

This month's *BJGP* is packed with material that explores and challenges the interactions between doctors, patients, and governments in the promotion and maintenance of health, and the management of disease and of dying. Many of these articles are, in one way or another, a salutary reminder of the limits of medicine, while others develop arguments to suggest that more collaborative partnerships between doctors and patients and with their communities are likely to be themselves salutary. Some touch on the future of our health service.

The clinical focus this month is on chronic obstructive pulmonary disease (COPD) and there are valuable contributions on differential diagnosis, the effects of ethnicity on disease prevalence and management, and the risks of air travel, along with a fine editorial from our colleagues in Utrecht, which concludes by saying that 'active patient information and involvement will remain key in primary care COPD management'. Too true — and true for a multitude of other medical conditions in which all the components of the biopsychosocial model are energetically in play. Emyr Gravell's affecting piece on certifying the death of a relatively young woman from lung cancer in a house wreathed in cigarette smoke gets us into the difficult territory of encouraging behaviour change. He is, rightly I think, concerned that central government advice for GPs to inquire routinely about 'lifestyle' will transform the relationship between medical staff and patients, but not in the way envisioned by the Future Forum. Daniel Edgcumbe also challenges the centralist thinking that views the NHS Outcomes Framework as the key to improving the health of the population. Almost 20 years ago Armstrong¹ sounded notes of concern about the rise of 'surveillance medicine', whose boundaries are 'the permeable lines that separate a precarious normality from a threat of illness' and whose gaze 'sweeps across innovative spaces of illness potential'. And all this in a country with more CCTV cameras per capita than almost any other.

Gervase Vernon's contribution on denunciation raises the question of 'medical surveillance' to a whole new level, in which GPs in some European countries are expected to report undocumented (migrant) people coming to them for medical attention to 'the authorities'; hardly the advocacy function that many still see as central to

their role as a GP. Questions about advocacy, support, and guidance feature in other papers this month: on the potential role of GPs in getting people back to work; the use of the Fit Note [not at all straightforward as Thomson and Hampton point out in their Debate & Analysis article]; and on the collaborations needed between doctors, patients, and families in dealing with dementia and in planning for terminal illness and death.

Getting the right balance between an unswerving commitment to the wellbeing of the patient in front of you in the consulting room, and wider responsibilities to other patients, the community, and to society was difficult enough when the NHS was in a less parlous state than it is now. When over 2500 GPs respond to the Royal College's survey and most support withdrawal of the Health and Social Care Bill, something is probably wrong, and what many seem to fear is that, in more or less subtle ways, the fundamental trusting and beneficent relationships we hold with our patients will be corroded. The resource burden, and for 'resource' read 'rationing', forced on GPs through their commissioning role will, it is argued, fundamentally alter their ability to act in a financially untrammelled way as advocates for their patients. If that is really it, then we need an entirely fresh debate in which we all acknowledge that our 'national' health service has become unaffordable, and that we shouldn't expect GPs or any other clinical sector to carry the can for shortfalls in service delivery. David Jewell leads us into this debate with his analysis of the possible components of 'a comprehensive, affordable, and just system for everyone'. We shouldn't be afraid to use words like rationing and co-payment, he argues, and we also need to recognise that the divide between public and private healthcare provision simply 'institutionalises health inequalities'. I hope we can extend this debate in the pages of the *BJGP* in the coming months.

Roger Jones
Editor

REFERENCE

1. Armstrong D. The rise of surveillance medicine. *Social Health Illn* 1995; **17**(3): 393-404.

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