are sadly, but predictably, ignored in this paper.

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1 Shortell SM, Addicott R, Walsh N, et al. The NHS five year forward view: lessons from the United States in developing new care models. *BMJ* 2015;350:h2005. (21 April.)

Cite this as: *BMJ* 2015;350:h2776

Authors' reply

We thank those who have commented on our article.[1-3] Our article had two main aims: to acknowledge that some of England's health policy leaders see commonalities (as well as differences) between England and the US's efforts to integrate care, and to share some early learning from the US experience with accountable care organisations (ACOs), which are designed to promote such care. Nowhere do we suggest adopting ACOs in England or that US ACO models are in any way superior.

As our article highlights and Moore underscores in his rapid response,[3] ACOs have had limited success to date. But some of the factors distinguishing the more successful ones from the less successful ones are beginning to emerge. These include the ability to focus on high cost patients with multiple chronic illnesses within the context of aligned payment systems that facilitate the work of technology enabled (electronic health record implementation) care teams that increasingly engage patients in their own care. As we point out, it will take time to build the necessary relations between GPs and specialists and the hospital and primary care sectors, as well as the links to community and social services that will be needed to increase the coordination and integration of care. This will require considerable clinical and managerial leadership and ongoing political support to achieve the goals of each country's intended reforms.

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SURGICAL TRAINING AND TRIALS

Clinical trials train surgeons?

As foundation doctors applying for surgical specialties at the end of the year, we find it difficult to know what to focus on to get the best chance of securing a competitive training post.

The apprenticeship of surgery is fading, with trainees' time being used up for service provision, portfolio tick boxing, audit, CPD courses, revalidation, and research. It is no wonder that trainees have to attend theatre on "off days" to receive comparable training to that received before the era of the European Working Time Directive.

In a world of increasingly under-reported, poorly designed trials, we should be careful before making involvement in trials compulsory. Research is crucial to progressing and improving surgical performance and outcomes, but this does not mean that it should be used as a tick box as part of surgical training.[1]

With fewer consultant jobs available post-CCT (certificate of completion of training), in an increasingly competitive environment, trainees are told to make themselves stand out. It is easy to translate numbers of publications, presentations, and degrees on to paper to tick boxes for application points. Does that make such candidates better surgeons? We're not so sure.

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1 Morton D, Bicknell CD. Should surgical training include involvement in a clinical trial? *BMJ* 2015;350:h2045. (22 April.)

Cite this as: *BMJ* 2015;350:h2774