We have a few. Mostly older chaps, retired now but have been the officers rather than the rank-and-file, and they'll damn-and-blast before accepting this new-fangled system. Today, though, the objector is female and unclassifiable.

‘I’m concerned about your health’, I start earnestly. ‘You’ve had heart problems and yet you don’t seem to be taking any of your medicines.’ Alerts and pop-ups ping as I open her notes.

‘They made me ill!’ She’s indignant, as though I have just insulted her pooch. ‘One of them had my bladder like a paper bag and yet my legs swelled like balloons.’

I am a coward at heart but desperate too: there are a lot of targets riding on this. ‘Fancy having another go at all?’ I ask, trying to sound light and optimistic.

But this has just wound her up further: ‘I have no intention of doing anything for someone I’ve never met!’

And so I crumble and we arrange to meet in the surgery later.

Which encapsulates the problem with the whole medical system. Not trying to sound too dramatic, but I can explain.

Medicine is beholden to Kant’s ethical system based on ideas of duty.1 The General Medical Council (GMC) upholds this system without blushing, even calling its top-line summary guidance ‘Duties of a doctor’.2 And this bleeds into clinical practice further via the organisations such as the National Institute for Health and Care Excellence (NICE), whose pronouncements on what constitutes good care cannot reliably be taken as optional.3 Duties breed guidelines that are not quite as take-it-or-leave-it as their name suggests. And endless targets too, I guess.

Diagnosis itself provides the fixed points on which duty-based guidance and targets hang. As much as diagnostic labels are often provisional, the system itself pressures us into fixing them as if they are certain so the rest can be applied — targets require a yes or no rather than a maybe to the question of ‘Does the patient have X?’

There is a third way. Virtue ethics promotes the idea that correct actions are not those that accord with duty or utility but rather those that promote character: a right action is what a virtuous person would do.4 Virtue ethics fits with our apprenticeship-based approach to medical education. And perhaps too with the fact most of us have never actually read the GMC’s publications. It encourages a focus on the goals of care with emphasis on promoting wellbeing in the broadest sense [the Greeks called it eudaimonia]. It is what patients want too — to believe their doctor is virtuous, not just dutiful.

When she enters the room, it is with a shuffle and a handbag. I expected a purposeful stride. She is small too — if she were a pony, my feet would touch the grass.

‘Well, I challenge her, ‘do you think I look like a good doctor or not?’ She fixes me for long enough I squirm. ‘I’ll try one of your potions,’ she says at last, ‘but lowest dose and it better not be like the last ones.’”

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