engine. We need a rational national transport policy, which should include making sure that each vehicle pollutes as little as possible, improved and cheaper public transport, and measures to encourage safe walking and cycling. Unrestricted expansion in our use of private cars is not sustainable. Not only must the government act but so must each of us who benefits both from the use of cars and from breathing fresh air.

Improving air quality will take time. How do we advise patients in the meantime? We can reassure them that air pollution is not a cause for panic. Patients whose respiratory disorders are made worse during pollution episodes should increase their treatment and make sure that they have adequate supplies. They could be advised to avoid optional visits to polluted cities and not to exercise, particularly in busy streets. Masks are a powerful signal to polluting drivers but probably have little protective effect.

While air pollution is a cause for concern and requires action, it is not causing a health crisis. We have, as a society, now started to come to terms with the adverse effects of the

internal combustion engine, and this process is likely to gather momentum over the next decade.

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British government's proposals on poorly performing doctors

Something much more inspired and fundamental is required

The British government earlier this week came up with a flabby and poorly written document as its contribution to the longstanding problem of poorly performing doctors (see also p 406).¹ The government announced that it would do something in the autumn of 1993, after a spate of media reports about incompetent doctors. The announcement led to questions about the future of self regulation, particularly when the government had failed to find parliamentary time for the General Medical Council's proposals on dealing with doctors who performed badly.

The government promised action by the end of 1993, but the working party discovered that "achieving the deadline was always likely to be difficult as the Group quickly identified a considerable number of issues requiring consideration." Consequently the report faded into the depths of the Department of Health until being rediscovered by a new secretary of state for health presumably feeling the heat over yet another round of high profile cases of doctors performing poorly. A clue to the poor quality of the report is given in the observation that "the members of the secretariat changed during the course of meetings and preparation of the report."

The primary diagnosis of the report—that the culture within medicine and the NHS is wrong—is surely right, but the exploration of the problem is shallow and the prescription inadequate. The report contains no data and no references to the considerable worldwide experience of poorly performing doctors. The problem is that medicine has had a culture in which medical students have been humiliated for not knowing and so have learnt to hide their ignorance, in which junior doctors are reluctant to call out their seniors and so take on more than they should, in which it is seen as weakness to admit to anxieties or shortcomings, in which errors are seen as unacceptable and so are hidden, and in which all doctors find it hard to confront colleagues who are performing poorly. What's more, doctors are encouraged to think of themselves as individual professionals, dealing one to one with patients, rather than as members of teams and a part of systems that include nurses, other health professionals, and managers. In

such a culture it is hard to follow the ideas of continuous quality improvement that "there are no bad people, only bad systems" and that "every defect is a treasure" (because systematic collection of defects allows constant improvement). Although individual responsibility can never be denied, dreadful cases of doctors performing poorly are most likely to be reduced not by honing the system for picking out the bad apples but rather by changing the culture to one in which all doctors accept that they could improve their practice and work continuously to do so.

But changing a culture is hard. Indeed, many management theorists doubt that managers or leaders can change a culture even within a small organisation, let alone one as large as the NHS. And the proposals of the government are desperately thin. The report recommends writing into doctors' contracts that they should take "appropriate action" when colleagues' standards of practice are poor, ensuring that all doctors know that the General Medical Council already requires such action, discussing the issue with the myriad of medical bodies, and passing legislation to allow the General Medical Council's proposals on performance review to begin (something that is now happening, with a bill going through parliament). But cultures are not changed through contracts, circulars, discussion with august bodies, and legislation.

Cultures, if they can be changed at all, are changed through outstanding leadership and through engaging day in day out with every member of the culture. Cultures are changed not from the top but from the bottom, and the art of leadership is to motivate people to want to do what needs to be done.

This is a report produced primarily so that the government can say that it is "doing something" when the next scandal breaks. Little will change. What is needed is something much more inspired and much more fundamental.

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¹ Department of Health. *Review of guidance on doctors' performance. Maintaining medical excellence*. London: DoH, 1995.