Flamingos? Nowt like that round here

In medicine we are taught that common things are common, as exemplified by the example that canaries are not common in the UK. I enjoyed Hadridge and Pow's article in January (*JRSM* 2008;**101**:7–11)¹ but I think flamingos will remain rare birds in the UK NHS. The centre at the Department of Health both fears and underestimates doctors. It has no confidence or trust in either doctors' abilities or motivations. Hence it seeks to regulate and control them, thereby stifling medical curiosity. This destroys medical connectedness, and ultimately it is only a residual medical professionalism that keeps compassion to patients in place, and this gets steadily reduced over time. Meanwhile a senior Department of Health adviser asks if doctors and other caregivers are knights or knaves.

Hadridge and Pow talk about tuning into the deep culture of an organization. In the NHS there are three alternative discourses. One is the orthodox management line emphasising 'clinical engagement'. It is exemplified by glossy newsletters and mission statements that the workers know do not reflect reality, but only the management's distorted version of reality. Another is the formal medical discourse which hardly trusts management and its motives, but expresses itself carefully. The frank expression of the medical view is given on the medical blogs by Dr Crippen (<http://nhsblogdoc.blogspot.com/>) and Dr Rant (www.drrant.net/) and in the discussion fora at www.doctors.net.uk. The stories that doctors tell of the NHS speak of despair and disconnection. Doctors struggle to make sense of what is happening in their organization, and the suspicion is of hidden government agendas.

The deep diagnosis of the NHS is of an organization divided. There are clear disconnections between good medicine and what the NHS provides, and between what the leadership say and what is actually happening.

I see no flamingos taking flight around here. That large, ungainly, flightless Mauritian bird, the dodo, comes more easily to mind. And for Dutch explorers read United Health Europe, aided and abetted by former journal editors and government advisers.

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Competing interests

None declared

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Evidence based management

Although waiting to witness flamingos in flight is a great improvement on pigs, I believe Hadridge and Pow (*JRSM* 2008;**101**:7–11)¹ understate some of the issues to be addressed before the NHS flock can take to the air. Their exhortation to have more confidence and curiosity, become more connected and show more compassion would seem worthy enough, but their strategy for inducing the cultural change required to 'sort out' the health system stops short of describing meaningful action below the layer of high level organizational leaders. This may be an unfortunate emphasis, as previous calls for studies to increase our improvement effectiveness have highlighted issues associated with the inverted power structure of healthcare organizations and the need to explore and understand this dynamic.²

In contrast to Hadridge and Pow, though sharing similar objectives, Keroack and colleagues³ describe how they developed and used a composite index of quality and safety, based on patient-level data and the six attributes of an ideal health system articulated by the US Institute of Medicine: safe, effective, timely, efficient, equitable and patient-centred.⁴ Keroack *et al.* looked in depth at 79 US Academic Medical Centres and identified a distinctive set of behaviours and organizational practices which were uniquely associated with the top-performing hospitals. Although themes identified by this group have clear echoes with Hadridge and Pow's 'four Cs', the work of Keroack *et al.* might help further NHS organizational quality improvement in at least two important ways. First, by describing an approach that produces robust evidence supporting the value of specific operational practices it helps address the increasingly heard call for evidence-based management. Second, by encouraging the pursuit of improved healthcare through interventions at levels deeper than senior leadership, it brings a focus to the interface between those in service-line clinical leadership positions and front-line workers. Having

experienced healthcare improvement efforts from the perspective of a Medical Director, Clinical Director and front-line clinician, I suspect that effective engagement at this interface may be a crucial factor if NHS improvement is to spread its wings.

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None declared

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NHS culture depends on enlightened leadership and aligned incentives

The recent article on 'What the NHS needs to improve' (*JRSM* 2008;**101**:7–11)¹ identifies four valuable ingredients of a good culture but omits what is needed to achieve it. As a professor of comparative health care systems who has worked closely with many parts of the NHS since the Thatcher reforms, I think the answers are most clearly found in the transformation of the US Veterans Health Administration from a public, politicized system considerably worse than the NHS in the early 1990s to one considerably better that outperforms even the great medical centres. The key elements are a coherent master plan for patient-centred care that rewards quality and value for money, a strong and steady leadership to implement the plan at every level from regional to individual service design, the elimination of perverse incentives, and the construction of aligned incentives at every level.

Most of the costly and extensive reforms of the NHS I have witnessed since 1990 have been half-baked and partially