Ministers are trying to reverse the fragmentation of the health service by introducing more central control and direction, but, as those knowledgeable about quality improvement remind us, telling people to do better will not improve quality. Nor will keeping scorecards improve quality. The NHS is a huge organisation, and nobody knows how to encourage the spread of best practice. The monolithic nature of the NHS may yet be part of its failure.

People's expectations may rise much faster than the ability of the NHS to deliver, particularly when expectations are stoked not only by the media and access to the internet but also by politicians themselves. Ian Morrison, the Scottish Californian futurologist, has a joke that in Glasgow death is viewed as imminent, in Canada as inevitable, and in California as optional. If a large number of Britons grow to have the expectations of Californians then a service that pretends to be comprehensive, free at the point of access, and high quality runs into serious problems. The Californians may ultimately be discouraged by the bills they have to pay, but the aspiring Briton encounters no such deterrent—and certainly won't elect a government that proposes to raise taxes. The demise of the NHS may lie in this mismatch between expectation and provision. And now the law is increasing the tension by insisting that the NHS must provide long term care and that blanket bans on particular treatments are illegal.

One group that suffers from the mismatch between expectation and provision is NHS staff. They are caught like hamsters in a wheel that must go faster and faster. Instead of being compensated for pay that is generally poorer than in the private sector by the feeling that they are doing an important job well, they are now conscious of increased pressure and of failing to deliver an optimum service. They have low pay and disappointment. So nurses and managers migrate to other sectors, and doctors begin to think about providing services outside the NHS. Wholesale demoralisation of the staff may be an important component of the endgame.

Can I end this editorial optimistically? I think so. A mismatch between expectation and provision can be approached in two ways. Clearly it's necessary to improve the provision, and politicians always promise such improvements. But it would also seem sensible for everyone—politicians, reseachers, clinicians—to work on the expectations: death is inevitable; most major diseases cannot be cured; antibiotics are no use for flu; artificial hips wear out; hospitals are dangerous places; drugs all have side effects; most medical treatments achieve only marginal benefit and many don't work at all; screening tests produce false negative results; and there are better ways to spend money than on more healthcare technology. "The best healthcare system in the world," which politicians in every country promise, will not be one that provides everything for everybody but rather one that determines what that society wants to spend on health care and then provides explicitly limited, evidence based services in a humane and open way without asking the impossible of its staff.

Richard Smith *Editor, BMJ*

The firing of Brother George

The AMA has damaged itself by sacking JAMA's editor

The American Medical Association damaged itself and medical journals when last week it sacked George Lundberg, the editor of its journal *JAMA*. Lundberg, who had edited *JAMA* for 17 years, was sacked for fast tracking publication of a study showing that many American college students do not think of oral sex as "having sex." The study, in the issue of 20 January, was fast tracked because of its relevance to President Bill Clinton's impeachment trial. According to the *New York Times*, Dr E Ratcliffe Anderson, the AMA's executive vice president, said that he didn't object to the content of the paper but to its acceleration. "I happen to believe that Dr Lundberg was focused on sensationalism here, not science."[1]

In sacking its editor the association is reverting to type. Editors used to be regularly browbeaten, sacked, or edged out for upsetting the deeply conservative membership of the association, and as a result the journal had little international respect. Lundberg turned a journal that was an embarrassment into a respected major journal. Yet while *JAMA* has flourished the AMA has withered. Its membership has fallen steadily to 38% of American doctors, and it is perceived as a reactionary organisation concerned only with self interest. (The BMA, in contrast, has over 80% of British doctors in membership and is seen as more than a doctors' trade union.) The already poor image of the AMA was then tarnished further by the "Sunbeam affair," which led to several senior executives leaving the association over a sponsorship deal that went wrong.[2] Anderson has been brought in to "clean up" the organisation, but firing Lundberg is a poor start.

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Editors do upset their associations, as the leaders of the BMA and the Massachusetts Medical Society (owners of the *New England Journal of Medicine*) will testify. Unsettling the establishment, one of my predecessors argued, is an editor's duty.[3] The challenge to the association leadership is to put the long term development of the journal, which can come only with editorial independence,[4] before short term political irritation. The AMA leadership has failed that challenge.

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2 McDaniel CG. AMA chief forced to resign. *BMJ* 1997;315:1560.
3 Clegg H. Some principles and problems of modern editing. *International Record of Medicine* 1960;173:414-25.
4 Smith R. Editorial freedom: empty slogan or holy grail. In: Delamothe T, Smith J, Smith R, eds. *Balancing act: essays to honour Stephen Lock*. London: Keynes Press, 1991.

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