should not judge the quality of medical care on these measures.¹⁵ Comparative performance tables should be reported only once a scientifically based and agreed definition has been produced.

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A memorable patient

The white coated man's burden

Mrs Jones was a truly delightful woman in her late 60s who struggled with the problems posed by diabetes, hypertension, angina, asthma, peptic ulceration, gout, rheumatoid arthritis, and a modest degree of renal impairment. Unsurprisingly, she was usually markedly symptomatic from one or more of these conditions. As a newly appointed medical registrar, I encountered her in my first outpatient clinic. I saw somebody who was clearly disabled trying to make the best of it but obviously becoming pretty low spirited in consequence of the constant struggle. My role, I knew, was to relieve her plight and restore her to a pleasurable and fulfilling life, so I set about tackling her multiplicity of problems.

Over the weeks, I improved her joint pain and her angina, but the drugs aggravated her ulcer and worsened her asthma. The worrying level of hypertension could, of course, be treated—but then the diabetes, gout, and renal function deteriorated. I grappled with the diabetes, the “improved” control I achieved coinciding with one of her periods of inability to eat because of the abdominal pain caused by her arthritis drugs. She had a nasty hypoglycaemic episode, and the decision to let her blood glucose level run rather higher, after all, led to her becoming dehydrated. The renal function went off like a rocket, and gout laid her low. And so it went on.

As the weeks turned to months, I saw Mrs Jones in the clinic with increasing frequency. I was dismayed by my inability to control her symptoms, and she was dismayed that she was unable to report an improvement to the young doctor who was trying so hard to help her. She began to bring in little gifts, such as eggs from her chickens, to keep my spirits up. These served only to intensify my sense of guilt at having failed her.

As a last resort, I asked my consultant for advice. I'd always done so as a senior house officer, but had vaguely thought there might be something in the rules that said that registrars weren't supposed to need to.

Certainly, that was the impression registrars had given me when I was a house officer. How could I render poor, brave Mrs Jones asymptomatic? “Do you know, I really don't think you can,” was the consultant's uncompromising, and—to my ears that day—rather unfeeling reply.

I reflected carefully, though, and light slowly dawned. My responsibility, I realised, was to do my very best to help her—including making use of all the advice available to me. If I had done that, and done it conscientiously, it was not my personal fault that medical science had not advanced to the point of being able to cure Mrs Jones and those like her. I should understand, sympathise, and medically do everything I could—but I should not carry a burden of guilt if all had not been solved.

I suspect that most doctors realise this after a while, even if they have never clearly formulated it in their minds. Equally, I suspect that concerns similar to those that I experienced with Mrs Jones trouble a greater number of junior doctors than their seniors might realise or remember. As for Mrs Jones, we both set more realistic goals for symptom control. Or, rather, I did. Her goals had probably always been more realistic than mine, but she had been too polite to mention it.

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