

comment

‘Were I truly a private, non-NHS based GP interested in profitable practice, I’d do executive health checks for rich people with a bit of Botox on the side’

NO HOLDS BARRED Margaret McCartney

The great QOF experiment

It’s April, and Scotland has abandoned the quality and outcomes framework (QOF) in the general practitioner contract—unlike in England and Wales, where it will remain, allegedly in lighter form. Currently, all GPs are paid basic rates for each patient registered (no matter how many times the patient attends), for points on the QOF, and for additional services on top (from contraceptive implants to prescribing reviews).

The framework creates perverse incentives. Administration is mainly by computer: unless we code, we don’t get paid. There are quality points for encouraging people to stop smoking. But the GP loses money even if a patient had never smoked and the GP hasn’t asked whether the patient started in the past five years. If patients are eligible for the flu vaccine but don’t want it, the GP loses money for missing the target. GPs in England were paid for screening people for dementia, an entirely non-evidence based activity, until the end of March. And, if GPs ignore the reason why a patient came but instead tick lots of boxes, they may lack morals but can at least pay their staff.

GPs are independent providers but are tethered by an inflexible and stupid NHS contract that possibly organised us better at the start but is now strangling us from within. Were I truly a private, non-NHS based GP interested in profitable practice, I’d do executive health checks for rich people with a bit of Botox on the side. NHS general practice doesn’t do this. We’re not just micromanaged but “nano-nagged” into compliance with the government’s will.

Scotland is launching a “peer led, values driven” contract, apparently, which will involve nurses and



pharmacists working to “the top of their licence” to offset the multiple vacancies in general practice. A trial is running near Glasgow that makes the GP the “senior decision maker” among a large team of other professionals. I worry about taking more responsibility for people mainly working to protocols—is this safe, or better?

The best contract would be based on mutual respect, professional values, trust, and transparency. If we could have a fair contract, I’d rather be employed directly by the NHS (as is the case with consultants) rather than through a contract that distracts from good patient care.

Over a year ago our practice lost money for supposedly failing to have palliative care meetings according to the contract. We had these meetings every three months, to the letter of the contract, but we were penalised for not having them every 12 weeks. After several appeals the government eventually agreed that we had indeed done the work. Bravo. The cost of the appeal paperwork probably exceeded the refund. This is not simply wasteful: for practices disputing bigger sums, such delays could spell disaster.

There may be a glimmer of hope, however. What will happen next is a great big uncontrolled contract experiment, with England versus Scotland. For those of us saying goodbye to the quality and outcomes framework, wish us luck.

Margaret McCartney is a general practitioner, Glasgow
margaret@margaretmccartney.com

Follow Margaret on Twitter, [@mgtmccartney](https://twitter.com/mgtmccartney)

Cite this as: *BMJ* 2016;352:i1763

Find this at: <http://dx.doi.org/10.1136/bmj.i1763>

LATEST ONLINE COMMENT AND BLOGS

- ▶ Read more articles by Margaret McCartney at bmj.co/margaretmccartney
- ▶ Read more articles by David Oliver at bmj.co/davidoliver

The doctors' mess is dead, long live the doctors' mess

I regret not fighting harder for the maintenance of the doctors' mess. Sure, we fought tooth and nail in the late '70s and early '80s when we perceived that the administration had its eyes on our central prime real estate. We always won because we were united, we valued the institution, and the consultant body backed us to the hilt. The defensive inaction I regret was later, when some of my more junior colleagues began to declare, in sometimes derogatory tones, that they had a life outside the hospital and had no need for a workmates' club. A lack of junior doctor support quickly sounded the death knell, and, even

Whatever phoenixes arise from the ashes of the current unrest, among them has to be a powerful junior doctor infrastructure

when the mess persisted, its relocation to some distance from the hub made it an impractical abode.

Of course, one has to move with the times, but this always runs the risk of chucking the baby out with the bath water. The problem is that we often don't recognise the baby before it's too late. My failing was that I couldn't clearly enunciate why I strongly supported the concept of a mess—not so now. As a houseman (F1, in today's currency), the mess was my home for the 128 hours a week I was in residence (and the 40 hours when I wasn't). We were well fed, had comfortable bedrooms



Doctor in the House: a workmates' club in 1954

(sometimes almost opulent), and felt cared for. We were trusted with a bar and, in the main, had the common sense not to abuse the privilege. Consultants could, and often did, come along in the early evening but only by invitation, and this helped to

PERSONAL VIEW Shirley Cramer

Label food with equivalent exercise to counter obesity

It would give consumers an immediate link between foods' energy content and physical activity

More than two thirds of the UK population are either overweight or obese.¹ We desperately need innovative schemes to change behaviour at the population level.

Little evidence has shown that the current information on food and drink packaging, including "traffic light" labelling, actually changes behaviour. Packaging should not only provide nutritional information but should also help people to change behaviour.

The Royal Society for Public Health has called for the introduction of "activity equivalent" calorie labelling, with symbols showing how many minutes of several different physical activities are equivalent in the calories expended to those in the product. The aim is to prompt people to be more mindful of the energy

they consume and how these calories relate to activities in their everyday lives, to encourage them to be more physically active.

Confusing information

Public polling by the society has shown that almost half (44%) of people find current front-of-pack information confusing.² Such information needs to be as simple as possible so that the public can easily decide what to buy and consume in the average six seconds people spend looking at food before buying.³

People find symbols much easier to understand than numerical

People need a balanced relationship between the calories they consume and the calories they expend

Burn off a quarter of a large pizza by running for 43 minutes

information,⁴ and activity equivalent calorie labels are easy to understand, particularly for lower socioeconomic groups who often lack nutritional knowledge and health literacy.⁵ For example, the calories in a can of fizzy drink take a person of average age and weight about 26 minutes to walk off. Given its simplicity, activity equivalent calorie labelling offers a recognisable reference, accessible to everyone.

Initial studies show that this approach can change behaviour by reducing intake or modifying choice.^{6,7} When the Royal Society for Public Health consulted the public, more than half (53%) said that they would positively change their behaviour as a result of viewing activity equivalent

calorie information—by choosing healthier products, eating smaller portions, or doing more physical exercise, all of which could help to counter obesity.²

Although we don't know about





TV/REX

break down barriers with what could be quite a crusty lot.

Bars have gone and are unlikely to return. But the stresses of being a junior doctor have not gone away, nor the need to care for all our colleagues—especially those new to the profession and its challenges. The mess provided that through camaraderie, helping

actual behaviour change, initial consultations such as this show promising intentions.

Active lifestyle

We won't reduce obesity by focusing on diet or physical activity alone. People need to create a balanced relationship between the calories they consume and the calories they expend.

Placing information on food and drink packaging to promote an active lifestyle could be a logical solution to a multifaceted problem, and the benefits of being active go far beyond maintaining a healthy weight. The Academy of Medical Royal Colleges has described regular physical activity as a “miracle cure” because it boosts self esteem, mood, sleep quality, and energy levels and reduces the risk of stress, depression, dementia, and Alzheimer's disease.^{8,9}

People can't out-run a bad diet, and messages about the importance of healthy and varied eating must also continue. Some concerns have been raised about activity equivalent calorie labelling and possible negative implications for people with eating disorders—but we have a

each other, and the watchful eye and often great leadership of the most senior trainees.

My argument is not that we should restore a bygone era but that, whatever phoenixes arise from the ashes of the current unrest, among them has to be a powerful junior doctor infrastructure with much greater influence and self determination, as well as a flatter hierarchy. As Bruce Keogh said in 2013: “Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50 000 young doctors.” We should, therefore, work together to build this better future.

Peter Lees is the chief executive and medical director of the UK intercollegiate Faculty of Medical Leadership and Management

Read this in full at thebmj.com/blogs

responsibility to promote measures to tackle the biggest public health challenges facing our society, such as obesity. In any future development of activity equivalent calorie labels, these risks can be mitigated by working with groups who have concerns about the unintended effects of this information.

Food packaging is governed by European legislation, and recent regulations have come into force requiring mandatory nutrition declarations for most pre-packaged food—so any fundamental change to packaging harbours little appetite among European Union officials and food manufacturers.

With this in mind, detailed research should explore the potential effects of activity labelling on consumer choices, including the potential harms. If it's shown to be an effective means of influencing consumers' decisions, we would implore law makers and the industry to implement it to reduce obesity in the UK.

Shirley Cramer, chief executive, Royal Society for Public Health, London E1 8AN
scramer@rsph.org.uk

Cite this as: *BMJ* 2016;352:i1856



ACUTE PERSPECTIVE

David Oliver

A mandate for mismanagement

The 2015 Conservative election manifesto committed to a “genuinely seven day NHS” in England, including “seven day a week access for everyone to a GP” and “hospitals properly staffed, so that the quality of care is the same every day of the week.”¹

Conservative ministers have repeatedly argued that the outright election victory has given the party an “electoral mandate” to govern, albeit in a system where only 37% of the electorate voted for it.² They maintain that victory also represents a mandate for specific pledges, such as those made on health.

Junior doctors and consultants have protested against imposing contracts on staff who already work at weekends and cannot contractually opt out of doing so.³ GPs, hospital doctors, and nurses have highlighted their serious workforce and funding crises and the high number of unfilled posts.⁴⁻⁶ Major cuts in social care funding have affected delivery and spending on the NHS.⁷ Performance is tailing off, even in existing weekday service provision, as demand rises.⁸

There was no mandate for Lansley's 2012 Health and Social Care Act, now universally regarded as a costly, if necessary train wreck

No matter, say defenders of the government's stance. They have an electoral mandate: they are pushing ahead.

But the Conservatives did not include any pledge to slash benefits to disabled people by a further £4.4bn, as announced in the 2016 budget.¹⁰ And there was no mandate in the 2010 election for Andrew Lansley's 2012 Health and Social Care Act, now pretty universally regarded as a costly, unnecessary train wreck, even by Conservatives.¹¹ Indeed, it breached a mandate for “no top-down reorganisation.”¹²

The 2015 Tory manifesto did include a mandate to implement a cap on long term social care costs, as recommended by the Dilnot Commission report¹³; the party reneged and delayed it until at least 2020. And there was no mandate to cut public health budgets by £200m despite manifesto pledges to “help you and your family to stay healthy.”¹⁴

Mandates require realistic plans and competent delivery: a costed, funded, staffed, and risk assessed government programme for implementation. Soundbites won't cut it. And delivery requires engaged, motivated frontline staff, so why is the government antagonising and demoralising them?

David Oliver is a consultant in geriatrics and acute general medicine, Berkshire davidoliver372@googlemail.com

Follow David on Twitter, @mancunianmedic

Cite this as: *BMJ* 2016;353:i2012

Alcohol related deaths and the UK's changing alcohol market

Nick Sheron and Ian Gilmore explore whether changes to fiscal policy could see alcohol related mortality increase in England and Wales

The population consumption theory¹⁻³ links population level alcohol consumption to alcohol related harm, forming a theoretical basis for modern alcohol control policy. As the late Professor Griffith Edwards stated, other things being equal, “the overall level of a population’s drinking is significantly related to the level of alcohol related problems which that population will experience.”²

According to HMRC duty and tax receipts, UK alcohol sales increased from around 400 million litres in the early 1980s, peaking at 567 million litres in 2008, an increase of around 42%, since when they have declined (fig 1).^{4,6} During this time alcohol related deaths in England and Wales tripled from 2314 in 1980, to 7312 by 2008, with most deaths being liver related (fig 2). The way alcohol is sold and the types of alcohol consumed have also changed over this period.

The population consumption theory suggests that alcohol related deaths have increased as a direct result of an increase in alcohol consumption. We examine whether the changes in population level alcohol consumption and the trends in alcohol related deaths over the past few decades are consistent with the population consumption theory.

As the affordability of stronger alcohol increased, so did liver and related mortality

Changing nature of UK drinks industry

In marketing terminology sales of any product are driven by the four Ps—place, product, promotion, and price—and all these factors have changed considerably. Numbers of on-sales (pubs, etc) licences increased from 131 000 in 1980, to 148 000 in 2012; off licences increased from 42 000 to 56 000 and consumption shifted from pubs to alcohol bought to be consumed at home.⁴ The nature of the product changed as sales of weaker draught beers decreased and sales of strong lager and cider increased. Furthermore, as a wartime generation of whisky drinkers passed away, the spirits industry shifted its target demographic to a younger audience, introducing “alcopops.”²⁴⁻²⁶ Wine consumption also rose as a result of cultural globalisation and the increased marketing and availability as supermarkets became the major alcohol retailers.^{30,31} Overall, the trends in alcohol related deaths coincide with trends in consumption of cider, wine, and to some extent white spirits and strong lager, and are consistent with the population consumption theory (fig 4, see thebmj.com).

Who drinks the alcohol

The Pareto principle, or 80:20 rule,³⁶ states that 20% of highest consumers consume around 80% of any product.

Harmful and extreme drinkers comprise a tiny minority, 4.4% of the population, but consume one third of all alcohol sold; the combination of hazardous, harmful, and extreme drinkers provides almost 70% of drinks industry sales by volume. The drinks industry uses its influence on government to protect this market.^{12,34} This has brought about remarkable changes in affordability—as the

'90s economy boomed and wages increased, taxation of alcohol was reduced in real terms. By 2008 it was possible to buy almost four bottles of vodka for the price of one bottle in 1980—and four bottles represents the weekly alcohol consumption of an average patient presenting with alcohol related liver cirrhosis.³⁸ As the affordability of stronger alcohol increased, so did liver and related mortality (fig 5).

Coincident trends cannot prove a causal link between alcohol affordability, consumption, and mortality, but they are entirely consistent with the consumption theory and suggest how the epidemic of alcohol related harm is likely to have come about.

Changing economic environment and peak in alcohol related deaths

The Lancet Liver Commission identified alcohol consumption as the main factor behind the increase in liver disease mortality and set a goal to bring deaths back down to 1980s levels by 2030.⁴² If the ongoing year on year increase in alcohol related deaths had continued, linear extrapolation of the trend suggests there would have been 11 400 deaths a year by 2030.⁴³ But alcohol related deaths peaked in 2008 (fig 3).

The inflexion in deaths and subsequent levelling off coincided with the banking collapse and worldwide economic recession, and this together with the new mood of austerity may have affected drinking behaviours. Another potentially important factor was a 2% above inflation escalator in alcohol duty introduced by the Treasury in 2008. The escalator has had a substantial effect on the affordability of alcohol. From 2007-08 onwards the affordability of wine fell by 54%, spirits 50%, cider 27%,



KEY MESSAGES

- Alcohol related deaths between 1980 and 2008 in England and Wales increased threefold, probably driven by the increased affordability and availability of strong alcohol
- Alcohol related deaths peaked in 2008 and have declined slightly since
- This change is likely to be due to economic factors affecting alcohol consumption of heavy drinkers—the recession and 2% duty escalator

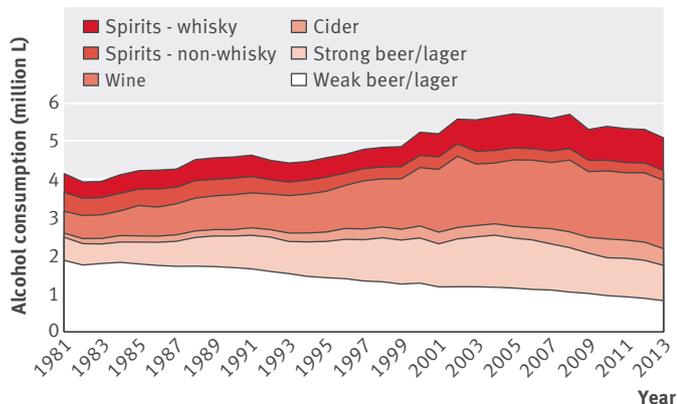


Fig 1 | Cumulative consumption of alcohol in England and Wales. Consumption of beer and lager is split between weak and strong beverages with a cut-off around 4.2⁴⁵

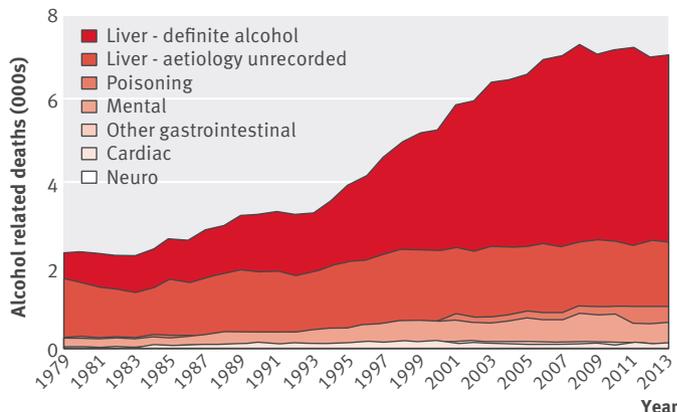


Fig 2 | Cumulative alcohol related deaths for England and Wales⁷¹⁰

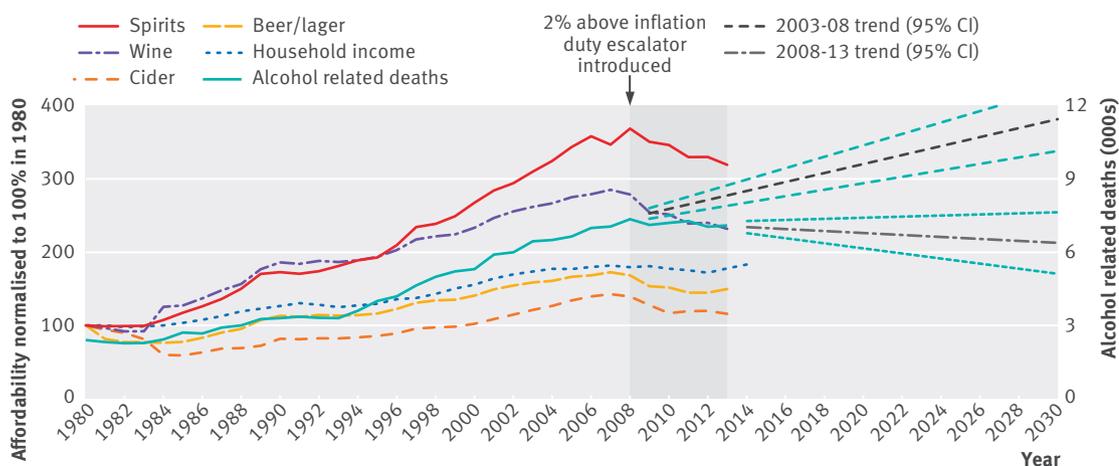


Fig 3 | Alcohol related deaths in England and Wales, household income, and affordability of different alcohol types (income and affordability normalised to 100% in 1980), with two mortality extrapolations to 2030⁶⁻³⁹

and beer 22%, whereas household incomes fell by only 9.5%, suggesting that of the various economic factors influencing alcohol consumption, the 2% duty escalator had the greatest effect (fig 5).

There have been no important developments in treatment or disease coding over this period, and we are not aware of any clinical or environmental factor that could account for the change in 2008. In any natural experiment there are always potential confounders and unknown factors, but on balance, we believe that economic factors are the most likely cause of the change.

It may be surprising that changes in alcohol affordability could have a rapid effect on alcohol related deaths; it can take 10 years or more of very heavy drinking to develop liver cirrhosis. But this is exactly what would be predicted from experience in other countries. When the minimum price of alcohol increased by 10% in a Canadian province, a 32% decrease in directly

By 2008 it was possible to buy almost four bottles of vodka for the price of one bottle in 1980

attributable alcohol related mortality occurred within 12 months, and most deaths were from liver disease.⁴⁵

Testing the theory

Our hypothesis is testable because the economic factors no longer operate. Incomes are starting to rise, and following a fierce campaign of lobbying by the Wine and Spirits Trade Association (WSTA) the duty escalator was dropped in 2014. In the budget of March 2015 alcohol duty was cut by a further 2% for spirits and cheap cider.³⁸

Threshold or minimum unit pricing is a fiscal policy that is exquisitely targeted at heavy problem drinkers who consume large quantities of the cheapest alcohol.³⁸ Although the legislation was passed by the Scottish government and the bill signed by the Queen, it was held up by a legal challenge from the drinks industry. A recent verdict from the European Court of Justice ruled in favour of minimum pricing provided that the Scottish

government can show that it is more effective than fiscal alternatives.^{51 52} This could lead to an interesting and unusual situation whereby cheap alcohol is constrained by minimum pricing in Scotland, perhaps swiftly followed by the Ireland, Northern Ireland, and Wales, all of which have unveiled plans for minimum unit pricing legislation.⁵³⁻⁵⁵ but remains unrestrained in England, where incomes are likely to outstrip changes in alcohol taxation. If the population consumption theory holds we predict that alcohol related deaths will decrease in the devolved nations, but in England the relentless rise is likely to resume as incomes outstrip rises in taxation.

Nick Sheron, head of clinical hepatology,, Clinical and Experimental Sciences Academic Unit, Faculty of Medicine, University of Southampton
Nick.Sheron@soton.ac.uk

Ian Gilmore, professor, University of Liverpool, Liverpool, UK

Cite this as: *BMJ* 2016;353:i1860



OBITUARIES

Robert Wilson Adam

Retired general practitioner Poole (b 1917; q Glasgow 1939), died 9 January 2016.

Robert Wilson Adam served with the Royal Army Medical Corps in Egypt and Italy before moving to Poole in 1946. After the introduction of the NHS he started what became the Adam Practice in Hamworthy, Upton, and Poole. He retired in 1984 but continued to work as a locum for another 10 years. A keen sailor, in 1950 he became the honorary medical officer to Poole Lifeboat Station and eventually, as a member of the medical and survival committee, was appointed life vice president in 1992. He was a keen amateur engineer. Predeceased by his wife, Margaret, in 2000, he leaves two children.

A keen sailor, in 1950 Adam became the honorary medical officer to Poole Lifeboat Station

Neil Kelly

Cite this as: *BMJ* 2016;352:i1720

June Pope Arnold

Consultant geriatrician Glan Clwyd Hospital North Wales (b 1924; q Liverpool 1948; MD, FRCP), died from cardiac failure and degenerate bone disease on 13 March 2015.

June Pope Arnold's family hosted numerous young Australian doctors during the war, and June went on to work in an outback post in general practice near Adelaide. On her return to the UK the relatively new specialty of geriatrics was developing, and in 1961 she was appointed consultant geriatrician in Clwyd. She developed the first respite care service in Wales with day unit facilities and contact with physiotherapy and social services. She retired in 1987 and subsequently travelled worldwide, from India to South America, and when older than 82 and despite her arthritis, she enjoyed trips to Antarctica and up the Norwegian coast.

D A Sutherland

Cite this as: *BMJ* 2016;352:i477



Andrew Scott Fisher

General practitioner High Peak (b 1960; q Manchester 1983; MRCP), died from metastatic pancreatic cancer on 21 January 2016.

After qualifying as a general practitioner, Andrew Scott Fisher spent many years building up a practice in inner city Manchester. He was a member of the local medical committee and medical audit advisory group and influential in developing quality standards to improve patient care across Manchester. He was a volunteer doctor for Freedom from Torture and a much valued appraiser. In 2007 he moved to the High Peak to live a more rural life. His many interests included playing music, the arts, choral singing, and country life. He had an enormous sense of fun and treated everyone with the same respect and kindness. He leaves his husband, Colin, and a huge circle of friends and family.

Rebecca Baron, Rosie Telford, Bob Mihajlovic

Cite this as: *BMJ* 2016;352:i1818



John Stuart Fraser

General practitioner East Bridgford, Nottinghamshire (b 1930; q Aberdeen 1953), died from carcinoma of the prostate on 8 February 2016.

In 1957, after two years as a general practitioner in Rotherham, John Stuart Fraser joined the practice in East Bridgford where he remained until he retired in 1990. In his time, he was chair of school governors, the local British Legion and horticultural society, and captain of the local golf club. In the mid-1970s Stuart was operating personal lists and pioneered A4 family folders, a 10 minute appointment system, and a multidisciplinary practice team in a purpose built village health centre. Predeceased by his first wife, Denise, he leaves his second wife, Pat; his three sons and their families; and Pat's three children and their families.

Andy Harrison

Cite this as: *BMJ* 2016;352:i1821



Elizabeth Ann Evelyn Harris

Former director of public health and community paediatrician (b 1937; q Royal Free Hospital, London, 1962; DPH, FPPHM, DCH, MRCP), died from carcinomatosis on 22 February 2016.

While bringing up her five children, Elizabeth Ann Evelyn Harris ("Ann," née Sibellas) followed a portfolio career, including family planning and community paediatrics in north London and director of public health in Great Yarmouth. In later life she worked for the courts and tribunal service and was highly respected for her ability to ask gentle but penetrating questions. She experienced poor health and deafness in later years. Predeceased by her son, Tom, and first husband, Neil, she leaves four children; a grandchild, Jessie; and her second husband, Ray.

Elizabeth F Brown

Cite this as: *BMJ* 2016;352:i1823



Peter Douglas Jackson

Former consultant otolaryngologist Lewisham Group of Hospitals (b 1930; q Cambridge 1956; DLO, FRCS), died from metastatic carcinoma from bowel cancer on 3 October 2015.

During his time in the Royal Navy from 1962 to 1978, Peter Douglas Jackson specialised in ear, nose, and throat medicine. He subsequently joined the Institute of Laryngology and Otology in 1978 as senior lecturer. He wrote several papers on tinnitus, including a chapter on tinnitus, hearing, and balance in elderly people in 1981. He joined the health authorities in Southwark and Lewisham as well as Greenwich and Bromley as consultant ENT surgeon in 1981, retiring in 1988. Peter sang throughout his life; he was in the Lewisham choir until 2014, and participated in numerous singing competitions. He leaves a widow, four children, one grandchild, and two great grandchildren.

Rumy Kapadia

Cite this as: *BMJ* 2016;352:i1824

Longer versions are on thebmj.com. Please give a contact telephone number, and email the obituary to obituaries@bmj.com

Frances Cress Welsing

African-American psychiatrist who developed theories on racism and white supremacy

Frances Cress Welsing (b 1935; q Howard University, Washington, DC, 1962), died after being admitted to hospital after a stroke on 2 January 2016.

In 1974 Frances Cress Welsing agreed to a debate with William Shockley on the topic of racial superiority—or, conversely, racial inferiority. The debate would be seen across the US on *Tony Brown's Journal*, a programme focusing on African-American issues that was broadcast by the public TV network PBS.

Television debate

At the time Welsing was a virtually unknown assistant professor of paediatrics at Howard University in Washington, DC. Shockley was a world famous physicist who in 1956 had won the Nobel prize for helping discover the “transistor effect” of semiconductors. During the 1960s and early 1970s, however, Shockley had become controversial for his theory that black people as a group were genetically inferior to white people, and therefore generally not as intelligent. But Welsing had also developed a controversial theory, which, in simple terms, states that the skin of white people is a result of a genetic recessive and deficiency condition that causes an inability to produce the skin pigment melanin. The result, she explained in an article for general readership in *Ebony* magazine in 1974, was racist behaviour in white people.

Journalist Tony Brown moderated the debate and defended the broadcast that gave Shockley a platform to reach a national audience. Shockley's views needed to be robustly challenged, and Welsing was chosen to be the challenger. Welsing expressed her views softly and calmly—but firmly—during the debate. She compared Shockley's views on racial superiority to the views of Adolf Hitler that lead to the Holocaust. Brown later indicated that Welsing was the clear winner of the debate and that afterwards “Dr

Shockley went back into oblivion.”

Despite widespread support in the African-American community, Welsing's views also remained highly controversial. In 1975 she was not granted tenure at Howard University, a historically African-American university founded in 1867 after the American civil war. Welsing contended she was denied tenure because of her theories on racism.

Welsing was born Frances Luella Cress on 18 March 1935 in Chicago, the second of three daughters in her family. After she received her bachelors degree in 1957, her parents financed a trip to Germany as a graduation gift, and it was there that she first began to develop her theories on racism.

On her return, Welsing started studying medicine at Howard University, receiving her degree in 1962. After an internship at Cook County Hospital in Chicago, she trained in general psychiatry at Children's Hospital in Washington, DC. This was followed by a two year fellowship in child psychiatry at Howard University. She also established a private psychiatry practice in 1967. She continued to generate controversy—and lots of it—through her writings, public lectures, and appearances on television.

Welsing's most controversial statements included her belief that illegal drug use in African-American communities was an effort by white people to kill young African-American men, and that homosexuality was imposed on African-American men by whites to reduce the African-American population.

Explanation and inspiration

A 1980 news article in the *Washington Post* notes that Welsing “has been called a crazy, black supremacist.” The writer of the article goes on to say that “although her views are sometimes simplistic, other times radical, Welsing essentially is trying to make one very important statement: she has an explanation, based on psychological



Despite widespread support in the African-American community, Frances Cress Welsing's views also remained highly controversial

and scientific data, that possibly can account for many of the social, economic, political, and interpersonal problems affecting black people in America and elsewhere in the world.”

In 1990 Welsing was surprised to learn that her theories on racism had helped inspire the hip hop group Public Enemy to record its highly controversial album *Fear of a Black Planet*, considered to be one of the most influential albums ever made. After learning that she was an inspiration for the album, Welsing told the *Washington Post*: “It was quite surprising to me. I'm not one to keep up with pop culture, and I do not have adolescent children or young people who are involved in rap.”

In 1991 Welsing published a book of essays under the title *The Isis Papers: The Keys to the Colors*, with Isis in the title referring to the ancient mythological goddess, whose many attributes include motherhood, nature, and magic.

Welsing felt strengthening African-American families was essential in the fight against racism. In order to be better parents, she encouraged African-American women to wait until they were at least 30 years old before having children, and men at least 35 years old. The keys to ending racism, she said, were self respect, discipline, and education.

Ned Stafford, Hamburg
ns@europfn.de

Cite this as: *BMJ* 2016;352:i783

CAD: SCREEN OR TREAT?

Ignoring adverse experiences of people taking statins

Many patients have muscle pain, fatigue, or weakness that resolves after stopping statins, yet, relying on a systematic review of clinical trials that excluded people who did not tolerate statins, Francis and Cole (Editorial, 26 March) assert that statins cause no more adverse effects than placebo. The HOPE-3 trial screened out 13.5% of healthy people during a four week run-in including rosuvastatin but found a 1.1% absolute increase in muscle pain or weakness in people who initially tolerated rosuvastatin.

Few patients disclose all pertinent clinical history without prompting. Were statin trialists asked about difficulty climbing stairs, post-exercise pain, or stiffness? At my swimming pool, asking people about statin experiences often elicits negative comments. Some problems might not resolve after discontinuing statins, yet people taking other drugs don't complain about muscle pain, weakness, or exercise limitation.

We need a large experiment to explore this before widespread use of even more powerful cholesterol lowering drugs.

Thomas L Perry (tom.perry@ti.ubc.ca)

[Cite this as: BMJ 2016;353:i2030](#)

Authors' reply

In practice, patients and doctors know when a statin is being taken, but in trials patients and staff are blinded. In trials, symptoms are equivalent between statin and placebo. In everyday practice, symptoms are reported but there is no blinded comparator group, and patients do not know whether symptoms are a pharmacological or non-pharmacological effect.



LETTER OF THE WEEK

Learning to walk before we fly in Northern Ireland

The 2016 budget (Seven days in medicine, 26 March) gave the NHS in Northern Ireland a small amount of new funding. We were delighted to hear the announcement, by the chancellor and the minister of health at the Northern Ireland Assembly, of funding for a helicopter emergency medical service (HEMS). For some time, Northern Ireland has been the only region of the UK without one. Evidence from around the world suggests that these services help increase survival among trauma patients.

Regrettably, Northern Ireland also holds the distinction of being the only region in which no centre contributes to a systematic audit of trauma patients. Our neighbours in the Republic of Ireland are strides ahead, not only with their successful HEMS service, but in their active contribution to the Trauma Audit Research Network (TARN).

We contend that systematic audit underpins quality trauma care and quality trauma systems. As the authors of a recent report highlighting potential deficiencies in elements of trauma care in Northern Ireland, we strongly advise that this basic element of governance is addressed before we introduce a HEMS service. The task of integrating Northern Ireland into a high functioning audit programme such as TARN is relatively straightforward. Participation would ensure that new developments in care are safe, efficacious, and cost effective. We should learn to walk before we fly.

Jonathan E Millar (j.millar@doctors.org.uk), Stuart Lutton, Russell McLaughlin

[Cite this as: BMJ 2016;353:i2025](#)

The British Heart Foundation is supporting a patient centred randomised controlled trial with multiple blinded segments for each patient (statin, placebo, and no treatment). This should enable patients to judge for themselves where symptoms are coming from—the statin or taking any tablet (even placebo).

UK based doctors with patients who have stopped statins because of symptoms should look at the SAMSON website (<http://www.preventingheartdisease.org/>) and get in touch with us. Together we may be able to move closer to providing a simple, scientifically

valid, and personalised answer to this question.

Darrel P Francis (d.francis@imperial.ac.uk), Graham D Cole

[Cite this as: BMJ 2016;353:i2031](#)

EVIDENCE ON RIVAROXABAN

Point of care INR devices: quality control essential

Quality control (QC) of point of care international normalised ratio (POC INR) testing devices is essential (This week, 6 February). External quality assessment (EQA) for them has been available in the UK for >20 years. NEQAS for Blood Coagulation programmes provides material for several POC

INR devices, with >4500 users enrolled. No programme provides EQA for the POC device used in the ROCKET AF study's warfarin control arm, making it difficult to assess the reliability of INR results obtained with this device.

POC INR testing has been used for more than two decades and is safe, provided that continuous QC assessment is in place. POC devices can give reliable results with a quick turnaround time. The key to ensuring accuracy and precision of all INR results, whether from a POC device or from a laboratory method, is the use of internal QC and EQA.

D P Kitchen (dianne.kitchen@coageqa.org.uk), S Kitchen, I Jennings, T A L Woods, M Makris, I D Walker

[Cite this as: BMJ 2016;353:i2019](#)

REPORTING HEALTH VIA MOBILE

Guidelines for digital healthcare

Agarwal and colleagues (Research, 19 March) highlight a poorly structured area of medical reporting. Digital healthcare—whether mobile, desktop telemedicine, or smart phone videocalling—has developed rapidly, and users are unclear about its value.

At the current rate of assessment even the better funded statutory bodies, such as the FDA, will not finish assessing apps that existed in 2015 for decades, let alone more recent ones. Thankfully, researchers have developed the mobile application rating scale, which dovetails nicely with the WHO mHealth Technical Evidence Review Group guidelines. The widespread adoption of both should bring much needed clarity and comparability to a currently commercially driven area, assisting doctors in rational prescribing and helping to curtail burgeoning costs.

M E Jan Wise (jan.wise@nhs.net)

[Cite this as: BMJ 2016;353:i1867](#)