work currently done by specialists in hospitals. If so, "it might well be at the expense of the more central and fundamentally generalist role of guardian of the illness/disease interface – and this could prove very much more costly in the long run". As J. M. Keynes pointed out, though, 'the long run' is not of great interest politically, and the whole of British life seems currently to be in the destructive grip of short-term financial calculations.

In hospitals, the average length of stay for acute services fell from almost 12 days in 1970 to 6.4 in 1990, but Fiona Moss, a London physician, points out that "such changes have been reactions to external pressures and not responses to a quest for a better deal for patients". Even more worrying is that the use of clinical interventions which are of proved value remains haphazard, even when they are cheap. Coming to the same conclusion as the GP, though from the other side, Dr Moss points out the "real risk that the response to the crisis in health care will be to push inadequate hospital care into an ill-prepared primary care service". She sees a possible new model in diabetes centres which "provide a wide range of advice and care given by specialist nurses, dietitians, chiropodists, and doctors.... Firm links exist between primary and secondary care and between secondary and tertiary care". This sounds very much like what is needed for most psychiatric patients, but what proportion of such centres should remain in hospitals, rather than in 'the community'?

Much more startling in its consequences is the surgical view by John Wickham, which suggests that conventional surgery and anaesthesia may largely disappear, except for the results of trauma. Instead of the painstaking dissection and reconstruction of tissue planes, most operations will be done by endoscopy or other minimally invasive methods, while general anaesthesia will rarely be needed. This paper talks of "interventional therapy", but fails to define it. The effects on hospitals of such a revolution will clearly be immense.

The 'reformed' NHS was supposed to reroute hospitals and units in their local communities, but Nicholas Timmins, a journalist, points out that this is scarcely possible when they operate in almost total secrecy. The membership of authorities and trusts (costing £20 million per annum in salaries) "is now deeply unrepresentative of the political plurality" – which is putting it mildly. Corresponding to the growing lack of local accountability for the NHS is the same process in Parliament; awkward questions are now passed to the Management Executive. Timmins, though, does not discuss the progressive gagging of NHS staff, which is part of the same process.

Professor Ian Kennedy has not generally been the doctor's favourite person, but it seems that he may now be finding himself on the same side of the barricades. Recent changes in the NHS are largely American-inspired, and he shows that their inevitable result will be the same infiltration of health care by lawyers – "medical policy will be made more and more by courts". People will go to law "because they will come to feel that they will not get satisfaction anywhere else", following the political rhetoric. This situation will replace "The sense of belonging to a flawed but noble enterprise... where the system tried to do its best by all for all". No doctor could have put it better. In his own contribution, Sir George Godber says that the new market "must never become a mechanism for profit", but since his words were written, this has already happened.

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Through the Rural Magnifying Glass. Meeting the mental health needs of rural inhabitants: a challenge for policymakers and purchasers. By Jan Sherlock. 72 pp. £8.95 (Plus £1.73 postage and packing). Available from Publications Department, Good Practices in Mental Health, 380–384 Harrow Road, London W9 2HU.

As the world's first industrialised country, Britain had a steady proportionate decline in its rural population from the end of the 18th century. In the post-industrial age, though, this trend has now been reversed, and some ten million people live outside settlements with a population of over 10 000. For most of them, this is no Arcadian idyll: rural employment is declining as much as that in towns, while tourism provides only seasonal and poorly paid work on the whole. Country dwellers also have the constant problem of getting around,

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since public transport has been deteriorating since the late 1960s and will now become even worse with rail privatisation.

The GPMH organisation has collected information on the mental health needs of rural inhabitants, and published it together with the reports of two regional conferences. One of the most striking points is the high rate of suicide among farmers and farmworkers: they are twice as likely as the average person to do this, suicide is the second most common cause of death for male farmers aged under 45, and the true rate is probably much higher, since many verdicts are left open. Scattered populations mean that the unit costs of all services are relatively high, while social support may be difficult (as traditional communities decline), and the stigma of psychiatric disorder is more difficult to avoid. That social services are now spending only about 3% of their total budget on mental health does not provide an encouraging basis for improving the provision to rural people, even if some problems are relatively smaller than in inner cities. The report ends with nearly six pages of summarised recommendations – all admirable in themselves, but it is difficult to see where a hard-pressed service could start, in trying to follow them.

The two reports of the regional conferences contain descriptions of local initiatives, many of them run by voluntary organisations or depending on mixed funding, which may not be long-term. The lists of participants show that out of a total of 270, there was one psychiatrist, one senior house officer, one public health physician, and one GP with psychiatric interests. The steady marginalisation of psychiatry, as mental health services change, could hardly be better illustrated. The representative of MIND, addressing one of the conferences, quoted a well-known GP from the Marylebone Clinic – "The amount we save on prescribing and referral to hospital easily covers the cost of additional (complementary) therapists. An average GP in one year will sign about £80 000 worth of drugs. The equivalent here is 30–35% of that". Neither of them mentioned any information as to whether the practice's patients were better or worse off as a result of this difference.

Psychiatrists with responsibilities for rural areas will certainly find this publication of interest, not least as a warning of the way they may be excluded from future developments.

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