

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.

PAUL THOMAS

2 Newell Rise, Claydon,  
Ipswich, Suffolk IP6 0AQ

#### 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<sup>1</sup> 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.

E D M TOD

12 Durham Road  
London SW20 0TW

#### 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.

V HARTLEY-BREWER

21 New King Street  
Bath BA1 2BL

## 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

missed a great opportunity for permanent change.

There is some good in the new contract, but the rate of change is too fast and there are too many general practitioners performing tasks and going through a process which has more to do with the generation of income than with the improvement of outcome. During the transformation of the NHS plc there is a good chance that for many individuals, energy will be dissipated, goodwill and motivation will be destroyed, to the detriment of the most important person of all — the patient.

J R MANTON

74 Station Road  
Marple, Cheshire SK6 6NY

### Ecchymosis hominis circulare

Sir,  
I was interested to see the case reports by

Hutchinson and Williams (December *Journal*, p.516), although the photographs might have been clearer. It is about 30 years since I became aware of this condition, which I thought of as autoiatrogenic.

I am not sure that I accept subnormal intelligence as being a risk factor, except in recurrent cases. That the suction pads were removed by the infants also surprised me — the rubber foot was so adherent to the forehead in my case that it took two adults to remove it, whence the circular area of capillary extravasation. I can assure the authors that the embarrassment of having a transient blot like an outsize caste mark in the centre of one's forehead is as nothing compared with enforced retention of the gaudy baby's rattle that caused it.

ALAN GILMOUR

106 Crock Lane, Bothenhampton,  
Bridport, Dorset DT6 4DH

Sir,  
I enjoyed the piece about ecchymosis hominis circulare (December *Journal*, p.516).

Many years ago a regular visitor to my surgery was a robust young boy who would never let me attend to him unless he was allowed first to 'shoot' at me with a bow and arrow. Despite the fact that the arrow was suction-tipped, I always insisted that he should shoot at my reflection in a full-length mirror. Fortunately, this satisfied the young man.

After all these years I now realize that my firmness may have saved me from serious injury. Having read this paper, I recommend all practitioners to buy a full-length mirror. I am confident it would be tax-deductible.

CYRIL JOSEPHS

16 Keswick Road  
New Milton, Hampshire BH25 5JA

## INFECTIOUS DISEASES UPDATE

### Human parvovirus (B19) infection

Human parvovirus (B19) was discovered only relatively recently, but it is the cause of an infection recognized over 100 years ago — fifth disease, also called *erythema infectiosum* or slapped cheek syndrome.

*Erythema infectiosum* is a common, rubella-like childhood illness in which the young patient is not usually systemically un-well, but exhibits a florid rash, typically with bright red cheeks and a reticulate pattern on the limbs and trunk. The rash tends to come and go especially with exercise or hot baths and can last several weeks. *Erythema infectiosum* occurs all year round every year, but it is particularly frequent in spring and 'epidemic' years also occur. It can co-circulate with rubella in the same community and, confusingly, the rash can sometimes be rubelliform or morbilliform — so an outbreak of 'rubella-like' rash illness in a well vaccinated community may not be due to vaccine failure, but to B19 infection.

Like rubella, *erythema infectiosum* is usually mild and self limiting and there is no indication for school exclusion if the child is feeling well, because by the time the rash has appeared, the infectious stage is over. However, *erythema infectiosum* can be serious in some circumstances: acquired by adults it can cause an arthropathy which is often prolonged and painful; acquired by subjects with haematological disorders involving a shortened red cell life span (for example congenital spherocytosis or sickle cell

disease) it may cause aplastic crises; persistence of the virus has been described in immunodeficient patients in whom it causes a prolonged anaemia; finally, when acquired during pregnancy, it may cross the placenta and cause hydrops fetalis and fetal death.

This last complication is clearly of particular concern, but it must be stressed that it is a rare event because among women of childbearing age, approximately half are naturally immune; even if the virus is acquired it may not infect the fetus and even if it does, fetal death is not inevitable. A recent study showed that the overall risk to a pregnant woman of having a fetal death due to the virus when exposed to B19 in, say, a classroom setting, is only just over 1%.<sup>1</sup>

The diagnosis of B19 infection can be confirmed by testing the patient's blood for the presence of the specific immunoglobulin (Ig) antibody. If the patient is pregnant, the risk to the fetus will have to be faced, but the emphasis should be on the rarity of an adverse outcome and the lack of an association with deformities (unlike rubella, B19 does not appear to be teratogenic). The only intervention available is controversial; it involves frequent ultrasound examinations to screen for development of fetal hydrops, which is then treated by intrauterine transfusion.<sup>2</sup> While this procedure has brought infected fetuses safely to term it can be hazardous and there is a theoretical concern that such severely affected fetuses may present stigmata of intrauterine infection not yet documented in the small

number so far described.

The final practical point for general practitioners is the need to resolve both lay and professional confusion between the human parvovirus and the canine variety. A recent letter in the *Veterinary Record* reported that veterinary surgeons were receiving requests for the family pet to be destroyed because clients' doctors had told them that the animal was the source of their or their children's infection.<sup>3</sup> In fact the two viruses are unrelated and canine parvovirus which apparently arose *de novo* in 1978 as a result of mutation of a feline parvovirus, is not infectious for man. It was clear from the veterinary surgeons' experience that some dog owners had suffered considerable emotional distress because they believed, quite unnecessarily, that they were faced with a decision between their family's health and the destruction of a much loved pet.

Contributors: Susan M Hall, PHLS Communicable Disease Surveillance Centre, 61 Colindale Avenue, London NW9 5EQ. Irene A P McCandlish, Canine Infectious Disease Research Unit, University of Glasgow.

### References

1. Public Health Laboratory Service Working Party on Fifth Disease. Prospective study of human parvovirus (B19) infection in pregnancy. *Br Med J* 1990; **300**: 1166-1170.
2. Peters MT, Nicolaides KH. Cordocentesis for the diagnosis and treatment of human fetal parvovirus infection. *Obstet Gynaecol* 1990; **75**: 501-504.
3. McCandlish IAP, Thompson H. Human parvovirus infections. *Veterinary Record* 1990; **13 Oct**: 385.