close collaboration between professions: abolition of the community pharmacists' monopoly would bring dispensing back into the surgery. Allowing doctors to sell 'over the counter' would benefit patients and result in considerable savings to the NHS budget, which currently duplicates costs in supporting both general practice and community pharmacy. Moreover, general practitioner and pharmacist would work more closely if they were partners or if the one employed the other.

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References

1. Prescription Pricing Authority. *Annual report 1 April 1989 - 31 March 1990.* London: Department of Health, 1990.

Postnatal depression

Sir,

I was extremely interested to read Dr Richards' review article on postnatal depression (November *Journal,* p.472). As the author of the first prospective study on this subject[1] I would like to add two further comments.

First the occasional severity of this type of depression must be recognized. In my series the criteria for inclusion in the depression group was attempted suicide or serious threat of suicide and the incidence was 2.9%. Secondly with regard to previous mental illness I used two control groups. The first included pregnant women in whom depression did not occur, the second a 10% sample of the practice female population aged 15–45 years. A history of previous psychiatric disorder was present in 45% of the depressed group compared with 7% of the pregnant controls and 25% of the practice female population sample.

Having treated patients with postnatal depression for over 30 years I endorse all Dr Richards' comments and hope that as a result of reading his article our colleagues will become increasingly involved in the prevention, diagnosis and treatment of what is a most distressing disorder to the patient and her family.

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Reference

1. Tod EDM. Puerperal depression. A prospective epidemiological study. *Lancet* 1964; **2**: 1264-1266.

Sir,

I must congratulate Dr Richards on a well presented review of the literature on postnatal depression.

I have often found when counselling women with postnatal depression that there are difficulties in mother–child relationships elsewhere in the family. These can be various but the circumstances surrounding the birth that has precipitated the current episode of postnatal depression will often have a link to earlier events. Thus it is common to find that the woman's mother suffered depression after the birth of the present sufferer, or that the sufferer's mother was depressed after the birth of her second child and the sufferer has recently delivered her second child. In one of my patients, the sufferer became depressed when her child was three months old and was very aware of her sister's loss of a child by cot death at three months old. In addition, the sufferer may have felt rejection when a young sibling was born and some of these feelings can recur when her own younger child is born. The present sufferer will thus have 'learnt' that a particular birth order or type of event surrounding a birth is equated with depression or perhaps with sadness and grief.

Examining earlier events and looking for possible connections often seems to be therapeutic and women seem to recover quickly if a plausible connection is made. I suspect that acknowledging the original sadness enables the mother to establish a better relationship with her child and will help to avoid further episodes of depression, but I have yet to establish this.

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Effects of the new contract

Sir,

The editorials by Hart, and Horder and Moore (November *Journal,* p.441-443), together with the letter on budget holding by Sykes (November *Journal,* p.480) brought together some important themes for discussion. Here, attention is focussed on the possible effects the new contract may have on the doctor–patient relationship.

Many of us could see the organizational implications of the new contract a year or so before it was implemented; what we could not have foreseen was the extent of managerial inconsistency nor the administrative inaccuracies and procedural trivia which have resulted. Grafting such a radical change onto an ill-prepared and incomplete infrastructure seems to have been a recipe for chaos.

The current excessive preoccupation with procedures not directly related to patient care may cause general practitioners and their staff to lose sight of their primary purpose. To quote Sir James Spence, 'The essential unit of medical practice is the occasion where, in the intimacy of the consulting room, a person who is ill or who believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and *all else in the practice of medicine derives from it'* (my italics). The real key to 'outcome', according to Spence, is the quality and effectiveness of the consultation, which in turn is dependent on the skills of the doctor, on the time spent on consultation and which is not directly related to the general practitioner's income.

It is understandable that under conditions where future income is vulnerable and therefore unpredictable, other activities — some of which are related to income generation — will invade the time available for consultation sessions. These activities include chasing and attaining targets for immunization and cervical cytology; so-called health promotion clinics — most of which have dubious value and some of which are frankly embarrassing; and assorted activities peculiar to the new contract such as surveillance of the over-75 year olds and screening patients not previously seen in the last three years.

Of course all these items can be delegated, but delegation itself requires planning, discussion and monitoring of execution to be effective — and even good managers have only so many hours in a day. The net result is that consultation time suffers and there is ample evidence shorter consultation times result in more inappropriate referrals and prescriptions. This is not only a quality problem, because both these activities generate the greatest part of a general practitioner's expenditure within the NHS.

By what criteria will a 'good' doctor be defined? — is it the one who rips through the clinics at a rapid rate, or the one who takes longer and who has longer waiting lists? Will the 'good' doctor have his good qualities plundered by the self-defeating strategy of increasing his list or money following his patients? This is not just a rhetorical question since this is how this government sees the 'good' doctor being rewarded.

It is my fear that cost-effectiveness will become a dominant force in the doctor–patient transaction, and that this could transform the relationship in the way that, for different reasons, it appears to have done in the USA. Will audit become the handmaiden of a cost-containment exercise, completely divorced from quality of care? If the educational component of medical audit is ignored in favour of an end of year balance sheet we will have