The archetype of the wounded healer emerges in different forms across cultures and across historical epochs, from the Greek myth of Chiron (the wounded centaur), to shamanistic healing in aboriginal societies to the complex figure of Paracelsus in 16th century Europe. Re-reading this book again, particularly in the light of his subsequent suicide, I think that John Sassall expresses that archetype. His story reminds us all that part of what we have to give to our patients is a reflection of our own weaknesses and failings, although I am not clear how to reconcile this with the onwards and upwards rhetoric of contemporary primary care.

As with so much of John Berger's work, *A Fortunate Man* packs a subtle political punch, finally asking what kind of doctoring is possible within prevailing social and economic structures. The question remains salient today. It is particularly acute for general practice within the UK, because the possibility of long-term relationships with patients is actively undermined by a government that either does not understand the value of these relationships or does not care enough to sustain them.

As part of a season in London celebrating the work of John Berger (*John Berger: here is where we meet*), there will be an event on *A Fortunate Man* held on 26 April from 7:00–10:00 pm at Queen Mary University of London. Speakers will include Iona Heath, Tony Calland (who was a partner in John Sassall's practice), Patrick Hutt (a recently qualified doctors and author of *Confronting an Ill Society*), Jane Simpson (junior doctor), Michael Rosen (broadcaster and writer) and Sukhdev Sandu (critic and writer). They will talk about what the book means to them and what it still has to tell us almost four decades after it was first published.

Further details on the event and the whole season: www.johnberger.org. Although we are not charging for seats, these need to be booked in advance: 020 8510 9786. Copies of the book can be purchased from the RCGP Bookshop: www.rcgp.org.uk/acatalog.

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REFERENCE

1. Berger J. *A Fortunate Man: the story of a country doctor.* London: RCGP, 2005.

Mike Fitzpatrick

Uniquely well-placed

According to a recent discussion paper produced by Tony Blair's in-house think tank, GPs are 'uniquely well-placed to reshape unhealthy behaviour'.[1] I keep a bulging file of things that GPs are 'uniquely well-placed' to do: it extends from the early detection of bowel cancer to spotting the signs of addiction to gambling, from identifying old people at risk from falls to interrogating pregnant women about their experience of domestic violence, from early diagnosis of skin cancer to deterring teenage pregnancy. I can see why expanding the role of the GP from medical practice to cover tasks of moral guidance and social surveillance appeals to government. But why should it appeal to GPs?

The prime minister's advisers candidly acknowledge the problem that 'the government cannot simply 'deliver' key policy outcomes to a disengaged and passive public'. What is required is the 'design and authorisation of more sophisticated methods of behavioural change, between state and citizen and between citizens themselves'. Implicitly recognising that politicians are too remote and unpopular to exert a direct influence on public behaviour, Blair's policy wonks suggest that 'it may be wise to rely more heavily on GPs and other trusted health professionals as agents of persuasion'.

The drive to expand the role of the GP proceeds in parallel with the conceptual inflation of health. In the not-so-distant past, doctors worked in a society which made a clear distinction between health and illness. At the level of society as a whole, improving standards of health were regarded as the benefits of wider social progress; at the level of the individual, health was the precondition for the achievement of wider social or spiritual goals. Illness was a transient phase requiring the treatment of disease and the restoration of the capacity to participate actively in society. The biomedical model of medical practice assumed a doctor skilled in diagnosis and treatment according to the principles of scientific medicine and a patient who was a self-determining individual whose personal conduct was their own responsibility.

The ascendancy of the new public health reflects a fundamental shift in society.[2] Health has become both the ultimate goal of individual existence ('a state of complete physical, mental and social wellbeing' in the notorious World Health Organisation formulation) and an unattainable ideal (as all those who worship in the gym can testify). The paradoxical effect of the widespread dissemination of the gospel of health promotion and the enhanced awareness of disease resulting from the relentless stream of healthy living propaganda is that everybody now feels ill. It is thus not surprising that the numbers on invalidity benefit have soared over the past decade, in parallel with the rising influence of the new paradigm.

Nor is it surprising that the Department of Health's 'Expert Patient Programme' should be offered to the '60% of adults who report some form of long-term or chronic health problem' (some 36 million people in the UK). As one advocate of this approach has argued, without a hint of irony, 'the principles underlying the Expert Patient Programme could be extended to the whole population'.[3]

Another paradox of the new public health is that while it promotes the rhetoric of empowerment, it both presupposes and reinforces the powerlessness of the individual. The key targets of contemporary health promotion initiatives are those hapless individuals — the obese, smokers, those who appear incapable of adopting healthy lifestyles in terms of diet, exercise and other socially-approved behaviours. These people — who make up at least one-third of the population — are deemed powerless in the face of chemical dependencies and fast food advertising and judged incapable of defining their own interests. Hence, they require 'support' to make healthy choices, and intensive therapeutic solutions supervised through Health Living Centres and Sure Start programmes and a thousand similar initiatives.

I fear that, if as GPs we allow ourselves to become instruments of the government's social engineering agenda, we will rapidly lose the respect of our patients. GPs are 'uniquely well placed' to refuse to surrender the doctor–patient relationship to the government's cynical quest to recover its legitimacy.

REFERENCES

1. Halpern D, Bates C, Beales G, Heathfield A. *Personal responsibility and changing behaviour: the state of knowledge and its implications for public policy.* London: Prime Minister's Strategy Unit, 2004.
2. Bowler S. Health in a sick society. http://www.spiked-online.com/Articles/0000000CA7F7.htm. (accessed 9 Feb 2005).
3. Gupta, S. Government programmes aim to improve engagement. *BMJ* 2005; **330:** 255.