Once again we are in the news

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There is only one thing worse than being talked about and that is not being talked about. The what, where and how of our work has, at the time of writing, extensive media coverage; the government has released proposals to streamline emergency care with closure of accident and emergency departments [sic], development of super (regional) accident and emergency departments [sic] and urgent care centres, extended paramedic responsibilities and so forth. It seems, at face value, that there are three reasons for these proposals, namely money, employment law and clinical outcomes. It is difficult to determine if they are mutually exclusive.

In September 2006, the then new NHS chief executive, David Nicholson, said that ''up to 60 hospital closures might affect accident and emergency, paediatric and maternity departments especially in the smaller district hospitals. Some of the changes would be aimed at reducing the NHS deficit of £512 million last year''. He continued ''I understand the politics of it, but this is about the way we deliver care which is predominantly closer to home.'' What does that mean? In relation to the NHS deficit he mentions, is it a *non sequitur*?

In December, the Conservative Party reported that 29 accident and emergency units [sic] face closure; the scale of the potential closures underlines a financial crisis which saw front line trusts run up a £1.3 billion deficit last year. Three quarters of the accident and emergency units under threat were in trusts that were deeply in the red. The 29 departments at most risk are in trusts with a combined deficit of £287.2 million last year. Only seven of the trusts considering closing or downgrading their accident and emergency units finished the year in surplus. The Tories also claim that the cuts are partly driven by the European working time directive, which will cut junior doctors' hours from 56 to 48 by 2009.

Also in December, the Institute for Public Policy Research (IPPR) gave two clinical reasons for reform. Sixty-one thousand heart attack (acute coronary syndrome STEMI) patients are treated each year in local hospitals but only 1,600 receive emergency care in specialist units. The IPPR argues that if patients have access to specialist techniques, about 500 extra lives will be saved each year with a significant reduction in secondary complications. The IPPR also says that international evidence shows that severely injured people are more likely to survive if treated in specialist centres rather than in local hospitals, even if they are further away. The Royal College of Surgeons estimates that a network of specialist trauma centres will save 770 extra lives each year. The Department of Health says the government's arguments are very similar to those presented by the IPPR. ''This is about people going to the best place, not the one round the corner, because the long-term outlook is better. We want to move on from the brouhaha about closures to set out the clinical case for delivering things in different ways.''

The Prime Minister made some interesting comments in a speech to the NHS Confederation in December, in which he gave clinical reasons for reform. Amongst other things he says (and I quote this section of his speech in full)

> ''Major emergencies only affect about 10% of people. Most people would actually be better served by care that was closer to home. At the moment, if you have a pressing medical need you end up almost inevitably in A&E. But in the light of the changes in medicine we need to do better than that; we need a diverse set of institutions, GP out-of-hours services, pharmacies, social services, mental health teams, minor injury units, walk-in centres—to treat the range of different needs. Lots of people, for example, who come straight to A&E, would, for a variety of reasons, be better treated elsewhere. For example, paramedics can administer life-saving drugs to heart attack and stroke victims on the doorstep. If you have a stroke at 0200 in the morning, you want to go to a centre with access to a CT scanner 24 hours a day. For the life-threatening emergencies, a specialist is needed at once. If you have the rupture of a major blood vessel, for example, you need an experienced vascular surgeon with access to 24-hour laboratory services and radiology. The right care for strokes is now to have a CT brain scan within three hours followed by aggressive rehabilitation with thrombolysis in appropriate cases. But that level of expertise can't be offered everywhere. That's why it makes sense, alongside local provision, to create specialist centres of excellence which have 24-hour consultant cover and access to state-of-the-art diagnostic equipment. Therefore, alongside that specialist emergency care, we can then offer a quicker and more immediately appropriate service. The patient gets a more specialised service; in most cases closer to home.''

You don't need me to point out the flaws and inconsistencies in his thinking.

Patricia Hewitt is clearly determined to see NHS trusts come in on budget this financial year despite the charges of financial mismanagement that stalk her wherever she goes, to the extent that she is putting her political credibility and maybe even her cabinet career on the line. Whatever the agendas (hidden or otherwise) and merits for such a course it is axiomatic to say that short termism with a view only to the next financial bottom line or election is blinkered and counterproductive. As a reason for reform it is nihilistic.

If the European working times directive on junior doctors' hours is the driver for reform then the whole NHS is in trouble. Coupled with changes in industrial employment and postgraduate education elsewhere in the NHS the long term ability to staff a 24 hour service comprehensive NHS has been fraught with challenges for many years and can only become more and more difficult.

If we look at the clinical reasons cited by both the IPPR and the Prime Minister, we get onto more solid ground with which to persuade or dissuade both clinicians and the public. The clinical arguments can be debated vigorously and robustly with an undercurrent of evidence based analysis. As a specialty we have promulgated evidence based approaches to much of our work; if there are valid clinical reasons for service reform we need to be open minded enough to accept them. When all is said and done we are here to serve the patient in the best way we can. If the reasons do not stand up to analysis then we need to say so clearly and confidently and the government, via the medical and nursing colleges and not just the tsars and tsarinas it has appointed, needs to listen carefully.

The government has privately conceded that it is in difficulty selling its reforms.

At a brainstorming in the first week of December the health secretary and her ministers expressed anxiety about the way the reforms are being presented to the public. May be one reason why they are having problems is that they are not clear in their own minds why they want reform. If they know what they want and the reasons why, then they are not saying so clearly. This is either deliberate misinformation or incompetent communication. One difficulty they face in trying to sell a message is that the government's track record from when it came into office (and indeed from when they were in opposition beforehand) is one of wrapping itself in a maelstrom of spin and media manipulation; people tend to take much of what it says with a large shovelful of salt. It is not helped when the level of trust in the Prime Minister is at an all time low.

If truth is the first casualty in war, clarity is often the first casualty in political communication. Obfuscation and Orwellian doublespeak float around like flotsam and jetsam on the ocean. We ask the government to come clean and be absolutely explicit about reasons for reform. Don't fudge; don't decentralise responsibility and blame for systemic shortcomings; with clinical issues please enter a genuine and professional debate with the medical and nursing colleges and listen to them as carefully as you do to your closest advisers.

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