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NEWS

Primary care pays only "lip service" to clinical governance, MPs say

Michael Day LONDON

Poor communication between primary care trusts and GPs is seriously compromising the safety of patients in England, a group of MPs said this week.

In its latest report the House of Commons Committee of Public Accounts also warns that 96% of GPs are failing to report dangerous incidents to the National Patient Safety Agency.

For its report, which examines the Department of Health's progress in implementing clinical governance in primary care, the committee had taken evidence from the chief executive of the NHS, the deputy chief medical officer, and the NHS's director general of commissioning.

Committee chairman Edward Leigh said, "Too many primary care organisations are paying lip service to the principles of the Department of Health's clinical governance agenda. The lines of communication between the primary care trusts, on the one hand, and their GPs and other healthcare contractors, on the other, are defective."

He added: "How can we be confident in the NHS's ability to share learning locally and nationally about what can go wrong in health care when only a tiny proportion of GPs—4%—routinely report patient safety events and incidents to the National Patient Safety Agency?"

In response to a series of high profile problems in the 1990s, including the Shipman murders and events at the Bristol Royal Infirmary, the health department introduced its 10 year programme to boost patient safety. The centrepiece was the clinical governance system.

The new report suggests, however, that clinical governance is not as well established in primary care as in secondary care. The committee says that this is due largely to the complexity of the role of primary care trusts in commissioning and providing care and to the independence of contractors delivering health care, particularly GPs.

The Committee of Public Accounts' 47th report of the current session can be found at www.parliament.uk/pac.

MARK THOMAS

Record investment in NHS fails to boost productivity

Zosia Kmietowicz LONDON

Greater spending on the NHS over the past five years, by more than £43bn (€63bn; $87bn), has failed to deliver improvements in productivity that could have led to better health care for all, a review has concluded.

The review by Derek Wanless, which has been carried out for the independent health think tank the King's Fund, follows up his 2002 report *Securing Our Future Health* (*BMJ* 2002;324:998), which was commissioned by Gordon Brown, then Chancellor of the Exchequer.

Although the extra spending on the NHS has led to many important improvements in healthcare infrastructure, staffing levels, and care provided for some conditions, the new report says, the opportunity to deliver better public health has been missed—with the prevalence of obesity in particular now higher than the worst case scenario forecast in the 2002 report.

"The extra resources, accompanied by fundamental reform, have undoubtedly improved patient care over the past five years," said Sir Derek, former chief executive of the NatWest Group. "But what is equally clear from this review is that we are not on course to deliver the sustainable and world class healthcare system and, ultimately, the healthier nation that we all desire."

If the NHS was going to meet the "fully engaged" scenario outlined in his 2002 report, where services were significantly more productive and people took greater responsibility for their own health, spending on the NHS would have to increase from an estimated £68bn in 2002-3 to £154bn by 2022-3 (at 2002-3 prices), says the report.

"Such an expensive service would undermine the current widespread support for the NHS and raise questions about its long term future," said Sir Derek.

Although the cost of providing hospital and other services has increased, the improvements in productivity anticipated in the 2002 report have not been realised.

The biggest increase in hospital activity has been in emergency care (up 21%) and attendances at accident and emergency departments (up 33%), which could be due to poor out of hours services being provided in the community, said Sir Derek.

He also complained that increases in pay across the NHS had absorbed an estimated £18.9bn, or 43% of the increased input costs without "robust evidence of significant productivity or other benefits arising."

The new report can be seen at www.kingsfund.org.uk.

Genome sequence of one person is published for first time

Susan Mayor LONDON

The complete genome sequence of one person—one of the US biologists working on the project, J Craig Venter—was published for the first time this week. By enabling scientists to compare the contribution of each of the parental chromosomes, it showed that genetic variation among humans was much greater than previously estimated.

The data indicate that variation from human to human is about 0.5% of the genome, not 0.1%, as previously thought.

The new genome, called HuRef (which stands for human reference), is the first time that the full or diploid genome, consisting of the DNA in both sets of chromosomes (one from each parent), has been published for one individual (*PLoS Biol* 2007;5(10): e244. Two previous versions of the human genome, published by the Human Genome Sequencing Consortium and by Celera Genomics, were mosaics of DNA sequences from several donors.

Data on more than 20 billion base pairs of DNA were analysed to assemble most of Dr Venter's diploid genome. This made it possible to determine the contributions of each of the parental chromosomes and to determine the amount of variation between them. Results showed that at least 44% of the genes differed in the two chromosomes.

Dr Venter, chairman of the J Craig Venter Institute, which is based in Rockville, Maryland, said: "We have shown that human to human variation is five to sevenfold greater than earlier estimates, proving that we are in fact more unique at the individual genetic level than we thought."

Sequencing the genome also showed a wider variety of DNA variants than previously thought. HuRef contained a total of 4.1 million variants between the two chromosomes, covering 12.3 million base pairs of DNA. Of these, 3.2 million were single nucleotide polymorphisms (SNPs, in which just one nucleotide—the basic unit of the DNA strand—is changed). The researchers said that this was a typical number, but they found at least 1.2 million variants that had not been described before.

They also found a surprisingly high number—nearly one million—of non-SNP variants, including insertions and deletions (where a single DNA unit has been inserted or deleted) and copy number variations (where the same gene occurs in multiple copies).

BRENNAN LINSLEY/AP/PA

US medical authorities are accused of failing to act over doctors in Guantanamo

Owen Dyer LONDON

The US medical establishment is failing to enforce professional ethics among doctors who serve in the US military, charges a letter signed by doctors from 16 countries that was published in last week's *Lancet*.

The letter compares military doctors working in the Guantanamo Bay detention camp to doctors who helped the South African police question detainees in the apartheid era.

"The attitude of the US medical establishment appears to be one of 'See no evil, hear no evil, speak no evil,'" the letter says, pointing out that no military doctor has been charged or disciplined for offences committed in what President George Bush describes as the war on terror (*Lancet* 2007;370:823). "The failure of the US regulatory authorities to act is damaging the reputation of US military medicine," it says.

The letter is signed by 260 people, almost all of them doctors, from 16 countries. Many also signed a letter that appeared in the *Lancet* in March 2006, criticising doctors who participated in the force feeding of prisoners at Guantanamo Bay.

Among the letter's organisers are David Nicholl, a neurologist at Birmingham's City Hospital, and the psychiatrist William Hopkins, of the Medical Foundation for the Care of Victims of Torture.

The letter is timed to coincide with the 30th anniversary of the death of the anti-apartheid activist Steve Biko. His death in police custody was at first attributed to a hunger strike but was shown at an inquest to have been caused by head injuries. The inquest also uncovered evidence of gross negligence and the falsification of records by two doctors working with the police, Ivor Lang and Benjamin Tucker.

South African regulatory authorities initially failed to take action, but an eight year campaign by South African doctors ultimately resulted in Dr Tucker being struck off, while Dr Lang received a reprimand.

The letter concludes that "doctors in Guantanamo and elsewhere have made the same mistake as Tucker who, in 1991, said 'I had become too closely identified with the organs of the State.'"

The AMA did not return calls from the *BMJ* for comment.

HANK MORGAN/SPL

Gene sequencing pioneer J Craig Venter is the first man to publish his own genome sequence

Teen suicide rate rises as prescribing of SSRIs falls

Owen Dyer LONDON

"Black box" labels ordered by the US Food and Drug Administration that warn of a greater risk of suicide from certain types of antidepressants may have had an effect opposite to that intended, says new research.

Comparing numbers of prescriptions of selective serotonin reuptake inhibitors (SSRIs) and reported suicides in the United States and the Netherlands, the researchers found that the rate of suicides among children and adolescents rose as numbers of prescriptions of SSRIs fell in 2003-4 (*American Journal of Psychiatry* 2007;164:1356-63).

"FDA is concerned about possible negative impacts of labelling changes"

Numbers of suicides among Americans aged under 19 years rose by 14% from 2003 to 2004, the study says, the biggest annual increase since systematic recording began in 1979. The same year saw a 22% decrease in the number of SSRI prescriptions to this age group.

In the Netherlands the number of prescriptions of SSRIs fell just as fast, while the country experienced an even larger jump in the number of adolescent suicides, which rose by 49% from 2003 to 2005.

The American data show a startling reversal in the long term trend towards fewer suicides among young people. From 1990 to 2003 the overall suicide rate in the 10-24 age group had fallen 28.5%. Overall, 4599 Americans aged under 24 killed themselves in 2004, making it the third leading cause of death in this age group.

Thomas Laughren, director of the US Food and Drug Administration's division of psychiatry products, said in a statement: "FDA is obviously concerned about possible negative impacts of labelling changes but also feels a strong obligation to alert prescribers and patients to possible risks associated with the use of antidepressants. We will continue to monitor antidepressant use and suicide rates, and will take appropriate regulatory actions as new data become available."

David Healy, professor of psychological medicine at Cardiff University, who is one of the people who first suggested a link between use of SSRIs and adolescent suicides, challenged the study's conclusions. He said that apparent changes in the rate of suicides may really reflect changes in coroners' verdicts.

Moreover, he said, "a drop in the script rate may involve primarily those on treatment chronically," accompanied by a "constant or even increased rate of new patients being put on the drugs." The beginning of treatment with SSRIs is a period that carries a high risk of suicide, he said.

He added that the increase in suicides might be due to doctors switching patients from antidepressants to antipsychotics. But Robert Gibbons, of the University of Illinois at Chicago, the study's lead author, said that there had been no increase in antipsychotic prescribing as SSRI prescribing fell.

Regulator gives green light to using human-animal embryos

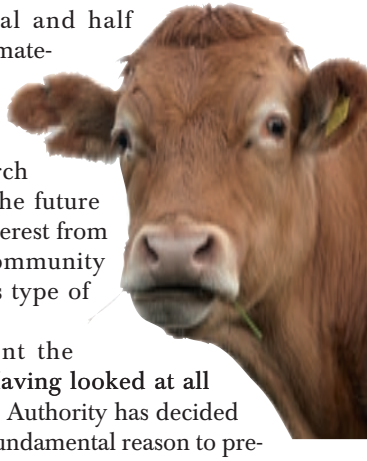
Zosia Kmietowicz LONDON

Scientists in the United Kingdom could be carrying out research using animal-human hybrid embryos by the end of the year, after a decision by the UK's fertility watchdog to approve in principle the use of certain types of hybrid embryos for research.

The Human Fertilisation and Embryology Authority (HFEA) has declared that cytoplasmic hybrid embryos, which are 99.9% human and are made using the shell of an animal egg (usually that of a cow) implanted with human genetic material, are desirable both scientifically and ethically.

The authority made its decision on Wednesday (5 September) following consultations with scientists and other stakeholders and the general public. The embryos should provide scientists with a more reliable reservoir of stem cells for research purposes. Currently, research is limited by the availability of human eggs.

However, the authority stopped short of approving research using true hybrid embryos—those which contain half animal and half human genetic material—because of uncertainties about what form the research would take in the future and a lack of interest from the research community in pursuing this type of work.



In a statement the HFEA said, "**Having looked at all** the evidence the Authority has decided that there is no fundamental reason to prevent cytoplasmic hybrid research. However, public opinion is very finely divided, with people generally opposed to this research unless it is tightly regulated and it is likely to lead to scientific or medical advancements.

"This is not a total green light for cytoplasmic hybrid research, but recognition that this area of research can, with caution and careful scrutiny, be permitted. Individual research teams should be able to undertake research projects involving the creation of cytoplasmic hybrid embryos if they can demonstrate, to the satisfaction of an HFEA licence committee, that their planned research project is both necessary and desirable.

IN BRIEF

Keogh becomes NHS medical director: The cardiothoracic surgeon Bruce Keogh, professor of cardiac surgery at University College London and director of cardiothoracic surgery at the Heart Hospital, London, has been appointed as the new medical director of the NHS in England, leading the work of the government's clinical directors (or "tsars"), and as deputy chief medical officer.

Prostate cancer is the most likely cancer to show family history: Twenty per cent of patients with prostate cancer had a family history of the disease, says a new study that was based on 206 000 cases (*Annals of Oncology* doi: 10.1093/annonc/mdm414). It is followed by breast cancer (14%) and colorectal cancer (13%).

Canadian research institute promotes open access: From 1 January 2008 researchers with the Canadian Institutes of Health Research will have to ensure that their original research articles are freely available online within six months of publication. James Till, who chairs a national task force of researchers and stakeholders, says that the new policy will serve as a model for other funding agencies. See www.cihr-irsc.ca/e/34851.html.

Elsevier introduces free web portal: The publisher Reed Elsevier has introduced a web portal for oncologists, financed by advertising, that gives them free access to articles from 100 of its own journals. Oncologists are asked to register their personal information in exchange for immediate access to articles on cancer. See www.oncologySTAT.com.

Israeli judge categorises indoor tobacco smoke as "assault": Proprietors of public places who fail to enforce smoking bans are "accomplices to assault," an Israeli district court judge said in a precedent setting ruling. The judge has fined a Tel Aviv restaurant owner the equivalent of $800 (£400; €580) for failing to keep the premises free of tobacco smoke.

HRT raises risk of breast cancer but lessens risk of colon cancer: Women who took hormone replacement therapy for more than two years had a lower risk of colon cancer than women who took it for <6 months (hazard ratio 0.8 (95% confidence interval 0.7 to 0.9)) but a higher risk of breast cancer (1.3 (1.1 to 1.6)), a study of 73 000 women found (*Annals of Oncology* doi: 10.1093/annonc/mdm404). The increase in the risk of breast cancer was less for transdermal HRT (1.3 (1.1 to 1.5)) than for oral HRT (2.1 (1.4 to 3.2)).

Off-label use of erythropoietin may be harmful, doctors told

David Spurgeon QUEBEC

Doctors should be vigilant about the off-label use of erythropoietin to treat anaemia in critically ill patients, says an early release editorial in the journal of the Canadian Medical Association.

The editorial (*CMAJ* 2007;177:697) is available on the journal's website (www.cmaj.ca) and is based on a meta-analysis in the journal.

Recombinant erythropoietin, a complex glycoprotein hormone, is approved for the treatment of anaemia in patients on dialysis, patients who have had major surgery, and those undergoing treatment for cancer.

When used off label to treat critically ill patients the drug, which costs about $400 (£200; €290) a dose, will save, on average, less than one unit of blood, will not improve clinical outcomes, and may increase the likelihood of thrombotic complications, says the editorial, by Paul Hébert, editor in chief of *CMAJ*, and Matthew Stanbrook, the journal's deputy editor (scientific).

The editorial's conclusion is based on findings from a meta-analysis of nine randomised controlled trials (*CMAJ* 2007;177:725-34) and a commentary on the use of erythropoietin in critically ill patients (*CMAJ* 2007;177:747-9), also available on the journal's website.

It says that in the United States the hormone's manufacturers have promoted it aggressively through direct to consumer advertising and incentive payments to doctors, prompting an investigation by the US Congress.

The meta-analysis, which compared erythropoietin with placebo or no intervention, showed that the drug had no significant effect on overall mortality (odds ratio 0.86 (95% confidence interval 0.71 to 1.05); I^2=0). The treatment and control groups did not differ in length of stay in hospital or intensive care unit.

(See Short Cuts p 537)

New partnership is set up to improve aid

Owen Dyer LONDON

A new drive to meet the health commitments of the United Nations' millennium development goals was announced last week, as Britain and other European countries joined many of the world's biggest health agencies and foundations to launch the International Health Partnership. The new partnership aims to simplify and improve the delivery of aid to selected developing countries.

Seven "first wave" countries in Africa and Asia will initially join the scheme: Burundi, Ethiopia, Kenya, Mozambique, Zambia, Cambodia, and Nepal.

Six donor countries have signed up to the scheme so far: the United Kingdom, France, Germany, Italy, the Netherlands, and Norway. Other partners include the World Health Organization; the World Bank; UNAIDS (the joint UN programme on HIV and AIDS); Unicef; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the European Commission; and the African Development Bank.

(See Personal View p 565)

JAMES GATHANY/CDC

The virus has been spread by the *Aedes albopictus* mosquito

Europe witnesses

Rory Watson BRUSSELS

The first known instance of transmission of chikungunya fever by mosquitoes in Europe is currently taking place in northeastern Italy. Previously some travellers from areas where the infection is endemic—parts of Africa, South East Asia, and the Indian subcontinent—had returned home to Europe with the virus. But never before had local transmission taken place.

Two thirds favour organ donation after death, but only one in 20 take steps to facilitate it

Clare Dyer BMJ

People in the United Kingdom have a positive attitude to use of human tissue and organs for medical research, education, or transplantation, with 68% saying they are certain or likely to donate their body, organs, or tissue, concludes an independent study carried out for the Human Tissue Authority. However, only 5% of people had already taken the necessary steps to do so.

The research, carried out by Ipsos MORI, found that consent was a key factor in whether people would allow their tissue or organs to be used. Interviewees were given a choice of three options about consent and asked which most closely represented their views. It was possible to choose more than one option.

The highest percentage (46%) said they would be happy for their tissue or organs to be used for any purpose with their prior consent. Some 33% thought it acceptable for their family members to give consent on their behalf after their death, and 19% believed that it was never acceptable to use tissue or organs for any purpose without the consent of the individual or family. Sixteen per cent of respondents said they didn't know, did not hold any of the three opinions, or refused to answer.

More than 2000 members of the general public were surveyed for the research, the results of which were released at a meeting last week to report on the authority's progress in its first six months.

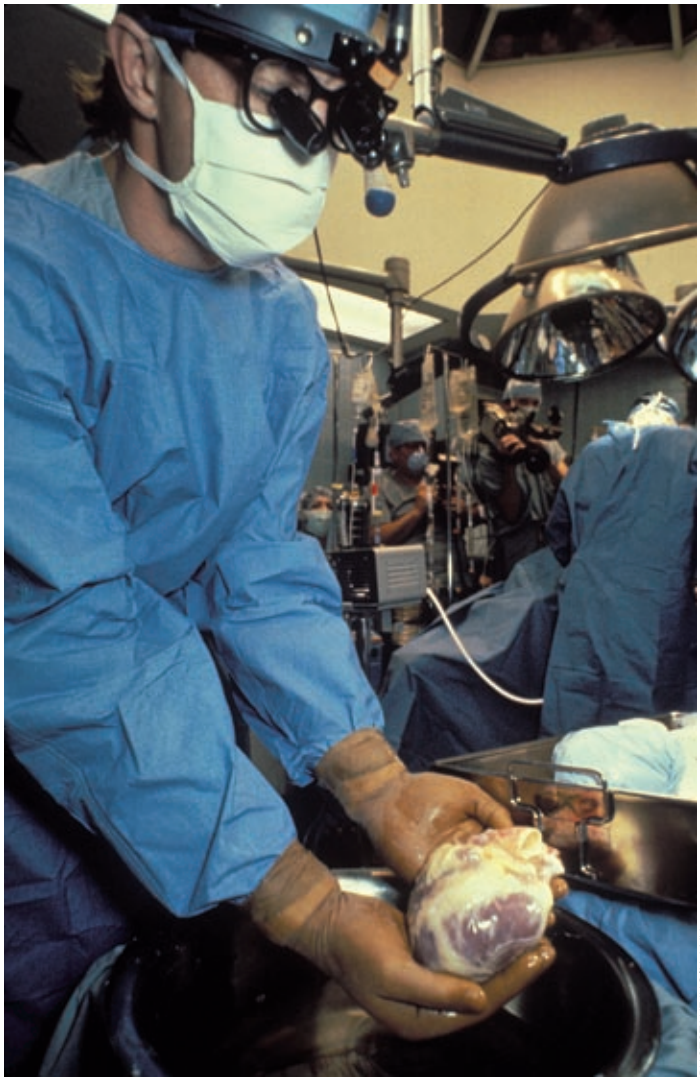
The study also included four general focus groups and in-depth interviews with four people: a disabled person aged over 60, a carer, a British Asian, and a practising Muslim.

White respondents, those in higher social classes, and those with confidence in the regulation of human tissue were most likely to see it as acceptable for their organs and tissues to be used.

The authority was set up to regulate the removal, storage, use, and disposal of human bodies, organs, and tissue.

Shaun Griffin, the authority's director of communications, said that the research would form a baseline for further work and help in formulating codes of practice and informing the public.

The Ispsos Mori report can be found at www.hta.gov.uk.



PHOTOTAKE INC/ALAMY

A surgeon holds a donor heart before transplantation

first local transmission of chikungunya fever in Italy

During August health authorities in the province of Emilia-Romagna detected an unusually high number of cases of febrile illness in two small villages near Ravenna, Castiglione di Cervia and Castiglione di Ravenna. Subsequent analyses confirmed the diagnosis of chikungunya fever.

Between 4 July and 4 September 197 cases were reported of patients experiencing high fever, joint and muscle pains, headaches, rashes, and gastrointestinal problems. The symptoms generally lasted one to two weeks. One death had been reported: an 83 year old man with underlying medical conditions.

The cause of the outbreak is understood to be a visitor from the Indian subcontinent. The person was already infected and developed the symptoms two days after arriving in Italy. The "Asian tiger" mosquito (*Aedes albopictus*) is thought to be responsible for transmitting the infection in Italy. The height of the epidemic was in the third week of August.

The Stockholm based European Centre for Disease Prevention and Control is working with the Italian health authorities and has issued advice to people visiting or returning from areas where chikungunya fever is present. It emphasises the need to minimise the risk of mosquito bites and recommends that anyone experiencing a fever or unexpected joint pain within 12 days of returning home should seek medical attention. Treatment takes the form of non-steroidal anti-inflammatory drugs or non-salicylic analgesics.

The centre is also encouraging EU governments to raise awareness among healthcare providers of the current outbreak in Italy.

See www.ecdc.europa.eu.

BMA calls for investigation into cost of MTAS

Lynn Eaton LONDON

The National Audit Office should carry out a full independent investigation of the cost to the taxpayer of the medical training application service (MTAS), the flawed computerised system used this year to appoint junior doctors to training posts in the UK, says the BMA.

Andrew Rowland, vice chairman of the BMA's Junior Doctors Committee, says in a letter to the National Audit Office that it's not just the reported £1.9m (€2.8m; $3.9m) paid to an IT company to set up an online recruitment system that needs to be investigated. He says the potential hidden costs to the tax payer should be looked at as well. These may include the continuing costs of using MTAS to collect data, he says, and of the extra interviews that had to be arranged after the system was abandoned.

"We know that thousands of doctors have had their careers messed up, that many of those who found posts still haven't been paid properly, and that others are going to be out of post next month," said Dr Rowland.

"What we don't yet know is how much public money has been wasted on this failed experiment. The £1.9m paid to the company that set up the failed MTAS IT system is the tip of the iceberg. In some ways we'll never know the real impact this disaster has had, because we'll never know how many doctors have been prevented from reaching their full potential or how many patients had their care delayed."

"The £1.9m paid to the company that set up the failed MTAS IT system is the tip of the iceberg"

The BMA is already investigating continuing problems since junior doctors started their new posts on 1 August. Some doctors are being underpaid, for example. Many are still in temporary posts. These were set up to plug gaps in the system after the collapse of MTAS and while the new arrangements were being sorted out.

A spokesman for the National Audit Office said it had yet to see the letter but that it was unlikely to take any action until the inquiry into the affair being conducted by John Tooke, dean of the Peninsula Medical School, has reported (*BMJ* 2007;334:818). The House of Commons select committee on health announced in July that it would be looking into the NHS's Modernising Medical Careers programme and the MTAS system. The audit office spokesman said it would wait until the select committee had reported.

GPs and patients clash over premium rate phone lines

Adrian O'Dowd MARGATE

GPs in the United Kingdom are being urged to consider dropping the use of 0844 phone numbers for their practices, which campaigners say force patients to pay a premium rate for the calls.

Doctors' leaders, however, have hit back at the accusations, saying that GPs are not making a profit from the lines and that they have improved patients' access.

Concerns are growing about the extra costs to patients who contact practices that have switched their surgery phone numbers from local geographical codes to the 0844 code. These codes are more expensive, say patients' groups and the "Say No to 0870" website (http://saynoto870.com), which campaigns against the use of premium rate codes such as 0870, 0844, and 0845.

But Richard Vautry, deputy chairman of the BMA's General Practitioners Committee, said his own practice used a 0844 number and that it cost the practice £1000 more than the previous system but was worth it.

The biggest advantage of using the code was to improve access. "We are able to manage the volume of calls much better," he said.

Students will no longer get free copies of *BNF*

Adrian O'Dowd MARGATE

The safety of patients could be threatened by a government decision that will affect the quality of training of young doctors in the use of drugs, say leaders of the profession.

The Department of Health has decided to stop paying for a free copy of the British National Formulary (*BNF*) for all medical students in England. The move has been described as illogical, shortsighted, and against the current drive to reduce the number of prescribing errors.

The *BNF* provides up to date information on all drugs available on the NHS and is used daily by more than 200 000 health professionals in the United Kingdom to help them select the correct treatment for patients.

The *BNF* also helps students develop their knowledge and skills before taking on clinical responsibility. It is published twice a year under the authority of a joint formulary committee comprising representatives of the medical and pharmaceutical professions and the UK health departments.

Dominic Vaughan, the *BNF*'s publishing director, said, "The *BNF* is a critical tool for the safe use of drugs. It gives health professionals the information they need to make the best treatment decisions for their patients."

A recent study of new doctors, published in the *British Journal of Clinical Pharmacology* (2007;64:363-72), found that training in pharmacology is insufficient to prepare medical students to prescribe safely and rationally.

In December last year students were told they would not receive the *BNF*, but this decision was overturned in March after pressure from the profession. This, however, proved to be a temporary reprieve, as the government has said it is withdrawing funding for good.

The BMA's medical students' committee has reacted angrily to the decision.

A Department of Health spokesman said, "The funding for the provision of the *BNF* has not been cut or deleted, it has been reallocated to the strategic health authorities, as we believe they are better placed to determine local education and training expenditure priorities.

"It is therefore up to the undergraduate medical deans and BMA medical student committees to approach all 10 health authorities to request funding of the *BNF* for medical students."

Competing interest: The BMJ Publishing Group co-publishes the *BNF* with the Royal Pharmaceutical Society.

Hospital closures: the great taboo

Closing a hospital always generates a public outcry, even if the evidence suggests that closure will improve services. **Nicholas Timmins** asks why it's so difficult

ANDREW SHAW/REUTERS

When Barts Hospital was threatened with closure, health secretary Frank Dobson said, "I'm not having a blue plaque on Barts saying, 'Founded by Henry I in 1123, closed by Frank Dobson in 1999.'"

Nick Timmins FINANCIAL TIMES

The Tory MP Kenneth Clarke used to tell a story, when health minister back in the 1980s, of meeting his Italian counterpart, who complained vigorously about the difficulty of closing hospitals, when rationalisation of health services was badly needed in his own country.

"We don't have a problem," Ken chortled. "We just close them." And, at the simplest level, that is clearly true. In the United Kingdom numerous hospitals have closed or merged with their neighbours over the past 40 years. The exact number is hard to pin down because of the frequency of mergers. But the number of beds has certainly decreased: in 1948, when the NHS was founded, the UK had around 550 000 beds; today the figure is half that, at around 228 000 in 2003-4.

True, the great bulk of that reduction is due to the closure of the old mental health asylums and the geriatric "back wards," whose patients are now in means tested care homes. And people with learning disabilities have been shifted out of hospital and into social care.

Even so, there are 50 000 fewer acute beds than in 1948. It is a measure of how medicine has changed that the amount of activity in that smaller number of beds is way up: more than 15 million finished consultant episodes in 2003-4, against fewer than 4000 discharges and deaths in 1951.

Yet everyone knows that even just reshaping hospital services, let alone actually closing a hospital, can be the most searing of experiences. Take the recent reconfiguration in Halifax and Huddersfield, Yorkshire—towns 8 km apart and covered by one NHS trust. As part of a fairly complex set of changes, Huddersfield became the centre for emergency surgery, while Halifax will become a centre for specialist paediatrics and obstetrics. As a result, Huddersfield will no longer have an obstetrician led maternity unit.

The public meetings "were horrendous, not once but three times," said Linda Riordan, Halifax's Labour MP. Doctors and managers were "shouted at and abused," she said. "They were accused of only doing this to keep their jobs, or to get a bonus, or of lining their own pockets at the expense of patients . . . You could see the gynaecologist by the end thinking, 'What am I doing? I'm trying to provide the best service possible, and I am getting all this.'"

So why are hospital services so hard to reshape, even when the clinical case for doing so is powerful? One reason is that although the great bulk of healthcare transactions may take place in general practice, hospitals have long been the symbol of health care. The very name still carries the medieval connotation of a hospital as a place of safety and asylum.

Hospitals bring with them, too, a sense of territory for doctors and staff. This may be less strong now than it was, but beds, and their number, can help define status.

Even when changes are being driven purely on clinical grounds, it can be hard to achieve medical consensus. John Maynard Keynes noted of economists that "wherever there are five gathered in a room there will be six opinions." Substitute doctors, and you can probably add one to that.

Human nature also tends to leave hard decisions until they have to be taken. So it is rare for big changes to take place until financial imperatives demand that what is clinically necessary be done—so closures and reconfigurations become tied up in "cuts."

Politicians' accountability for tax funded health services does not, of course, make the task any easier. The former health secretary Frank Dobson summed it up: "I am not having a blue plaque on the wall of Barts saying, 'Founded by Henry I in 1123, closed by Frank Dobson in 1999.'"

Local newspapers and other media get more mileage from highlighting opposition than support. Local MPs—witness Hazel Blears, Labour party chairwoman, campaigning against recently approved changes to services in Manchester—find it hard to go public, even when privately convinced of the case. Kidderminster is engraved on politicians' hearts. There, in 2001, Richard Taylor, a local doctor, took the parliamentary seat from a Labour minister when the local hospital was due to lose its "blue light" accident and emergency department. That case too, however, showed how horribly things can go wrong when health authorities do a lousy job of presenting the case for change. During that election campaign it was almost impossible to find anyone in the town who did not believe that the entire hospital was closing—not just the blue light service.

"Doctors were accused [of making changes] to keep their jobs or to line their pockets"

Perhaps too, for understandable reasons, there is a reluctance to spell out clearly that changing technology and work patterns have made existing services unsafe—or less safe than they should be. NHS managers worry that saying this bluntly risks frightening patients and demoralising staff. So the talk is of improvement, not risk. A better, blunter, language may be needed; it is not impossible. Aneurin Bevan managed it. He would, he declared, "rather be kept alive in the efficient if cold altruism of a large hospital than expire in a gush of warm sympathy in a small one."