Let them eat quality

The history of the NHS has been characterised by a struggle for the right organisational solution and a continual failure to find one. Enter the latest masterstroke — if you can't change the organisation, repackage the brand and change the language.

Having trawled the management shelves of airport book shops for inspiration, health care academics have finally come up with the latest blueprint, guaranteed to keep the research funds flowing for at least another accreditation cycle.

Enter 'quality', a skilful syntactical manoeuvre that changes a term associated with exclusivity to a meaningless menagerie that includes dimensions of efficiency, effectiveness, equity, access, appropriateness, acceptability, and need; conveniently overlooking the fact that most of these concepts are contested and in many cases mutually exclusive. Combine with a random assortment of terms taken from religious and political discourses, such as mission, vision, empowerment and self-actualisation, wrap it in a clingfilm called culture and we have arrived at the next hot idea.

Fortunately, no-one really takes any notice of these linguistic acrobatics. Faced with limited resources, conflicting demands and limited room for manoeuvre, 'street-level bureaucrats' keep their heads down and carry on as normal. The real policy becomes the devices they use to cope with paradox and ambiguity, and which bear little resemblance to 'top-down' directives. Only by ignoring the expanding metaphorical amalgam does the system survive.

But beneath this latest fad lies a more fundamental concern. The confident assumption that machine thinking from industrial production can be applied to problems in the delivery of health care. That an independent observer can stand outside the system, define criteria and engineer it towards specific objectives. The quality glitterati have conveniently overlooked that health care is a complex hierarchy of interrelated systems that interact in a non-linear fashion (no simple relationships between cause and effect due to reiterative feedback loops in the system).

Better, perhaps, to view health care as an ecosystem that develops in a topography of co-evolving elements. Where the trappings of rationality, such as performance frameworks and strategic plans, are important only as binding mechanisms, holding people just long enough together to reflect and make sense of what has happened; where a performance outcome is not an end in itself but part of a learning experience where the whole process can start again; where practitioners are themselves in the best place to judge the appropriateness of their actions.

Engaging with non-linearity means that we can only make general remarks about the condition of a system, its future direction and its 'quality'. The phenomenon of interest is the interaction between people that directly affects the meanings of their lives and those around them, with the emphasis on trust and reciprocity. There can be no quality standards in a network that is engaged in producing itself. Quality is knowing what you can't know and then learning.

Meanwhile, models that reflect our reality and facilitate the choices we make seem as distant as ever. As we wait to lurch towards the next big idea, practitioners remain pragmatic, keep their heads down, and make sure the system just keeps going.

DAVID KERNICK
General practitioner, Exeter

Address for correspondence

Dr David Kernick, The St Thomas Medical Group, The St Thomas Health Centre, Cowick Street, Exeter EX4 1HJ. E-mail: su1838@eclipse.co.uk