concentrated. Perhaps the government's Medicine Control Agency could or should extend its role from safety to include efficacy, cost-benefit, and appropriate limited availability. Such an agency would work to establish clear evidence of benefits in relation to cost and provide a more informed basis for rationing decisions. It might be vulnerable to political pressure but it is less likely to allow the local variations in availability of very expensive drugs that now exist. In particular, it could ensure that funding decisions properly reflect where the drugs should be used—in hospital, primary care, or shared care. If this centralised approach is not followed then a similar approach should be adopted by regional health authorities, which control allocation of funds to both the family health services authorities and hospital and community health services. The region not only has greater purchasing power but its budget base is so much larger and more amenable to accommodating expensive items. An example from one region is that only 10% of growth hormone is purchased by hospitals while the remainder is purchased by retail chemists from four different suppliers. This does not represent effective purchasing within a total budget in excess of £4m a year.

The current approach of leaving hard decisions to local providers has not been in the best interests of patients because too often it has resulted in unpleasant squabbles between health professionals and allegations of "buck passing." It has also led to media publicity being applied to individual cases, which have been judged irrationally and without reference to other cases of need.

We suggest that the government and regional health authorities urgently consider these issues and provide guidance to the local prescribing working groups. Pivotal to any discussions at a local level is for the method of funding to accompany the pattern of prescribing devised jointly by hospital and general practitioners. This requires government and regional approval and financial support. Only in this way may there be hope for the rational use of expensive drugs until a national mechanism is established.

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1 Gabriel R. Picking up the tab for erythropoietin. *BMJ* 1991;**302**: 248-9,864. (2 February; correction 13 April.)

Postnatal depression and infant development

SIR,—I hope that every general practitioner reads, marks, and inwardly digests the review of postnatal depression and infant development by Dr Lynne Murray and colleagues.[1] I entirely concur with their conclusions but would like to sound a word of caution about the use of a screening questionnaire in the early puerperium.

I have found that several patients who I have identified with the Edinburgh postnatal depression scale have not wished to be labelled "a patient with depression" while others have asked me not to inform our excellent health visitors of their high scores. As some women with postnatal depression may not wish to inform their general practitioners or health visitors that they are depressed[2] the primary care team should be "patient friendly" and apply the tool with sensitivity.

Grant, in a small study in my practice, found that 65% (15/23) of a sample of depressed (11) and non-depressed (12) mothers feared that disclosure of depressive symptoms would meet with an unsympathetic response; 48% (11/23) felt that depression in the puerperium carried a serious stigma, and 39% (9/23) believed that depression implied "failure as a mother" (unpublished data). She found that 74% (17/23) would have appreciated more discussion about the possibilities of postnatal depression in their antenatal care and 78% (18/23) would have liked more information about postnatal depression in the puerperium.

Patients with postnatal depression should not have any stigma attached to them either by society or by general practitioners.[2] Information about the condition should be more readily available, particularly in the antenatal period, so that more women are prepared to acknowledge it and seek help should they experience it.

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1 Murray L, Cooper PJ, Stein A. Postnatal depression and infant development. *BMJ* 1991;**302**:978-9. (27 April.)
2 Richards JP. Postnatal depression: a review of recent literature. *Br J Gen Pract* 1990;**40**:472-6.

SIR,—The review by Dr Lynne Murray and colleagues maintains the possibility that an adverse relation exists between postpartum depression and the cognitive development of the offspring and stresses the importance in diagnosing and treating depression in the postnatal period.[1]

To date there have been no epidemiologic studies to evaluate whether infant development may be affected by the presence of maternal depression or by the secondary exposure of the infant to psychotherapeutic agents ingested by the mother for the treatment of postpartum depression and excreted in breast milk. It is hoped that, as larger populations are studied to evaluate the association between postpartum depression and its effects on infant development, efforts will be made to answer the longstanding question as to what part, if any, chronic secondary exposure of the infant to psychotherapeutic agents may play.

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1 Murray L, Cooper PJ, Stein A. Postnatal depression and infant development. *BMJ* 1991;**302**:978-9. (27 April.)

Rehabilitation of elderly people with prostheses

SIR,—Mr R S Hanspal and Ms Keren Fisher's interesting study of outcome in unilateral amputees[1] warrants further comment. The results of prosthetic rehabilitation at first seem too good to be true, with only 3% of patients having abandoned the prosthesis while 66% were walking both indoors and outdoors. I suspect the explanation lies in the recruitment of patients from those reattending the clinic rather than from all patients provided with a prosthesis. This suggestion is supported by the sex ratio of more than two women to one man, being the reverse of that normally encountered among vascular amputees. There is no evidence that these results can be extrapolated to an unselected prospective group of unilateral amputees.

The authors correctly point out that achieving grade III mobility (indoor walking only) is a worthwhile rehabilitation aim, but achieving grade II mobility (use of a prosthesis to achieve a transfer) is also a valuable rehabilitation aim. Being able to transfer independently can have a significant effect on reducing the cost of care to the community and with this skill patients can safely look after themselves throughout the day. What is questionable is whether a state of the art, expensive modular limb is the appropriate prosthesis if grade II mobility is the rehabilitation goal.

The functional effectiveness of achieving grade II mobility could have been nicely illustrated by using an activities of daily living assessment—for example, the Barthel, measuring it with and without the prosthesis. Similarly, a patient's ability to transfer with an expensive modular system could be compared with that with a simpler low specification prosthesis, providing an opportunity for savings without compromising on functional results.

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1 Hanspal RS, Fisher K. Assessment of cognitive and psychomotor function and rehabilitation of elderly people with prostheses. *BMJ* 1991;**302**:940. (20 April.)

AUTHORS' REPLY,—Our study did not aim to describe the functional results and outcome of prosthetic rehabilitation of elderly amputees, but to show the significance of the relation between cognitive and psychomotor function and mobility.

We recognise that achieving grade II mobility is also a valuable rehabilitation goal, especially for below knee amputees. In our paper grade III mobility was just an illustration in case some readers believed that we were suggesting that low cognitive assessment scores automatically precluded limb fitting.

Although the use of the state of the art modular limbs to achieve grade II mobility may be questioned, it is worth noting that the simpler low specification prostheses is more labour intensive and hence more expensive (about 15% for below knee amputees and 20% for above knee amputees).

Because the aim of the study was not to address functional effectiveness of any grade the use of Bartel indices for assessing activities of daily living was not relevant. The point was to investigate the predictive value of cognitive state for achievable mobility. Having established the relationship, we are now undertaking a prospective study on the value of the use of cognitive assessment scales in rehabilitation after amputation.

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Preventing needlestick injuries

SIR,—To prevent needlestick injuries the principles should be (*a*) to minimise the duration of time for which the needle is exposed; (*b*) to avoid as far as possible manoeuvres that bring the hand close to the needlepoint; and (*c*) to discourage complicated manoeuvres while the needle point is exposed. The more complicated the manoeuvres, and the longer the period that the needle point is exposed, the more likely is the risk of a needlestick injury to the operator and to third parties.

Dr D C Anderson and colleagues proposed that resheathing needles would prevent injuries to a third party and illustrated three methods for doing this.[1] We doubt the safety of the manual techniques illustrated.

The gravity resheathing method has the potential for causing a self inflicted injury, especially if the operator were tired, distracted, or bumped into—all of which can occur to staff, particularly in busy departments. It would be more appropriate in busy areas to dispose of the needle as soon as possible after use into a safe and secure container and to avoid any prolonged manipulation of the needle.

If a two handed technique is used in the scoop resheathing method (one hand steadying the sheath while the other advances the needle into the sheath) there is a risk of stabbing the hand holding the sheath. If a one handed technique is used,