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New mums' mental health is neglected



Dr Vijay Roach

Obstetrician, gynaecologist and chairman, Gidget Foundation

OBSTETRICIANS work with women and their partners towards a healthy, safe and positive experience of pregnancy and delivery. While obstetricians do not specifically treat mental health issues, the unique relationship we have with pregnant women allows us the opportunity to screen new mothers at risk of anxiety or depression.

At least one in five women suffers from postnatal anxiety or depression. The aetiology is multifactorial and may have premorbid features. Pregnancy-specific events, difficulties with the infant and adjustment reactions are all contributors.

After the birth of our second child 16 years ago, unrecognised and untreated my wife spiralled into a depression that would eventually see her hospitalised and medicated and the happiness

of our family threatened. We hid the problem. Now, she is brave enough to expose her story to public scrutiny and works tirelessly to educate mothers and healthcare providers. My failure as a husband and a doctor all those years ago has affected me deeply.

As an obstetrician, I see women suffer from perinatal anxiety and depression. Screening and diagnostic tools are poor, and resources for assessment and treatment are inadequate and difficult to access. Left untreated, the illness can have devastating effects on every facet of the new mother's life. With access to the right treatment, women get better.

Mental health has finally reached political awareness, and Kevin Rudd last year pledged \$85 million over five years to combat postnatal depression.

While our society is supportive of pregnancy and babies, the media presents a romanticised view of motherhood, a "yummy mummy" construct that is both demeaning and unattainable. Society is busier and the new mother is often isolated. While local services are plentiful, the approach to identification of

the woman at risk is ad hoc and relies on a weak screening tool, the Edinburgh Depression Scale.

Obstetricians in private practice have limited contact with their patients following the birth of their baby. I rely on my 'radar' to detect mood disturbance. Surely this significant life event justifies a mandatory postnatal visit to a GP for formal assessment of mental health status and the instigation of appropriate management when illness is identified. Cholesterol, breasts and colons get that sort of attention. We need a change in attitude toward new parents. The mental health of a new mother should not be left to chance.

The Gidget Foundation was established in 2001 in memory of 'Gidget'. Suffering from postnatal depression, she sought help from her GP. No counselling or follow-up was instigated. She took her own life. The aim of the foundation is to promote awareness of perinatal anxiety and depression to ensure that mothers in need receive timely, appropriate and supportive care to aid their recovery.

The Gidget Foundation is a supporter of the International



Marcé Society's Conference on Policy, Planning and Effective Delivery of Perinatal Mental Health Care, to be held in Sydney this month.

The foundation is currently working toward the development of a comprehensive resource centre that will be accessible online and by telephone. The centre will provide a contact point for consumers,

Forced rural stints will not work



Dr Peter Rischbieth

President, Rural Doctors Association of Australia

THERE'S been a recent revival of the debate over geographic provider numbers as a way of correcting the chronic undersupply of doctors in the bush. It's one of the old chestnuts of medico-politics – and one with which RDAA has significant concerns.

Well-respected commentator John Menadue, of the Centre for Policy Development, started up the debate again when he argued that rather than having a shortage of doctors, Australia has a "maldistribution" of them. He went on to call for the auctioning of provider numbers as a way

of addressing the problem.

Geographic provider numbers have been touted before as a mechanism for a more equitable distribution of the medical workforce. Although the idea appears attractive at first glance, it is in fact unlikely to achieve its aim and could actually undermine other initiatives to support rural practice.

As a rural doctor, I strongly believe rural practice is an excellent career choice for medical graduates – it offers great clinical diversity, the chance to take on procedural roles and close involvement with your local hospital and community. We need to sell these and other positive benefits of going bush.

Undoubtedly, there are some challenges involved with working in rural and remote locations. But forcing doctors to go to the bush isn't the approach to take – we must instead be enticing them

to rural practice through an integrated package of incentives and supports.

It's understandable that a young doctor will want to invest where they know their asset will grow. Under a geographic provider number system, that would mean buying into prized metropolitan areas like the eastern suburbs of Sydney or southern suburbs of Melbourne. The fact is doctors will pay a tonne of money to get a provider number in these metropolitan areas, but that's not going to be the case when it comes to our rural and remote towns.

RDAA's research project, *Viable Models of Rural and Remote Practice*, suggested that less than 20% of rural and remote practices are sustainable. Medical graduates going bush must have the assurance of financial security and adequate remuneration, rather than being

forced to purchase an unreliable asset.

Incentives come through robust fee-for-service payments, rural incentive supports (as proposed by RDAA and the AMA through a Rural Rescue Package), other assistance mechanisms like locum and infrastructure supports, and an assurance that rural doctors can achieve a good work-life balance. If we get that right, then more doctors will want to move to our country communities.

And it's critically important that we do get it right. If we are to narrow the disparity in health outcomes between those who live in the city and those in the country, we *must* expand our rural medical workforce.

You don't do that by imposing punitive strategies, you do it by ensuring the appropriate rewards, incentives and supports are in place.



Mark Tremlett

Delayed acne treatment unacceptable

EDITOR: It is with interest that the Cosmetic Physicians Society of Australasia (CPSA) observes the debate concerning the restriction to prescription of isotretinoin ('Specialists fight GP access to acne drug', 29 August).

In the last 10 years there has been a plethora of newer acne treatments that augment the general practice role in the treatment of acne. Cosmetic physicians often treat acne due to their facilities and ability to provide clinical strength home programs, as well the use of microdermabrasion and photodynamic therapy.

In addition, the CPSA is at the forefront and is the largest representative group that treats acne scarring, due to its interest in laser devices.

However, in severe nodulocystic acne cases, referral to a dermatologist is required and our patients experience delayed treatment with Roaccutane due to limited dermatological resources. Ultimately, this does not provide timely intervention or the best care for patients who experience acne. These delays will often lead to increased scarring and stigmata, as well a detrimental psychosocial impact for the patient.

Most cosmetic physicians

have come from a primary care background and are often well trained in contraception knowledge. In addition, a large number of our members have gained the Diploma in Practical Dermatology (Cardiff, Wales), which is a criterion for GP prescribing rights for Roaccutane in the UK. With the advent of the Australian version of a dermatological diploma, hosted I believe by the RACGP, this may provide equivalent qualifications.

In addition, most cosmetic physicians would be pleased to undergo further training and examination to increase their knowledge and management abilities in this area, if this is a requirement.

It must be remembered that there are a number of other medications that also have an adverse risk profile and are often prescribed by GPs as well as cosmetic physicians. In addition, ongoing restrictions could continue the increase of "natural" treatment options such as OTC vitamin A tablets, where there is little chance to warn the patients of its teratogenic effects, or provide contraceptive advice.

Any treatment regimen should endeavour to place the patient's needs as paramount,

and their needs both physically and psychologically should be met.

For a teenager to wait up to six months to gain access to a dermatologist for a prescription presents a failure in patient management. In rural locations, apart from the delay, travel time and distance will often see management passed back to the general practitioner, but the family accrues these additional

expenses for healthcare.

While we acknowledge Australia's admirable record in preventing pregnancy while on Roaccutane, better access for patients and further education for those wishing to prescribe Roaccutane can only lead to better patient outcomes.

Dr Mary Dingley
President, Cosmetic Physicians Society of Australasia



carers and professionals.

As an obstetrician, a father and a husband, I want to achieve a better response to perinatal anxiety and depression with better resources for health professionals. Motherhood, parenthood, early childhood – what matters more?

For more information, visit www.gidgetfoundation.com.au

We are all being nationalised by stealth

EDITOR: Dr Klaus Stelter's ('Nationalisation in all but name', Opinion 29 August) is so right. We are being nationalised by stealth.

Alternative health practitioners charge appropriate fees for their advice (usually higher than those of a GP), then sell their pseudo-medicines at a 300% markup. On the other hand, GPs feel guilty if they charge more than a few dollars over the rebate, and that only to their non-pensioners.

Dr Stelter, please run for president of the AGPN and get your down-to-earth ideas through to our government, who are constantly complicating, regulating and bureaucratising the health system. GPs just want to help people, not fill in plans and forms.

Dr Warwick Carter
Sumner, Qld

Retinoid 'scaremongering' is an insult to GPs

EDITOR: First the Australasian College of Dermatologists is against GPs setting up skin cancer clinics, now it's against GPs prescribing simple drugs like retinoids ('Specialists fight GP access to acne drug', *MO*, 29 August).

What is wrong with this precious group of people? Money is there for all to share.

It is an absolute insult that the college is degrading GPs with scaremongering propaganda that GPs can't deal with contraceptions, doctor shopping, depression, lipids and abnormal LFT, and muscular skeletal pain issues. Who are the greater champions at dealing with these issues? GPs or dermatologists?

If they are so very concerned about foetal deformity and not the size of their wallet, then let's start

with a trial of GPs prescribing them to males. And hey, how about teaching GPs how to prescribe to females!

Dr Dai Tran
Parramatta, NSW

Right to choose is undemocratic

EDITOR: Is Victoria still a free democracy when health professionals are legally compelled to override their own ethical and medical judgement?

Under Victoria's new abortion Bill, many doctors would find their practices under threat because they believe there are equal obligations to protect the life and health of both mother and the unborn child she carries.

Doctors, nurses and pharmacists would have to refer for abortion if they were unwilling to advise or perform an abortion. Those of us who

hold that doing abortion is unethical also regard it as unethical to professionally cooperate in abortion by "referring to another whom the practitioner knows does not have a conscientious objection to abortion".

Nurses have an even worse problem because they would be "under a duty to assist" in a late-term abortion, if a doctor requests and claims that it is an emergency. Doctors at least can exercise their discretion, and many hold that late-term abortion is never medically necessary. Attempting live birth is a safer option if the woman's life is in danger.

Late abortion usually involves an additional procedure such as fatal injection to the child *in utero*. Nurses are not permitted to object even though doctors can.

Dr Mary Walsh
Lower Templestowe, Vic

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