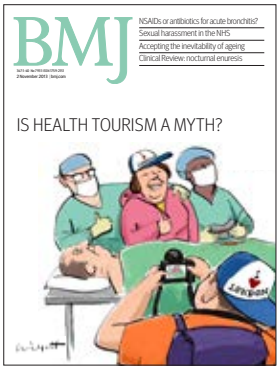

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Articles appearing in this print journal have already been published on bmj.com, and the version in print may have been shortened. bmj.com also contains material that is supplementary to articles: this will be indicated in the text (references are given as w1, w2, etc) and be labelled as extra on bmj.com.

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A note on how to cite each article appears at the end of each article, and this is the form the reference will take in PubMed and other indexes.


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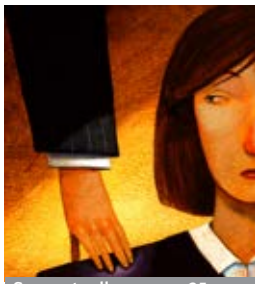
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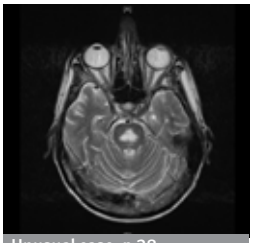
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PICTURE OF THE WEEK

London has become the tuberculosis capital of western Europe. Last year, the city had about 3500 cases of tuberculosis—more than the Netherlands, Belgium, Greece, Norway, and Denmark combined (News, p 2). In an effort to stop the spread of the disease, health officials are taking to the streets of London to offer free check-ups with the help of a high tech van equipped with an x ray machine. The entire process from having an x ray picture taken to getting the results takes about 90 seconds.

RESPONSE OF THE WEEK

The fact that I am only the second person to post a response to the *BMJ*'s cover article suggests to me that the answer to 'Who's afraid of the GMC?' is most doctors who have reason to know anything about the way it operates.

One of the most pernicious tactics employed by the GMC case examiners is to accuse doctors of lack of insight if they have the presumption to deny their allegations, and therefore to escalate the matter because lack of insight is a reason to strike a doctor off. In an era when insight and constant reflection have become mandatory, we need an example from the GMC itself. I would like to know how the GMC audits its own performance, and how, for example, it scrutinises the roles of complainants, case examiners, and its own expert witnesses in prolonging cases that are then found to have no credible evidence base.

Hilarie Williams, specialty doctor, Imperial College NHS Trust, London, UK, in response to "GMC and vulnerable doctors: too blunt an instrument?"
(*BMJ* 2013;347:f6230)

MOST READ

BMJ.COM POLL

Last week's poll asked: "Have you witnessed or experienced sexual harassment by a colleague?"

30% voted yes
(total 956 votes cast)

SEE PERSONAL VIEW, p 25

This week's poll asks: "Should patients with psychosis be paid to adhere to maintenance treatment?"

BMJ 2013;347:f5782

Vote now on bmj.com

EDITOR'S CHOICE

Boundary crossings

It seems that the founding principle of the NHS—being free to everyone at the point of care—is ultimately the source of its current predicament

The UK government's new Immigration Bill has caused ructions among politicians, health economists, and the medical profession. The resulting fallout continues to smoulder, but it is often fuelled by perception rather than fact. John Appleby (p 17) presents the facts about the costs to the NHS of treating non-UK residents, the proposed changes in the bill, and how much money they might save. Theoretically the proposals could increase NHS revenue by £500m, but will they in practice?

"Well, it's possible," Appleby says. "But there are many uncertainties." The crux of which seems to be the government's admission that "a fundamentally different system and supporting processes" would be needed. It doesn't sound easy, or cheap—in her editorial, Johanna Hanefeld and colleagues say that the administrative cost of collecting this money is about £3m over 10 years (p 7).

More importantly, is it necessary to restrict access to health services by migrants? Sophie Arie (p 16) unpicks whether European migrants are the drain on resources that they are perceived to be.

According to the 2013 International Migration Outlook report, "the fiscal impact of immigration is close to zero" and "most immigrants do not come for social benefits, they come to find work and to improve their lives."

Despite the government's assertions about the cost of so called health tourism, accurate data are hard to find. But recent research suggests that Britain actually exports more health tourists than it imports. Many other EU countries' policies are more stringent than the UK's, made possible because of the fundamental difference in how patients pay for services. Patients pay upfront, then claim back the costs through social security and insurance programmes. So it seems that the founding principle of the NHS—being free to everyone at the point of care—is ultimately the source of its current predicament.

Crossing geographical boundaries is not all the NHS has to worry about. According to a senior female doctor, crossing personal and professional boundaries is also a problem. She describes her experiences of sexual harassment as a junior doctor, and being regularly criticised and humiliated by male consultant surgeons (p 25). One "made an offensive remark about the size of my breasts." Despite her rage and humiliation, she just bit her lip, "suppressed the tears, and carried on." Why? "I did not speak up because I did not know where to go for support. Would I have been labelled as a pathetic woman who could not take the heat?"

Such experiences are by no means limited to the NHS; the BBC has recently announced it will review sexual harassment allegations that came out of the Respect at Work report. The NHS would be wise to follow the BBC and survey the extent of the problem within its organisation.

This week we launch the annual BMJ awards. Details of categories and how to enter are on page 18 and at www.thebmjawards.com.

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