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DIGITAL HEALTH

Vol. 26 No.4 | Summer 2024

a RANZCOG publication

O&G MAGAZINE

Vol. 26 No. 4 Summer 2024

Contents

The College

Digital Health

Obituaries

From the President

Dr Gillian Gibson
President

Advocacy Updates from the President, Dr Gillian Gibson

Over the past three months, we've made significant strides in the College's advocacy efforts. It has been an inspiring period of progress, and I'm pleased to share some of the key milestones and updates with you.

Private Practice Roundtable

On 14 November, the College's Private Practice Committee convened the *RANZCOG Preserving Women's Choice and the Future of Private O&G Roundtable* to address the growing challenges facing Australia's private obstetrics and gynaecology sector.

Discussions at the roundtable highlighted several key themes and urgent reforms necessary to sustain private obstetrics and gynaecology services. Participants identified the ongoing need for a systematic review of the Medicare Benefits Schedule (MBS) to identify all instances of gender bias. All parties agreed with the general consensus that the risk equalisation regulations that govern private insurance need to be reviewed to allow for better inclusion of obstetrics and gynaecology. This likely includes opening up the relevant federal legislation, and as such will not lead to an immediate solution. Participants also identified the barrier to access of having pregnancy care restricted to 'gold' level private insurance plans, accompanied by a 12-month waiting period (a period that often doesn't apply to other equivalent health needs). Participants stressed the need for steps to make these services more accessible across the product portfolio. Insurers did express openness to this change, whilst conveying the need to be supported by regulatory changes.

These themes and proposed reforms will be detailed in RANZCOG's Private Practice Report.

Rural, Regional, and Remote Workforce

RANZCOG has made significant progress on two key initiatives which will help address ongoing healthcare inequities in rural, regional and remote communities. The College will launch its new FRANZCOG Rural O&G Specialist Advanced Training Pathway (FROGS) starting in 2025. This program is tailored to equip specialists with the unique skills needed for rural practice and will embed trainees in rural communities during their final training years to encourage retention. FROGS also offers government-funded financial grants to support childcare, housing, relocation assistance, and professional development, to foster connections and improve workforce retention.

Additionally, the Obstetrics and Gynaecology Education and Training (OGET) project has continued, holding more sessions across Australia. OGET brings specialist-led training to multidisciplinary teams across 33 peripheral sites and 8 hubs, ensuring the continued delivery of high-quality care in rural, regional and remote areas. RANZCOG calls for continued government funding to sustain these two critical initiatives which help address workforce challenges in O&G.

Specialist International Medical Graduates (SIMGs)

Furthering the College's advocacy around workforce, together with the allied medical colleges of the Council of President's Medical Colleges (CMPC), RANZCOG has called for an immediate pause on the Medical Board of Australia's expedited pathways for Specialist International Medical Graduates (SIMG). The College argues that the current MBA proposal fails to address the complex workforce challenges facing obstetrics and gynaecology and may actually compound issues like resource imbalances and poor retention in underserved areas. Without a pause and redesign, the MBA's one-size-fits-all approach will not meet the unique needs of obstetrics and gynaecology. RANZCOG has committed to creating a pathway with safeguards to support SIMG O&Gs assimilating into the workforce in Australia.

Abortion Care

Abortion has become increasingly politicised in Australia over the past six months, posing a significant risk to women's reproductive freedoms. RANZCOG strongly opposed the Termination of Pregnancy (Live Births) Amendment Bill 2024 in Queensland, which did not progress out of the Committee. The College commended the Health, Environment and Agriculture Committee for recommending that the bill not proceed, recognising the risks of creating additional barriers to abortion access. RANZCOG provided evidence and testified at the public hearing of the bill, highlighting that abortion is essential healthcare and legal restrictions would do nothing but harm reproductive rights. A similar bill in South Australia was defeated in a vote in the Legislative Council, with RANZCOG's advocacy contributing to its rejection. The College will remain vigilant in its commitment to protecting access to abortion and upholding women's reproductive rights across Australia and Aotearoa New Zealand.

Launch of the 2024-2027 Strategic Plan and Advocacy Priorities

Looking ahead, RANZCOG's 2025-2027 Strategic Plan – launched in October – outlines the College's key advocacy priorities. These priorities, listed below, will guide where we focus our efforts in the coming years:

- Advancing health outcomes for Aboriginal, Torres Strait Islander women, and wāhine Māori.

- Addressing gender bias in healthcare, research, and the regulatory environment.

- Enhancing access to obstetrics and gynaecology services, particularly in rural, regional, and remote areas.

- Preventing birth trauma.

- Ensuring sexual and reproductive health rights, including access to abortion.

- Expanding access to medicines and devices crucial for women's health.

- Promoting the sustainability of both public and private obstetrics and gynaecology services.

- Tackling workforce challenges across Australia and Aotearoa New Zealand, including the availability of subspecialist care.

A Personal Thank You to Our Members

Our ongoing advocacy efforts would not be possible without the dedication and expertise of our members, trainees and consumers. Your contributions—whether through workshops, consultations, or participation in meetings—are integral to driving meaningful change in the healthcare system and improving health outcomes for women.

Sincerely,
Dr Gillian Gibson
President, RANZCOG

LEADERS IN FOCUS

Dr Talat Uppal
MBBS, FRANZCOG, DDU, FAAQHC, FACHSM

This feature sees Dr Talat Uppal in conversation with women's health leaders in a broad range of leadership positions. We hope you find this an interesting and inspiring read.

Join the conversation on Twitter

#CelebratingLeadership   @RANZCOG

Dr Amandeep Hansra
BMed (Hons), FRACGP, FACHI, ACCAM, MPH&TM, Global EMBA, GAICD, CHIA

Dr Amandeep Hansra is the Chief Clinical Adviser (Medicine) at the Australian Digital Health Agency. She is both a GP with 18 years of experience, and a leader in digital health, entrepreneurship, and investment. Dr Hansra has served as the CEO of Telstra's ReadyCare and was the inaugural Program Director for the Australian Clinical Entrepreneur Program. She co-founded the Australian Medical Angels, one of the world's largest syndicates of medical angel investors, and founded Creative Careers in Medicine, an organisation with 25,000 members.

Why did you choose to do medicine?

From a young age, I was drawn to a career that involved caring and nurturing. My mother was a nurse, so I was introduced to healthcare early on. Being a people person, I also wanted a job that allowed me to interact with people from diverse backgrounds.

Growing up in rural India for part of my childhood, I witnessed firsthand the impact of health inequity on communities. This experience sparked my early interest in public health and equity. By the time I began my medical degree, I knew I was in the right place. I enjoyed the practical elements of the course and quickly realised what a privilege it is to provide healthcare.

After graduating, during my junior doctor years, I enjoyed every specialty I encountered, which made it difficult to choose just one to pursue. Eventually, I chose General Practice because it offered a solid foundation to explore my various interests, including women's health.

What led you to pursue a career in digital health and tell us how this evolved with time?

I was fortunate to stumble into digital health through one of my roles. I didn't know much about the field at first, but I was fascinated by how technology could transform healthcare access and patient outcomes. This role opened doors to the public and private sectors, working with technology providers and funders. It gave me a broader systemic perspective on healthcare that I had been missing as a frontline clinician. With this broader view, I could identify the challenges driving ongoing health inequities in Australia.

My involvement in digital health also exposed me to the startup sector, where I developed a passion for working with entrepreneurs solving significant healthcare challenges. I especially enjoyed collaborating with clinician-entrepreneurs who had experienced problems firsthand and were turning their ideas into impactful businesses. This led me to create Australian Medical Angels, an angel syndicate investing in health tech startups.

Venturing into the funding space also highlighted the inequity in funding women entrepreneurs—not just in healthcare but across all sectors. Only 2% of venture capital funding goes to women-led startups[1], which creates a significant barrier to innovation, particularly for women's health issues. Women often develop solutions for women's health problems, but the lack of funding limits the number and success of these businesses. This funding gap directly impacts our ability to address critical health challenges.

> *What excites me about digital health is that it's an emerging but rapidly growing field.*

Beyond startups, my passion for incorporating digital health into the women's health field is driven by the potential of technology to gather better data and improve our understanding. Historically, women have been underrepresented in clinical research and trials. However, with new technology and data capture methods, we now have a chance to fill gaps in understanding how conditions affect women differently. Technology also enables us to provide more personalised care, moving away from a one-size-fits-all approach toward treatments tailored to the individual.

What excites me about digital health is that it's an emerging but rapidly growing field, providing opportunities for research, advisory work, governance, innovation, and system redesign. While having so many options is exciting, it can also be overwhelming. Balancing work that I'm passionate about with life outside of work is challenging, but I'm fortunate that my current work doesn't feel like work—it's fulfilling. I've found a great niche where I can combine digital health with my clinical role in General Practice, which keeps me connected to the medical workforce and the industry.

What advice do you have for those who may want to progress a digital health interest?

One challenge for clinicians entering digital health is the lack of a clear career path. My journey into this field has been quite creative, and I feel like I stumbled upon it. For those interested in digital health, my advice would be to start by networking. There's a vibrant community passionate about this space, and the beauty of it is the diversity of the backgrounds. You get to collaborate with people who have technical, business, project management, user design, and commercial expertise, as well as other clinicians from various specialties. The digital health community is very welcoming, and there are always people willing to help newcomers find the right opportunities.

What does the future of healthcare in Australia look like?

One of my most recent roles is Chief Clinical Advisor for the Australian Digital Health Agency. I'm passionate about this position because it allows me to work with the government on critical policies and programs to build the digital infrastructure needed for healthcare innovation. I'm also excited about the potential of artificial intelligence (AI) and machine learning in healthcare. While AI has been around for a while, its role in improving healthcare efficiency and patient care is only now gaining momentum. I believe that in the next five to ten years, our health system will look very different, with changes that will surpass those of the past decade. I look forward to a future where healthcare is more connected, offers better access and equity, and delivers personalised care to every patient.

References

1. PitchBook Report. Female Founders Received Only 2% of Total Capital in 2023. Forbes, 11 December 2023. Referenced from *https://www.forbes. com/sites/dariashunina/2023/12/11/female-founders-received-only-2-of-total-cap*

RANZCOG Historical Collection: Francis J Browne

Greg Hunter
Archivist & Historical Collections Administrator
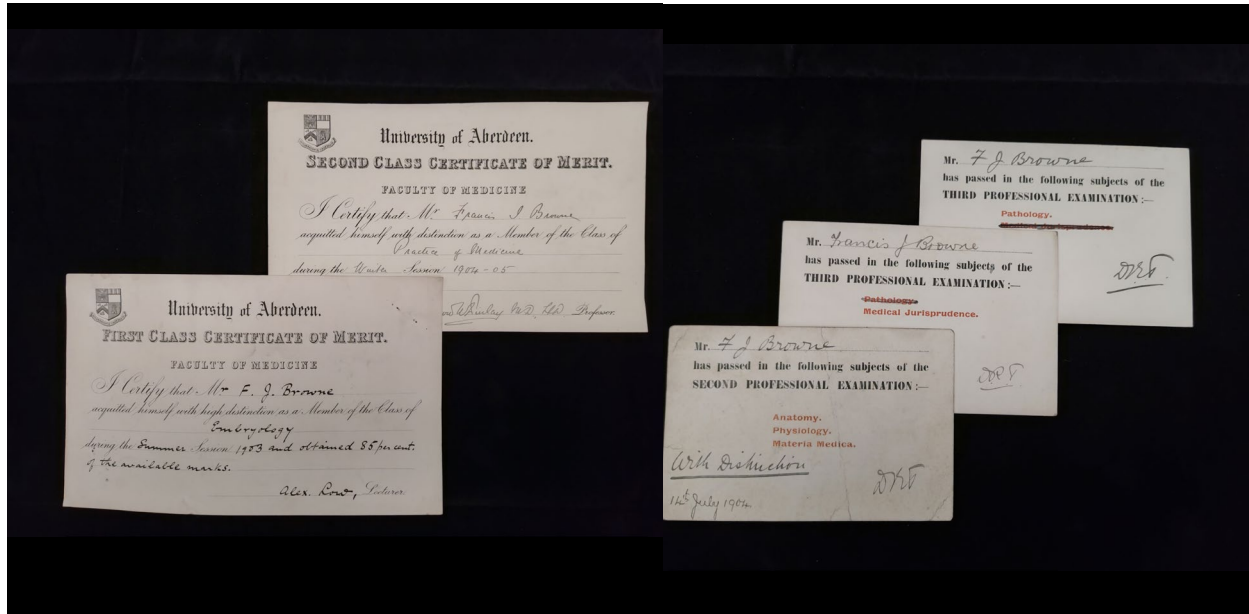
Figure 1 and 2: Certificates of Merit and Pass Cards awarded to Francis J Browne by the University of Aberdeen. Photo: Jess Bacon

Born in Ireland on October 1, 1879, Francis J Browne (known as 'FJ') was the fourth of eight children born into a farming family. Finding that farming life held little appeal for him, FJ tried joining the Irish Guards in London and worked as a railway porter before entering the University of Aberdeen to study medicine in 1901.

FJ qualified as a doctor in 1906 and immediately took a salaried post as a GP attached to a colliery (coal mine) in Abertillery, a small mining town in South Wales. He "was keen to get started in the practice of medicine as quickly as possible and intent on paying off his debts so that he could get married."[1] And get married he did, marrying his first wife, Minnie, in 1908. At this time, much of the work of a general practitioner consisted of midwifery, and due to "the rising birth rate and the custom of having babies at home,"[1] it required a lot of travel. To navigate the steep streets and hills of Abertillery, FJ acquired a pony and trap.

FJ worked in Abertillery as a GP for 13 years, until, having discovered an interest in obstetrics, he took up the speciality at the age of 39. A late starter, but also an outstanding talent, by 1926 he had been appointed as Professor of Obstetrics and Gynaecology at University College Hospital, London. In 1929, FJ Browne was one of the Foundation Fellows of the British College of Obstetricians and Gynaecologists.
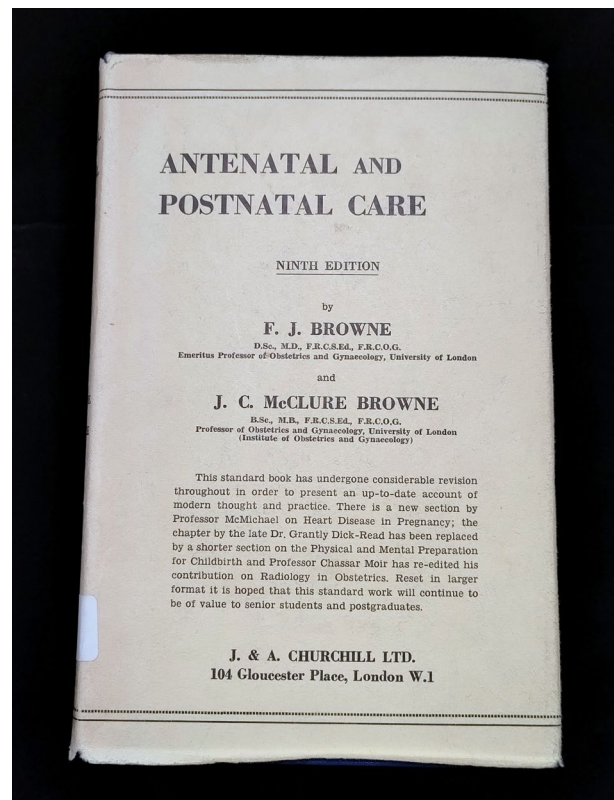
Figure 3: Antenatal and Postnatal Care by F.J. Browne and J.C. McLure Browne, Ninth Edition, 1960. Photo: Jess Bacon

Figure 4: Collection of memorabilia relating to Francis J Browne. Photo: Jess Bacon and Amber Spiteri

FJ was renowned throughout his career as an exceptional teacher and inspirational leader. In 1935, FJ published the first edition of his landmark text *Antenatal and Postnatal Care.* This was the first book of its kind, focusing on the care of women during pregnancy rather than on labour and delivery. Herbert Reiss notes that the book's impact "was instant and enormous," becoming "essential reading for many generations of medical students and residents."[1] Subsequent editions of Antenatal and Postnatal Care were released throughout FJ's lifetime, with the 9th and final edition released in 1960 (co-edited with his son John McClure Browne).

In 1950, at the age of 71, FJ travelled to Australia and New Zealand on a travelling scholarship. Having lost his wife Minnie to carcinoma in 1948, FJ was accompanied on the long trip by his daughter, Eileen. While, in Sydney, he met Grace Cuthbert, a well-known local obstetrician and the director of Maternal and Baby Welfare in the Department of Health in New South Wales. Their relationship blossomed, and FJ remarried, eventually moving to Australia and living out his later years with Grace in New South Wales. In recognition of his significant contribution to the specialty, FJ Browne was awarded the Blair-Bell Medal in 1960.

Following FJ's passing, the FJ Browne Medal was presented by the College to outstanding achievers for a period of 25 years. First presented in 1964, and initially awarded for the most outstanding scientific contribution at an Australian Congress, it was subsequently awarded to the most successful candidate in College examinations between 1971 and 1999.

In 1991, Grace Cuthbert Browne donated FJ Browne's personal papers to the College. This extraordinary collection includes documentation from his university days, diaries, personal and professional correspondence, and a small selection of objects, including medals and badges, a lucky cat charm given to FJ during his time in Wales, an academic cape, and items relating to his military service during World War I.

In his biography of FJ Browne, Herbert Reiss lauds FJ as "The foremost obstetrician of his day and the founder of modern antenatal care."[1] It is not difficult to see why he is held in such high regard. The College is honoured to hold such a fascinating collection of objects relating to such a significant figure in the field of obstetrics.

A range of objects relating to FJ Browne are currently on display at Djeembana College Place in Naarm (Melbourne). Members and trainees are invited to visit the College to view these fascinating insights into obstetrics history.

Scan the QR to see more of RANZCOG's Historical Collection

References

1.   Reiss H. Francis J Browne: A Biography. Cambridge University Press; 2013.

Volunteering in Papua New Guinea: An O&G Trainee's Experience

Dr Praneel Kumar
BMedSc, MD

The mainlands of Australia and Papua New Guinea are separated by only 150 kilometres, but the experiences of patients, families and healthcare workers are at times worlds apart.

As an obstetrics and gynaecology registrar, I joined a team of local doctors and midwives at Port Moresby General Hospital (PMGH) on a volunteer assignment with the Australian Volunteers Program, an Australian Government-funded initiative that supports global volunteering and locally led change. At the country's largest hospital, this small group of staff managed up to 50 deliveries a day and 15,000 births every year. The focus of the assignment was on capacity strengthening within the maternity department, which sees high patient loads in a low-resource setting.

Capacity strengthening activities primarily centred on education, including leading journal clubs and tutorials, bedside teaching for medical students and providing research support to local registrars. Clinical work rotating through the birthing unit, theatres and antenatal wards provided an opportunity to practise my *Tok Pisin* language skills—much to the amusement of staff and patients.

During clinical work, the pressures faced by healthcare workers and facilities became evident. Local consultants and registrars were generous in sharing their skills with breech vaginal deliveries and complex open gynaecological surgeries, despite significant challenges. A small number of doctors attended to well over 100 women seeking care in the hospital's antenatal and gynaecology clinics each day. Midwives often tended to women delivering on the waiting room floor due to a shortage of beds.

Port Moresby in Papua New Guinea
Photo credit: Harjono Djoyobisono - Australian Volunteers Program

Dr Praneel Kumar with Port Moresby General Hospital's O&G team, Port Moresby, PNG

> ❝ *The fortitude and resilience of the healthcare workers in this environment was inspiring.* ❞

Poverty, combined with systemic challenges, all too often led to stillbirths of unclear cause, as well as premature deaths of young pregnant women with complex medical comorbidities and middle-aged women from preventable cancers.

The fortitude and resilience of the healthcare workers in this environment was inspiring. The maternity department had a strong culture of quality improvement, with regular consultant teaching for registrars, daily tutorials for medical students and monthly maternal and perinatal mortality reviews.

There was an emphasis on active management of labour with diligent use of partograms and clinical protocols. The local registrars could command any emergency with proficiency, despite limitations in resources.

The dedication and skills of healthcare workers highlighted the contextual challenges they faced. Limited primary care and prevention services led to many unplanned pregnancies in severely anaemic women. A growing urban population in Port Moresby placed increased demand on services, leading to power cuts, housing shortages and unemployment. These social determinants of health further contributed to poor health outcomes.

Given the commitment of the Australian Volunteers Program to sustainable development, I would encourage any registrar who has the opportunity, to undertake one of their assignments as part of their training. This assignment has facilitated my engagement with public health practice in a low-resource setting, which has been a fulfilling experience. It has underscored the importance of addressing the social determinants of health through cross-sector collaboration with education, employment and housing to implement durable change to maternal health outcomes.

Stepping outside my comfort zone has been an invaluable training experience, helping me build lasting relationships with local clinicians in PNG. These relationships over time, can lead to further capacity-building partnerships, bridging the divide in health inequity between our different worlds.

I would like to acknowledge the Australian Volunteers Program staff in Australia and PNG, RANZCOG Women's Health Foundation and Global Health Committee, Professor Glen Mola, and all the local healthcare staff, students and patients in PMGH for their support and generosity.

A fleet of ambulances owned by St John Ambulance PNG, Port Moresby, PNG
Photo credit: Harjono Djoyobisono - Australian Volunteers Program

Updates from our Research and Policy Team

Prof Cindy Farquhar
MB ChB, MD, FRCOG, FRANZCOG,
CREI, MPH, MNZM, PMMRC

It has been a busy year for Research and Policy, with the publication of five key new clinical guidelines. These are:

- Pre-pregnancy Counselling (C-Obs 3a)

- Contraception (C-Gyn 3)

- Screening and Diagnosis of Fetal Structural Anomalies and Chromosome Conditions (C-Obs 35)

- Substance Use in Pregnancy (C-Obs 53)

- Early Pregnancy Screening and Prevention of Preterm Preeclampsia and Related Complications (C-Obs 61)

Research and Policy and the Women's Health Committee would like to thank all Guideline Development Group Chairs and members for their valued work and contributions. All new guidelines can be accessed on the College website.

Looking ahead to 2025

The Team have an exciting program of work planned for 2025, including but not limited to:

- Development of a new evidence-based RANZCOG guideline on Menopause (including genitourinary syndrome and premature ovarian syndrome).

- Development of a new and Robotic Surgery in Gynaecology (including urogynaecology and gynae-oncology).

- Updates to RANZCOG's portfolio of Patient Information Pamphlets.

Digital Access and Improvements

In keeping with the theme of this issue, Research and Policy Team acknowledges that timely and easy access to clinical guidance via digital platforms is important. Currently, RANZCOG's evidence-based clinical guidance statements are accessible online, and work is ongoing to improve search functions and layout to ensure you can access information when its needed.

Get involved in 2025!

Opportunities to participate in guideline development and provide feedback on draft work are advertised in *Connect* - please keep an eye out throughout 2025. RANZCOG trainees with a keen interest in evidence-based medicine are also encouraged to the new Evidence Based Medicine Special Interest Module. This will be available from February 2025. Please contact Professor Farquhar via womenshealth@ranzcog.edu.au for further information.

Thank you to College members for your support and engagement with the Research and Policy Team in 2024.

Contact us

To contact the Research and Policy Team, or to provide feedback about guidelines or Patient Information Pamphlets, please contact: womenshealth@ranzcog.edu.au

Editorial

Dr Talat Uppal
MBBS, FRANZCOG, DDU, FAAQHC, FACHSM

The Digital Evolution of Healthcare

The integration of technology into healthcare is no longer a vision for the future, it is now a reality that is actively shaping the way we practice, connect, and innovate today. From artificial intelligence to telehealth, this issue of O&G Magazine—Digital Health—explores how technology is transforming many aspects of women's health practice.

At the forefront of this transformation are tools like AI Scribe, which is designed to streamline documentation and free up clinicians so they can spend more time on patient care. We delve into the promise of AI-driven solutions, including insights from an AI PhD candidate, who explores the intersection of research and practice in advancing personalised medicine and diagnostics.

Another key focus is how technology is breaking down barriers to healthcare access. In this issue, we profile the establishment of a remote ultrasound service, which demonstrates how digital innovation can bring vital services to rural and underserved communities, helping overcome some of the geographical barriers that persist in women's health.

Australia's world-leading cervical screening program, combined with the HPV vaccination initiative, puts us in an enviable position to potentially be the first country to eliminate cervical cancer as a public health concern. This effort is underpinned by the National Cancer Screening Register (NCSR), which maintains a single electronic record for every participant in cervical and bowel screening programs. We are currently exploring strategies to integrate the NCSR with various practice management software systems, ensuring this vital information is readily accessible to gynaecologists.

As healthcare becomes increasingly digitised, maintaining the human connection remains paramount. In our piece on the *Highs and Lows of Being an Doctor Online*, we explore the challenges clinicians face in maintaining empathy and quality of care in virtual environments. Similarly, we highlight the experiences of healthcare professionals engaging with digital platforms, including an article titled *So You Want to Be a Social Media Influencer?*, which offers a practical look at how doctors are navigating the complexities of social media to share knowledge and build awareness for medical conditions often riddled with taboo and stigma.

This issue also shines a spotlight on the Pregnancy Uncut Podcast —a refreshing and raw exploration of the less-discussed aspects of pregnancy and motherhood. This aligns with our ongoing mission to amplify diverse voices and perspectives within obstetrics and gynaecology.

Adding to the breadth of content, we include a book review that delves into the nuances of healthcare in a digital age and a Global Health feature, examining the implications of digital tools in improving maternal health outcomes worldwide.

As we navigate this new digital frontier, we must remember that technology is not a replacement for compassion, clinical acumen, or patient-centred care. Instead, it is a powerful tool designed to support and enhance these foundations. Whether you are a seasoned specialist or a new trainee, the insights and reflections in this issue aim to inspire and inform your practice in this exciting era of digital health.

RANZCOG is proud to work with Sparked AU[1], alongside leading colleges, as part of a community committed to driving the adoption of national FHIR standards for healthcare information exchange. This collaboration ensures women's health remains a key focus in shaping the future of digital health.

We hope you enjoy this edition of *O&G Magazine* and find it both thought-provoking and practical as we collectively embrace the opportunities and challenges of digital transformation.

References

1.   For more information about Sparked, Australia's first FHIR accelerator, visit the Australian e-Health Research Centre's page: https://aehrc.csiro.au/home/interoperability/sparked-australias-first-fhir-accelerator/.

The Power of Podcasting: Reclaiming the Narrative in the Digital Age

Dr Alex Umbers
BSc (Honours), PhD, MBBS, Advanced Diploma
RANZCOG, RACGP Registrar Southwest Victoria

Dr Kara Thompson
MBBS, BmedSci, FRANZCOG, Obstetrician Berth Geelong

Reclaiming the Narrative in the Digital Age

The digital age has ushered in an era of unprecedented access to information, transforming the way people seek knowledge and make decisions about their health. While this explosion of information holds immense potential, it also presents challenges, particularly in maternity care, where informed decision-making relies on quality information. The growth of social media and online platforms has given rise to a proliferation of unqualified influencers, often disseminating misinformation and promoting potentially harmful practices. In this environment, where evidence-based information competes with unsubstantiated clickbait claims, the voices of qualified healthcare professionals risk being diminished or drowned out.

Our Aim: Empowering Consumers and Professionals Through Shared Stories

Pregnancy Uncut was developed during a night shift on the birth suite at a regional hospital, sharing stories of our own personal fertility and pregnancy struggles. We wondered, "why are these stories so hidden? If we as maternity professionals, felt shame and stigma about sharing our experiences, what must the women and families we look after be feeling?". From this honest conversation in the early hours of the morning, *Pregnancy Uncut* was born. As patients, these are the conversations we wished we had heard. As doctors, these are the conversations we wanted to share.

We had three core objectives:

- **Amplifying consumer voices:** To provide a platform for individuals to share diverse experiences of pregnancy and birth, including those often marginalised or silenced. By centring these narratives, we aimed to foster community, reduce stigma, and validate the realities of pregnancy and birth.

- **Promoting evidence-based practice:** To counter misinformation by offering accurate information grounded in research and clinical expertise. We sought to bridge the gap between academic knowledge and lived experiences, ensuring listeners understand both the "why" and the "how" of maternity care.

- **Fostering collaboration and understanding:** To create a space for dialogue and mutual learning between consumers and healthcare professionals and between multidisciplinary care providers.

Our Methods: Weaving Birth Stories with Expert Commentary

Each episode of *Pregnancy Uncut* features a guest sharing their personal journey through a specific pregnancy or birth-related challenge. These raw and emotional narratives provide listeners with invaluable insights into lived realities of conditions such as pregnancy loss, birth trauma, and perinatal mental health.

To demonstrate the power of vulnerability, co-host Dr Alex Umbers shared her own personal experience with recurrent miscarriage and pregnancy loss. This resonated deeply with the audience, demonstrating that healthcare professionals are not immune from these challenges. By openly sharing her story, Alex created a space for patients to feel comfortable discussing their own vulnerabilities and seeking support.

Interwoven with these personal stories are insights from multi-disciplinary health professionals, including obstetricians, midwives, psychologists, physiotherapists and social workers. These experts offer evidence-based information, practical advice, and compassionate support, contextualising the lived experiences and providing listeners with a comprehensive understanding of the topic.

Results: Reaching a Wide Audience and Making a Tangible Impact

Over almost four years and six seasons, *Pregnancy Uncut* has become a trusted resource for expectant parents and healthcare professionals. The podcast has achieved significant reach:

- **Diverse range of topics:** With 60 episodes, the podcast covers infertility, miscarriage, stillbirth, complicated twin pregnancies, obstetric emergencies, and topics like postpartum psychosis, congenital cytomegalovirus (CMV), cancer in pregnancy, and uterine transplantation. No topic is off-limits. To ensure diverse representation, we have featured voices from remote and regional areas, Indigenous Australians, queer and gender-diverse people, and those embarking on solo parenthood and surrogacy.

- **Guests include:** Positive birth advocates, Amy Dawes, (CEO Australasian Birth Trauma Association) and influential author and doula, Gabrielle Nancarrow. We have also been privileged to feature the voices of our colleagues who have bravely shared their stories, including Dr Pip Costley, Dr Carmen Brown, Professor Caroline de Costa, and RANZCOG Vice President, Dr Nisha Khot. By sharing their deeply personal stories, these leaders in women's health have shown our audience that specialist doctors can also be vulnerable and struggle to navigate difficult pregnancy and birth experiences.

- **Growing listenership:** The podcast has garnered over 80,000 downloads, demonstrating a strong demand for accessible and relatable information on these important issues.

- **National recognition:** The podcast has been profiled in national media outlets in both print and radio, further amplifying the podcast's message and contributing to broader conversations about maternity care in Australia.

Discussion: Transforming Perspectives and Inspiring Change

Pregnancy Uncut has driven meaningful change by showing our diverse audience how authentic storytelling and open dialogue can improve maternity care.

For our listeners: The podcast has become a source of validation and empowerment. By hearing others' stories, listeners have reported feeling less alone and more equipped to advocate for their needs. The podcast also provides valuable information, empowering consumers to make informed care decisions.

For healthcare professionals: *Pregnancy Uncut* offers a unique opportunity for professional development and personal reflection. By listening to the unfiltered experiences of consumers, clinicians gain invaluable insights into the emotional, social, and psychological impact of various pregnancy and birth complications that often endure for years beyond when we wave goodbye to them after their hospital experience. This fosters empathy and understanding, leading to more compassionate and patient-centred care. Furthermore, the podcast encourages reflection on communication styles, the use of inclusive language, and clinical practices prompting healthcare professionals to consider how they can better support their patients throughout their journey. It is often said that it takes a village to raise a child, and we would add that it takes a village of care providers to support a mother.

By sharing expertise of various disciplines and strengths in maternity care, we have fostered a mutual appreciation of the value in multidisciplinary collaborative care.

For us as producers: This project has been profoundly transformative. By flipping the intrinsic power imbalance between patients and care providers, it has deepened our understanding of the consumer experience and reinforced our commitment to compassionate, holistic care. At times, it has shed light on our own unconscious biases and reminded us that in maternity care, there is so much more to our jobs than making the right clinical call. By immersing ourselves in the stories of our guests, we have gained a renewed appreciation for the resilience, strength, and vulnerability of those navigating the complexities of pregnancy and birth, and how each of our encounters can shape these experiences. This has undoubtedly enriched our clinical practice and strengthened our connection with the individuals we serve.

Ultimately, *Pregnancy Uncut* demonstrates the power of podcasting to bridge the gap between lived experience and evidence-based practice. By fostering open dialogue and amplifying diverse voices, we have created a platform that empowers consumers, educates and inspires healthcare professionals, and contributes to a more informed, compassionate collaborative maternity care system.

Conclusion: A Trusted Voice in the National Conversation

In an era of misinformation, *Pregnancy Uncut* aims to be a trusted voice in maternity care. By harnessing the power of podcasting, we have created a platform that amplifies consumer voices, promotes evidence-based practice, and fosters collaboration between consumers and healthcare professionals. We remain committed to providing a safe and informative space where individuals can share their stories, seek support, and find connection, contributing to a more compassionate, informed, and equitable maternity care system for all.

Artificial Intelligence: Language or Understanding

Dr Glenn Blanchette
MB, ChB, FRANZCOG, BSc & PGDip (Distinction) in Computer Science, PhD Artificial Intelligence

The motivation for this article comes from an outburst of mine at a RANZCOG Multiple Choice Question examination (MCQ) workshop regarding the use of ChatGPT for setting exam questions. I felt uniquely justified in my criticism, as I had returned to university in my fifties to obtain a computer science degree and a PhD in artificial intelligence. My research papers relate specifically to cognition, exploring knowledge representation and inference in artificial neural networks[1,2,3].

Unfortunately, there is no useful definition of intelligence, artificial or otherwise, and no practical test to detect it. Most of the information 'we know' about intelligence is assumed from human cognition—we know that humans have cognition because we are sentient.

In the 21st century, literature in artificial intelligence has exploded, its rate of publication probably outstrips all of medicine. I have therefore limited this article to a single theme: presenting the complementary nature of language and understanding (knowledge representation and inference) as a guide to changes in the domain of artificial intelligence. I propose that although language is a component in the expression of intelligence, its presence alone is not sufficient to guarantee intelligence.

A historical perspective

It is necessary to present this theme from a historical perspective. The 'new' science of computing arose in the 20th century amid a revolution of doubt that overturned many scientific beliefs: in biology, Darwin's 'On the Origin of Species' (1859); in physics, Einstein's 'Theories of Relativity' (1905, 1915); and in mathematics, after two and a half thousand years of certainty, Gödel's 'Incompleteness Theorems' (1930s) challenged the very philosophy of logical proof. These theorems demonstrated that even within a closed mathematical system, there are truths that cannot be proven.

Alan Turing's universal computing machine (1940s) was engineered around a language—a grammar with defined syntax—and the algorithms required for performing specific tasks[a,b]. This type of machine is intuitively understood by today's society. Coded instructions and data from a human programmer are input into the machine, whose central processor follows the algorithm analysing the data and produces an output. The machine would check that the language was syntactically correct; however, it could not check the meaning or correctness of the algorithm. The program might fail to find a solution (the Halting Problem). Moreover, entire categories of tasks were identified where no exact solutions were possible (NP-hard problems). Consequently, doubt was incorporated into the very foundation of the new computing dogma: the "Church-Turing Hypothesis". Turing's informal test for intelligence sought only to distinguish an artificial response based on language, it avoided any implicit definition of understanding. At the time, semantic understanding was thought to be beyond the reach of computing.

The concept of a linguistic machine and its algorithmic task has continued to be hugely pervasive in our society. Within the computing domain however, this symbolically coded model of a computer was gradually abandoned. Barely 50 years after its inception, the new science of computing began to turn away from discrete engineering, refusing to accept that practical solutions to NP-hard tasks were unattainable. Instead, solutions were sought through approximation methods inspired by biology[c].

Artificial neural networks imitate human neurobiology. They are characterised by distributed processing involving multiple simple, locally connected processing units—the equivalent of human neurons. The networks are not built to rely on individual nodes but on the collective of internodal connections. These networks are not symbolically programmed to perform a task; they are constructed to learn. The networks are given a task and learn its solution. Their ability to represent knowledge lies in the strength (pattern) of their internodal connection weights. This concept of learning and knowledge representation, derived from local synaptic information, was first proposed by Hebb in the 1950s[4] (Hebbian Learning), a concept familiar to all medical students.

Personally, it is an enduringly novel realisation that a neural network, which can learn and almost certainly has the ability to understand and reason, can be virtually programmed within the shell of Turing's symbolic machine—a machine initially believed to be inadequate for such higher purposes. The concept of the neural network is now widely accepted in computing philosophy and currently many personal computers are being marketed without a traditional central processor. Their core is a 'neural chip'.

Knowledge acquisition

Today there are many different kinds of learning machines, not just neural networks. In general, these machines implement the well-researched and mathematically proven methods of statistical approximation[5]. Although, as yet, the tasks given to these machines have been very discrete and specific, they have also been complex. The results have been extraordinarily successful, particularly in any variety of classification or predictive tasks—including medical diagnosis, interpretation of radiological images, voice recognition, facial recognition, autonomous driving, and autonomous flight.

It might seem like a fairy tale, but on the shores of Lake Geneva in Switzerland there is an evolutionary robotics centre. Here, small insect-like robots (with dual wing motors, forward-facing visual sensors, and a tiny neural network of less than 200 nodes) have been genetically evolved—not programmed, not taught, but virtually bred—to fly. They can take off, land, and navigate three-dimensional environments without remote control. Their chromosomes are expressions of their internodal weights. Moreover, these flying robotic insects can communicate with each other and perform tasks cooperatively as a swarm[6].

How do machines learn? I would need another 2,000 pages to describe all the approaches available[d,e]. In general, these machines learn like a human child, by trial and error. Some degree of pre-programming or genetic wiring is often included in the solution to any problem. A machine builds on this foundation, learning in successive attempts to find a solution. Similar to (but far faster than) a human child, the machine learns from failure.

Considering the most common approach of error-directed learning: the machine calculates a delta—the difference between the expected, desired outcome and the actual outcome for this particular attempt at the solution. This error delta is appropriately distributed across the network weights in various ways: by backpropagation in feed-forward networks or by two-phase comparison of cross-firing statistics in recurrent networks. In both cases, the most common formula governing the end local weight adaptation is a compromise between current knowledge and past experience:

$$\Delta Wt = \eta(\Delta Error^{Current}) + \mu(\Delta Wt^{Past})$$

Here, typically, the response to the current information is depreciated (learning rate: $\eta \sim 0.2$) in exchange for past experience (momentum: $\mu \sim 0.8$). An approach medical researchers should note when criticising elder clinicians for 'inertia'. Momentum (inertia) is a very desirable characteristic. It protects any (human) machine from in-appropriate oscillations in learning and helps it escape 'potholes' in the problem surface.

The threshold of intelligence

Utilising biological methods, computing science is approaching the threshold of true machine intelligence: a reasoning machine that can generalise its thoughts or solutions to a variety of tasks. This is a concern expressed by Geoffrey Hinton, a pioneer in artificial intelligence.

Hinton's Boltzmann machine is a recurrent network, currently the most biologically plausible mechanism for human cognition[1]. It consolidates its memory during batched resting phases (the equivalent of sleep). It adjusts its internodal weights (memory) using synaptically local Hebbian information[1]. The Boltzmann machine has been modified to form the basis of much larger networks (deep learning), which are at the frontier of current research.

Where is the evidence for any current expression of intelligence? I would like to return to the event that initiated my rant at the RANZCOG MCQ workshop. Let's look at two current candidates for artificial intelligence to illustrate the complementary nature of language and understanding (knowledge representation and inference).

1. Language:

There are a host of applications currently catching the public imagination that could be viewed as form of machine plagiarism. These applications create 'new' data files from existing sources of text, images, audio and programming code on the web. Whilst I have no proprietary knowledge of ChatGPT, it must rely on two main components: the web as the largest data repository in existence, combined with the speed of an online search engine. Even computer science students are taught to write such a program—a piece of code that can search and index terabytes of data in a second. The speed of modern computing machines is magical. Imagine a human reader finishing all the literary works of recorded human history in a minute. But is this intelligence? It may seem expedient to delegate writing exam questions to a machine that has libraries of information at its fingertips; however, the veracity of most of that data is uncertain. Moreover, ChatGPT is little more than a 'typist' and currently demonstrates no understanding of the subject beyond linguistic association.

2. Understanding:

By contrast, I would like to present the results of a philosophically elegant experiment. Frank et al.[7] examined language comprehension in small, recurrent neural networks similar to the Boltzmann machine. They provided their machines with a language necessary to learn a tiny "micro-world". The micro-world contained a few games (chess, hide and seek, soccer, a jigsaw puzzle, a toy) with various descriptors (game type, number of players, outcomes, playing styles), played by three children (name, gender) in four different places. In total, a lexicon of just 40 words. The machines were trained on more than 13,000 sentences in this language. Then they were given a test sentence and expected to output the correct state of the current micro-world, thereby demonstrating a knowledge representation. In a series of systematically graduated scenarios, Frank and his team degraded the language information provided to these machines for training but continued to test them against the full language including all the missing nouns and descriptors. This forced the machines to form inferences about the state of the micro-world based on information they had never seen before. Remarkably, even in the most deprived scenario, these machines maintained their knowledge representation and chose correct inferences in the face of uncertainty[7]. This may be a small example, but computer solutions can easily be scaled.

In contrast to the 'magical' output of ChatGPT, the results of Frank's experiment may seem trivial. However, they are profound. Frank et al. did not program their machines in the fashion of Turing's linguistic machine, nor were their machines just taught a language. Even in the absence of a fully functional language, they were still able to learn—to form a systematic representation of their micro-world. They learned enough to correctly reconstruct the information of which they were deprived. Absolute proof of artificial intelligence will probably never be possible, a victim of Gödel's theorems of incompleteness. Frank's experiment is the best evidence we might ever have, until one day the development of artificial intelligence unwittingly crosses the unknown threshold to sentience.

Post-script:

Sentience is a topic on which the domain of artificial intelligence is uncharacteristically silent. Researchers have no idea what constitutes the threshold or nature of a sentient machine. Presumably, such a machine would have the ability to adapt[3]—to intentionally change the strength (pattern) of its own internodal network weights, nullifying any software 'kill-switch'. As parents, most of us realise how complex and fragile it is to teach ethics, morals, compassion, beneficence... In the context of artificial intelligence, no effort is being made to examine such learning.

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The National Cancer Screening Register: Supporting Cervical Screening Through Digital Innovation

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In supporting Australia's National Cervical Screening Program (NCSP), the National Cancer Screening Register (NCSR) plays a crucial role in facilitating participant and healthcare provider engagement and providing comprehensive data to inform policy development and support program quality.

Launched in 2017, the Australian Government's key objective in setting up the NCSR was to facilitate the transition from a state-based cytology test (the pap test) every two years to the NCSP's five-yearly HPV test (the cervical screening test).

A significant data migration project saw the eight already existing state and territory cervical screening registers transferred to the NCSR, forming a single national record for each participant doing cervical screening under the NCSP.

This merge of state and territory participant data ensured full screening histories (i.e. before 2017) are available for participants. Having a national record also helps assist with appropriate testing and/or follow up if participants move between jurisdictions.

Under the NCSR Act 2016[3], the NCSR is formally called a 'register', however, it is more than a data source for reporting. The NCSR is a complex digital platform integrated across different healthcare systems, and is designed to support the end-to-end processes of the NCSP by:

- Facilitating digital screening related interactions by participants and healthcare providers (i.e. general practitioners, gynaecologists, colposcopists, nurses, and pathologists).

- Streamlining the process for engaging with cancer screening.

- Providing screening reminders and a safety net by following up participants with abnormal screening results, and their healthcare providers.

Generating high quality data to inform:
- Program and public health policies.
- Program quality and safety.
- Program clinical guidelines.

The NCSR houses one overarching record for each individual participating in any of the national cervical, bowel, or (from July 2025) lung cancer screening programs.

Using Medicare records, the NCSR can identify eligible people and send them:

- An invitation when they should begin screening (i.e. when they reach eligibility age).

- Invitations when due to screen.

- Reminders when overdue for screening.

- Follow-up notifications and reminders for individuals with abnormal results.

Correspondence issued to screening participants can be sent by SMS, email, and postal mail, depending on the participant's preference.

The NCSR holds accurate and complete screening information from all pathology laboratories around Australia, as well as histopathology results from cervical biopsies.

The NCSR also records Medicare Benefits Schedule (MBS) data for diagnostic procedures relevant to screening including colposcopy, colonoscopy and cervical biopsies, as well as relevant treatment procedures.

When clinicians access a patient's record in the NCSR they can view their full and complete screening history, from when they first started screening in Australia. This history is invaluable for clinical management, particularly for encouraging uptake in under-screened and never screened patients.

Colposcopists are required to submit data to the NCSR on colposcopies performed, as well as the participant's treatment information. This treatment information is important for compiling a complete screening history and for informing further clinical management, particularly where participants have moved or have had a prior cervical abnormality, for example adenocarcinoma in situ (AIS). Documenting colposcopy and treatment information is also critical for monitoring and analysis of NCSP quality indicators, such as colposcopy wait times.

The NCSR provides digital channels to submit colposcopy forms. Digital submission is strongly encouraged as an alternative to paper/fax and can be done via the channels listed below.

How do the NCSR's digital channels benefit healthcare providers, including colposcopists?

The NCSR offers a range of functions to allow clinicians to:

- **Access patient screening information:** Complete and accurate screening histories can be viewed for each patient.

- **View alerts:** Alerts aligned with Clinical Guidelines provide functions that show when a patient is due or overdue for screening. These alerts support clinicians to recognise if the patient has special circumstances, for example if they have a significant abnormality or clinical circumstance (e.g. Diethylstilbestrol [DES] exposure). There are also alerts to show that a follow-up test (for example, a test of cure following a high-grade screening abnormality) has been completed or is in progress.

- **View and submit forms:** Including colposcopy forms for quality assurance and informing patient management.

- **Update patient contact and demographic details:** Accurate information is important for ensuring the NCSR has the correct details for inviting, reminding and following up participants.

- **View NCSP-related correspondence:** Stay updated with program communications and tracking patient's screening journey.

- **Nominate providers and personal representatives:** Assign a healthcare provider or personal representative to ensure comprehensive patient care and assist with clinic workflows.

How do I access and submit information to the NCSR? Integration with Primary Care and Specialist Systems

The NCSR is integrated with major clinical software platforms widely used in primary care, such as Best Practice, MedicalDirector, and Communicare. It's estimated that these systems collectively support approximately 80% of primary healthcare clinics in Australia. This integration allows healthcare providers to access real-time cervical screening information directly through their practice management software.

In May 2023, the NCSR integrated into specialist software, Gynaecology Plus, which is used by over 700 gynaecologists and colposcopy specialists across Australasia. This integration allows specialists to submit data, update patient histories, and communicate with other healthcare providers.

"Integration of our latest version of Gynaecology Plus with the NCSR marks an important step towards building effective women's health software", stated Malcolm Briggs, CEO of Solutions Plus.

By integrating with both primary care and specialist clinical software platforms, the NCSR can help enhance clinical safety, streamline workflows, and reduce administrative burdens – giving healthcare providers more time to focus on patient care.

The Healthcare Provider Portal: Supporting Broader Access

For healthcare providers who do not use integrated clinical software, the NCSR offers an alternative through the NCSR Healthcare Provider Portal (Portal). This secure portal, accessed via PRODA, allows providers to view patient screening data, submit clinical forms, and update demographic information.

Importantly, healthcare providers can delegate Portal access to authorised staff so they can also check patient screening histories. This can assist in streamlining workflows in colposcopy clinics and laboratories. For example, delegates can obtain a patient's screening history prior to an antenatal clinic visit, ensuring that under screened patients are identified and offered the opportunity to screen. This is particularly beneficial for healthcare professionals who may not have a Medicare provider number, such as nurses who are trained in and perform screening.

John Lee, Head of Engagement and Communications NCSR, highlights that the Portal and software integrations are "...helping create a more efficient process for providers, meaning better outcomes for their patients."

The introduction of these digital options has significantly reduced the need for paper-based processes. Over 91% of cervical screening histories are now accessed online, with faxed requests dropping by 94%.

How is the NCSR supporting self-collection for HPV testing?

The option to self-collect a Cervical Screening Test has emerged as a powerful tool to address inequities in screening rates and is potentially game-changing in Australia's goal of eliminating cervical cancer by 2035.

The self-collection option provides individuals the choice to do their own test by collecting a vaginal sample using a simple swab. Self-collection offers autonomy, privacy, convenience, and a culturally sensitive alternative to a speculum examination. A pilot showed 85% of people who previously declined a doctor-collected test with a speculum were willing to take a self-collected test when it was offered.

As of June 2024, almost 34% of all cervical screening tests were done by self-collection[2] (a significant increase from 1% in June 2022 before the option was universally available for all screeners). Further statistics on the Program can be found at the Australian Institute of Health and Welfare's National Cervical Screening Program monitoring report 2023[3] and on the National Cervical Screening Program webpage[4].

The NCSR assists healthcare providers to offer self-collection by identifying patients who are under-screened. The NCSR also sends alerts and reminders for patients who have had a self-collected test and require specific follow-up.

As the NCSR has matured, a range of functions have been added to support clinicians in providing cervical screening and improving outcomes for participants. More than 3,500 practices have integrated their clinical software with the NCSR, and more than 22,000 healthcare providers have active registrations for the Healthcare Provider Portal.

If you would like to realise the benefits of linkage to the NCSR for your practice and your patients, we encourage you to visit NCSR.gov.au/register-access or call the NCSR on 1800 627 701.

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A Medical Student's Perspective: The Birth of an OBGYN

Emily Light
Medical Student

Emily Light is a fourth-year student at the University of Otago, Dunedin School of Medicine. She is passionate about improving women's health and is the Aotearoa New Zealand Sponsorship Officer for the Prevocational Obstetrics & Gynaecology Society. Emily undertook a Summer Research Studentship with Dr Celia Devenish to investigate the incidence of placental and umbilical cord insertion anomalies and their association with perinatal adverse outcomes in Otago, Aotearoa New Zealand.

I am so grateful to have had the opportunity to research women's health this summer. I undertook a retrospective cohort study on the incidence and perinatal adverse outcomes of placenta and umbilical cord insertion anomalies detected on a routine 20-week ultrasound scan in Otago. International research has shown there is an association between placental and cord insertion anomalies and adverse outcomes for the mother and fetus. However, to our knowledge, this was the first study in Aotearoa New Zealand to investigate this topic. We were motivated to undertake this research given that the Referral Guidelines for Consultation with Obstetric and Related Medical Services in New Zealand currently only include velamentous cord insertion.
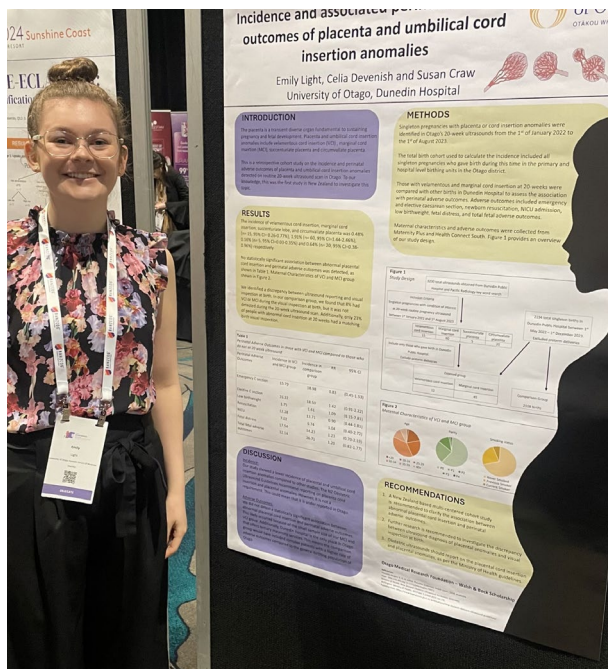
This research has taught me many important lessons about the research process and the technical skills required. I strongly believe that teamwork and mentorship are fundamental to successful research. I had an amazing opportunity to blend both the academic side of research with my first clinical experience in obstetrics and gynaecology.

The first time scrubbing into a caesarean section, the first time you see someone realise that they are a parent, the first time you hold a newborn baby - your routine practices as an obstetrician-gynaecologist are life-changing and fundamental milestones in the development of a doctor.

We have an incredible privilege as health professionals in that we are trusted to help women when they feel most vulnerable. What I found most touching during this attachment was how, even in tragedy, we could create beauty. I followed a woman's journey from learning that her baby had Trisomy 18 through to her stillbirth. The exceptional care provided by the team helped transition her from a state of distress to feeling at peace. This was one of the standout moments for me during this clinical attachment and a key reason why I aspire to do obstetrics in the future.

> *Research is so powerful because by connecting the experiences of so many individuals, we can gain insight into how we can improve patient care for an entire population.*

This clinical attachment highlighted the importance of recognising that behind each data point is the experience of a woman trying to form her family. Behind every count of fetal distress, postpartum haemorrhage, or emergency caesarean section is a highly emotional experience for that family which we have the opportunity to improve. Research is so powerful because by connecting the experiences of so many individuals, we can gain insight into how we can improve patient care for an entire population.

I am privileged to have met so many incredible women whose passion for women's health has inspired me to journey into obstetrics and gynaecology in the future.

RANZCOG Symposium 2024

I felt incredibly honoured to present my research at the RANZCOG Symposium on the Sunshine Coast . This event was an incredible experience that showcased the frontier of medical advancement. The extensive topics presented ranged from the management of menstrual disorders in able women and women with a disability, to the technological advancement of fetal surgery. It showcased the broad dimensions of obstetrics and gynaecology which I had never encountered before.

As a medical student, I particularly benefited from networking with people working in various roles within women's health who helped me understand how this can be incorporated into my future. The inclusion of medical students, GPs, registrars, consultants, and other allied health professionals enriched the event and provided substance for mutually enlightening conversations.

During one presentation, someone commented on the importance of providing safe medical care to avoid repeating past medical tragedies. Unexpectedly, the hospital I was born in, Shrewsbury Hospital, was listed. This then led me on a journey of self-discovery, as I learned that my family was part of the "worst maternity scandal in the history of the NHS." This has fueled my desire to provide safe maternity care in honour of the mothers and babies who were unfortunately harmed during this time.

I also had the opportunity to present this research again at the RANZCOG 2024 Annual Scientific Conference in Aotearoa New Zealand; another fantastic event.

AI Scribes in Women's Health: Transforming Documentation at Women's Health Road

Dr Talat Uppal
MBBS, FRANZCOG, DDU, FAAQHC, FACHSM

Dr Talat Uppal is a gynaecologist, Director of Women's Health Road and has pioneered Australia's first AUB Hub, she is an ambassador for Heidi Health (AI Scribe) & Remie Australia (Remote healthcare reception).

Artificial Intelligence (AI) is rapidly reshaping Australian healthcare, with AI-powered note-taking tools, or 'scribes,' emerging as a transformative solution for clinical documentation. Digital scribes are designed to streamline patient care pathways by transcribing clinical notes and creating documents such as GP letters, care plans, and patient information leaflets. This minimises the manual burden on clinicians and practice reception staff, helps transfer detailed patient data seamlessly between specialists, and enables more cohesive care planning.

This article delves into the role of AI scribes in women's health, focusing on the test case implementation at my practice, Women's Health Road in New South Whales. I will discuss the benefits and challenges we encountered and provide a glimpse into the future of AI in healthcare. The discussion blends firsthand experiences, practical insights, and broader industry perspectives.

The System: From Implementation to Innovation

AI scribes have been used in clinical practice at our women's health service for a just under a year now, acting as a virtual 'resident,' taking notes in real time, transcribing patient consultations, and integrating into cloud-based practice management systems (PMS) to facilitate same-day communication with General Practitioners.

One of the standout features of this system is its intuitive design. The scribe is context-aware, meaning it can recognise and adapt to some of the specific needs of various clinical situations.

We have a developed both initial and follow-up templates, for patients with heavy menstrual bleeding (HMB) that specifically capture details relating to iron deficiency and anaemia, while also incorporating information from the Heavy Menstrual Bleeding Standard. Our multidisciplinary team has tailored the system to address the unique needs of women's health. For example, we integrated the FIGO Abnormal Uterine Bleeding (AUB) terminology, enabling the AI scribe to document patient descriptions of their periods in a standardised manner. This standardisation supports AUB-based research and audits.

Our practice has an integrated digital system that is managed by a dedicated IT team with medical centre expertise, who work alongside our skilled administrative team. As Australia's first AUB hub, we operate a hybrid reception with two remote secretaries, onsite ultrasound services, and patient operative pathways. Additionally, we host a CRC-funded digital health intern from the University of Sydney who is mapping our digitally enhanced multidisciplinary service as part of their research.

Initially, the AI scribe functioned as a standalone web tool. However, it has since been integrated into our PMS, allowing us to launch the embedded AI technology directly from our clinical dashboard, transforming consultations into templated notes for review. It is important to note that occasional technical issues still occur, such as software connection glitches; however, they are infrequent.

To prepare our practice for the future, we implemented a practice management system (PMS) with Fast Healthcare Interoperability Resources (FHIR) capability and Systematized Nomenclature of Medicine (SNOMED) terminology coding. FHIR is a transformative standard that addresses some of the limitations of previous HL7 standards and leverages modern web technologies, making it easier to implement in diverse healthcare settings. It aims to standardise and simplify the exchange of electronic health data across systems. This enhances patient care by supporting interoperability.

RANZCOG is part of Sparked Au community, a dynamic FHIR implementation community led by CSIRO's Australian eHealth Research Centre. This initiative, in collaboration with the Department of Health and Aged Care, the Australian Digital Health Agency, and HL7 Australia, has provided me with invaluable learning experiences.

Training and Costs

Training our clinicians and administrative staff on the AI system posed initial challenges, particularly in navigating and creating history and examination templates, as well as ensuring accuracy across diverse patient backgrounds. However, the tool's structured format made it easier to correct errors and to train the AI over time.

FIGO-AUB system 1
Revision of terminologies and definition of symptoms of abnormal uterine bleeding

Parameter	Normal	Abnormal	☑
Frequency	Absent (no bleeding) = amenorrhea		
	Infrequent (>38 days)		
	Normal (≥24 and ≤38 days)		
	Frequent (<24 days)		
Duration	Normal (≤8 days)		
	Prolonged (>8 days)		
Regularity	Normal or "Regular" (shortest to longest cycle variation: ≤7-9 days)*		
	Irregular (shortest to longest cycle variation: ≥8-10 days)*		
Flow Volume (patient determined)	Light		
	Normal		
	Heavy		

Parameter	Change
Frequency	Amenorrhea is now part of the frequency category
Regularity	Refined definition of regularity Normal variation (shortest to longest) 7-9 days Slight variance depends on age
Duration	Now only two categories for duration Normal: ≤8 days Prolonged: >8 days
Volume	Definition of the symptom of HMB NICE definition Bleeding volume sufficient to interfere with the woman's quality of life
Intermenstrual bleeding	Definition of the symptom of inter-menstrual bleeding Spontaneous bleeding occurring menstrual periods Can be either cyclical, or random

Intermenstrual Bleeding (IMB) — Bleeding between cyclically regular onset of menses	None		
	Random		
	Cyclic (Predictable)	Early Cycle	
		Mid Cycle	
		Late Cycle	

Unscheduled Bleeding on Progestin ± Estrogen Gonadal Steroids (birth control pills, rings, patches, or injections)	Not Applicable (not on gonadal steroid medication)	
	None (on gonadal steroid medication)	
	Present	

Abbreviations:

FIGO, International Federation of Gynecology and Obstetrics

HMB, heavy menstrual bleeding

NICE, National Institute of Care Excellence

FIGO AUB Parameters:

[Frequency: Absent (no bleeding) = amenorrhea, Infrequent (>38 days), Normal (>24 and <38 days), Infrequent (<24 days)]
[Duration: Normal (≤8 days), Prolonged (>8 days)]
[Regularity: Normal or "Regular" (shortest to longest cycle variation: <=7-9 days)]
[Flow Volume (determined by patient): Light, Normal, Heavy]
[Intermenstrual Bleeding (IMB) - Bleeding between cyclically regular onset of menses: None, Random, Cyclic (Predictable) - Early cycle, Mid cycle, Late cycle]
[Unscheduled Bleeding on Hormone Medication: Not Applicable (not on gonadal steroid medication), None (on gonadal steroid medication), Present]
(only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)

The financial cost of deploying AI scribes can be prohibitive for some practices, although basic models are available for free or at minimal cost. Training remains an ongoing process, as we continually refine the system's performance to meet our team's evolving needs. I believe that the AI scribe will always be a work in progress, as we strive to keep pace with its growing capabilities while continuing to improve the accuracy and outputs of the software.

Data Security and Patient Consent

Data security is a critical concern. Our AI scribe technology meets stringent data security standards, including GDPR, APP (Australian Privacy Principles), ISO27001, SOC2, and HIPAA compliance. Patient data is stored exclusively within Australia, maintaining full alignment with medical board codes and AHPRA regulations to ensure Australian clinicians retain oversight and accountability. Before starting this journey, we consulted our Medical Defence Organisation (MDO) to seek advice on informed patient consent.

We use a consent form that details our privacy practices and the role of the AI scribe. Information is also readily available in our reception area, in each clinician's room via a QR code, and on our website. Patients can opt out of using the AI scribe or provide feedback on their experience at any time.

Workflow Changes: A More Efficient Model of Care

Since integrating the AI scribe, our workflow has become more streamlined. Although appointment durations have not significantly shortened, the AI scribe has freed up more time for holistic care, allowing clinicians to focus on meaningful patient interactions—the human aspect of medicine—rather than administrative tasks.
Medical students, observers, and international medical graduates (IMGs) at our practice have expressed that AI scribes enhance their training by reducing the manual burden of note-taking while improving overall accuracy. Ultimately clinicians remain responsible for the consult notes, reviewing each line before finalising the medical records.
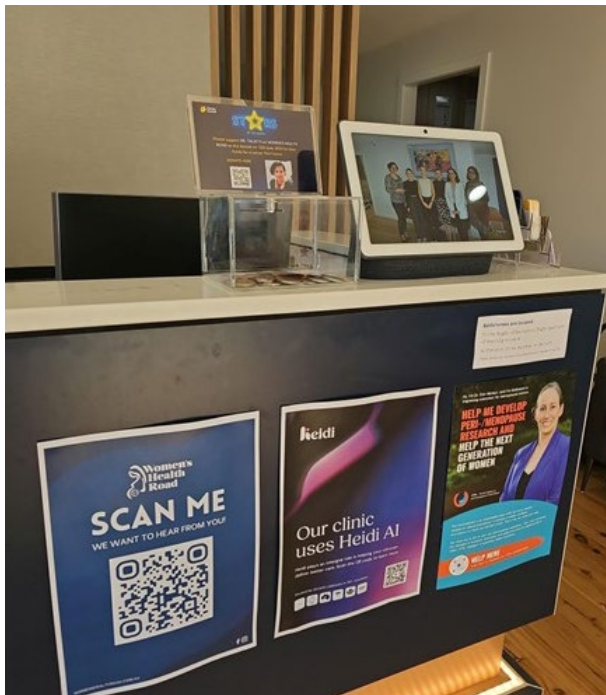
The multilingual capabilities of the AI scribe (currently available in 26 languages) have also been invaluable in supporting our diverse patient community—an essential feature in multicultural Australia.

We integrate both private services and not-for-profit work for patients with AUB, and our investment in a sophisticated digital ecosystem has allowed us to expand our capacity to care for vulnerable patients. AI scribes operate in a rapidly evolving space, which presents unique ethical and logistical challenges. To ensure the system's safety, we adhere to strict clinical governance structures, including continuous monitoring and quality improvement initiatives. All outputs from the AI scribe undergo human oversight, with clinicians, including myself, reviewing each note for accuracy.

The introduction of AI scribes has brought numerous benefits, chief among them being the reduction of the administrative burden on clinicians. With less time spent on documentation, clinicians can focus on providing patient-centred care, fostering better patient engagement, and reducing the risk of clinician burnout.

The Future of AI Scribes in Women's Health

AI scribes are an essential part of the future of healthcare in Australia, particularly in women's health. As the technology continues to evolve, it will enable more personalised care, improve clinical efficiency, and help address the health inequities faced by priority populations. For clinicians, the challenge will be to strike a balance between leveraging these advanced tools and maintaining the human touch that remains central to healthcare.

In conclusion, AI scribes are not just a solution to administrative inefficiencies—they are transforming how we deliver care, making healthcare more connected, equitable, and patient-centred. For women's health, in particular, the benefits of these tools are only beginning to unfold.

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Women's Health Road Reception Desk

Wearable AI

Dr Helena Qian
B MED, DIP LANG, CHIA, AICGG, ARANZCOG (CERT)

Smallpox vaccine. Penicillin. Ether anaesthesia. Insulin. Sonography.

These groundbreaking discoveries not only revolutionised the entire healthcare landscape but fundamentally transformed the very fabric of medical practice and patient care. Once again, our profession is on the cusp of yet another frontier, poised to navigate the exciting but unfamiliar territory of artificial intelligence (AI) in healthcare, heralding new ethical dilemmas and paradigm shifts.

AI is defined by the Australian Health Practitioner Regulation Agency (AHPRA) as any software or system 'able to perform tasks that normally require human intelligence, such as visual perception, speech recognition, decision making and translation between languages.' From its inception in the mid-20th century, when early computational algorithms began to assist in medical diagnoses, AI has evolved dramatically. Arne Larsson received the first pacemaker in 1958, but it took decades before there was widespread adoption of implantable cardiac devices. Conversely, in this era of globalisation, increased popularity of telehealth since the COVID-19 pandemic, rapid advancements in computing power, maturation of data analytics, and the formidable capabilities of large language models based on transformer architectures (GPT-3), interest and adoption of AI in healthcare has accelerated astronomically.

With growing concerns about an overstretched and unsustainable healthcare system, AI is an attractive solution with estimated net savings of up to $360 billion, found by McKinsey and Harvard researchers. The Productivity Commission also deduced that up to 30% of healthcare tasks could be automated using AI, allowing clinicians to have more time to spend on direct patient care. Moreover, improved cost effectiveness and reduced travel time secondary to uptake of telehealth, digital therapeutics and remote patient monitoring facilitates consumer gains of approximately $895 million annually. As such, the Australian government invested $2 billion into My Health Record and has pledged to invest almost $30 million into researching how AI can enhance access to health services and drive innovation.

In many instances however, AI health tools are already being utilised in real time without adequate validation, peer-reviewed guidelines, or regulatory oversight. Amidst this enthusiasm, have we sufficiently explored potential unintended consequences? Are health practitioners equipped with the resources and healthy scepticism needed to discern which technologies have clinical potential and which have more risks than benefit? Is our current integration of AI technology in healthcare outpacing regulatory bodies and broaching the feared technological singularity?

Professor Karin Verspoor, Executive Dean of the School of Computing Technologies at RMIT University, co-founder of the Australian Alliance for Artificial Intelligence in Healthcare and Fellow of the Australian Academy of Technological Sciences and Engineering (ATSE) cautions that "health decisions should be augmented but not replaced by AI". Evidence of efficacy is lacking whereby of the 84 randomised clinical trial studies of AI published between 2018-2023, none were conducted in Australia - 37% were in the EU, 31% in the US and 29% in China. AI also reflects inherent biases in collated data and adoption of biased models can compound existing healthcare inequalities. Given that health decisions are multi-faceted and dependent on each patient's unique clinical and psychosocial contexts, it is crucial to recognise that "AI model generalisability is not a given; AI model localisation is essential." It is imperative to consider the context and ethical implications of integrating AI into healthcare, to harness its benefits while simultaneously safeguarding public trust and patient rights.

Wearable AI devices especially, have become more mainstream and play a vital role in empowering both patients and clinicians with the added capability to collate large quantities of data for quality assurance. These devices encompass a variety of smart technologies that monitor physiological signals and include continuous electronic fetal monitoring, automated closed loop insulin systems, and smart sensors for tracking reproductive health metrics which have translated into timely interventions and improved patient outcomes.

Evaluating Safety and Efficacy

To help with comprehensively evaluating the safety and clinical efficacy of AI tools, the following steps are recommended:

1. **Clinical Evidence Review:** Assess the clinical studies supporting the AI tool's claims, focusing on trial size, population diversity, conflicts of interest and control measures employed.

2. **Regulatory Approval:** Contact the vendor or verify if the device/tool has been registered with the Australian Register of Therapeutic Goods (ARTG).

3. **User Feedback and Technical Efficacy:** Routinely gather insights from peers and evaluate the tool's real-world practical application.

4. **Integration with Clinical Workflow:** Assess how seamlessly the tool integrates into existing workflows.

5. **Quality Assurance:** Implement comprehensive acceptance testing and ongoing periodic quality control procedures to identify and address issues proactively.

6. **End-User Training:** Provide comprehensive training on the tool's intended use and limitations, including a trial period with local patients to identify biases.

7. **Ongoing Monitoring and Re-Validation:** Establish a structured process for ongoing monitoring of AI performance with local test datasets, including routine evaluations of the tool's accuracy and reliability. Periodic re-validation should be conducted whenever changes in workflow, technology or patient demographics occur.

Guiding Principles for AI in Clinical Practice

AHPRA and National Boards recommend the following core principles to be considered when utilising AI in clinical practice:

- **Transparency:** Health practitioners must be open about how AI technologies function and influence clinical decisions. The depth of information provided should align with the context of AI use i.e. more detail is required when AI impacts personal data directly.

- **Accountability:** Clear accountability for AI-generated outcomes is essential, maintaining health practitioners' central role in decision-making. For instance, if using AI scribing tools, the health practitioner is responsible for reviewing the accuracy and relevance of the generated records, regardless of Therapeutic Goods Administration approval.

- **Patient-Centricity:** Any AI application should prioritise patient needs, enhancing overall care.

- **Understanding:** Health practitioners should cultivate a strong understanding of the AI tool(s) including their intended use, limitations and training methodologies to ensure safe and relevant application. Research indicates that while experienced health practitioners often trust their expertise over AI systems, they are susceptible to automation bias. This can culminate in reliance on AI guidance without adequate verification, further underscoring the need for enhanced AI literacy to preserve patient safety.

- **Informed Consent:** It is essential for health practitioners to involve patients in decisions regarding AI tools that require personal data input, ensuring informed consent is obtained and documented.

- **Ethical and Legal Issues:** Health practitioners must adhere to professional obligations outlined in their board's code of conduct, specifically ensuring that data collection, storage, use, and disclosure comply with legal requirements and that patient privacy is preserved. Additionally, health practitioners must be aware of whether patient data is also being used to train AI models (the current focus of a data breach probe into one of Australia's largest medical imaging providers), understand potential biases in AI algorithms, and apply AI only when appropriate, particularly concerning the health and safety of Aboriginal and Torres Strait Islander peoples and other culturally diverse populations. It is also recommended to hold adequate professional indemnity insurance to cover the use of AI tools in practice.

Effectively harnessing AI in healthcare offers a cost-effective opportunity to synthesise real-time data, enable customised decision-making, and improve patient care efficiency. While the benefits are substantial, risks related to privacy, clinical efficacy, and regulation remain. By proactively addressing these challenges and enhancing digital health literacy for both patients and practitioners, we can significantly improve the quality, accessibility and effectiveness of Australia's healthcare system whilst maintaining public trust, minimising harm and strengthening our clinical capabilities through cautious adoption of innovative technologies.

Care on Country: Embracing Digital Innovation to Achieve Equity

Dr Cecelia O'Brien
MBBS, FRANZCOG, DDU, CMFM, PHD

Women's Health Circle acknowledges the traditional custodians past and present on whose land we walk, work and live including the Bindal and Wulgurukaba People of Townsville, Bwgcolman people of Palm Island and the Lardil, Gangalidda, Waanyi, Garrawa and Yunjulla peoples of the Southern Gulf of Carpenteria.

If you were to draw a hypothetical line from the Tropic of Capricorn across Australia, you would see a significant disparity in maternal, fetal, and neonatal outcomes in Northern Australia with fewer resources, personnel, and perinatal specialists to manage the increased morbidity and mortality as shown in Figure 1.

Stillbirth rates 11 per 1000
Maternal mortality ratio 8.7 to 21.3
Preterm Birth 9 to 10%

Population 1,000,000

Tropic of Capricorn

Stillbirth rates 6.2 per 1000
Maternal mortality ratio 4.8
Preterm Birth 7.3%

Population 23,000,000
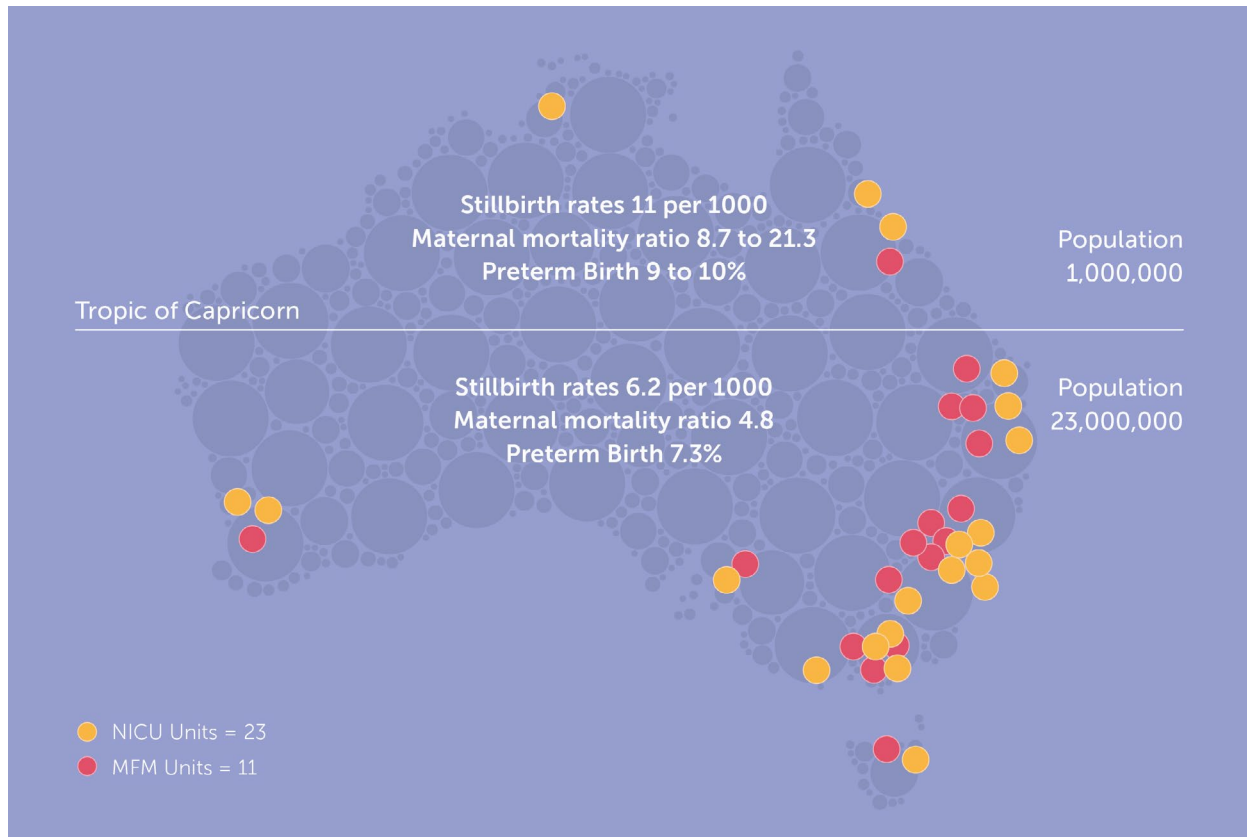
NICU Units = 23
MFM Units = 11

Figure 1. Number of NICU and MFM Units across Australia

There are many contributing factors, including the environmental diversity, wet seasons, restricting travel and access, low population numbers and density, a higher proportion of First Nation peoples living remotely, food insecurity, along with the significant distances to access health care.

The vast distances that women living in remote Australia have to travel for routine pregnancy care and ultrasound is unfathomable. It can be a minimum of one or two flights on commercial aeroplanes (which often have significant delays), or five to eight hours by car with limited options for accommodation en route – notwithstanding the financial burdens and transportation challenges faced once women and their families arrive in town.

Things that we take for granted include the need to get transport out of hours, to and from the airport and their accommodation and then travelling to the health services in time for appointments, the cost of food while women are away, not to mention the fact that many women do not get to bring an escort or have a family member with them during their travel times for routine ultrasound and pregnancy care. For a young 16-year-old woman living on Mornington Island in the Gulf of Carpentaria, in her first pregnancy, these barriers are prohibitive to accessing routine ultrasounds at the correct gestation.

Our story began on Palm Island over 20 years ago, when a sonographer and midwife team, Sue Bloomfield, and Alexandra Gosden, established a monthly visiting sonography service via Queensland Health to compliment the visiting midwifery services.

In the last four years, I became involved as a visiting obstetrician/sonologist to Palm Island to facilitate the timely reporting of ultrasound scans, appropriate management of abnormal ultrasound findings, and to provide higher risk models of care to prevent women from travelling back and forth. This evolved into the development of pregnancy screening to prevent obstetric complications, working collaboratively with the local medical service through the Palm Island Community Council. Check Up Australia funded additional visits for both obstetric care, sonography, and gynaecology visits.

Other remote communities in the Gulf of Carpentaria approached Check Up Australia with a request for a similar service, and we were engaged to formally establish the Care on Country Program. The communities included Mornington Island, Normanton, Karumba, Doomadgee and Burketown, from which 96% of women usually deliver at Mount Isa Hospital in Mornington.

The aim of the Care on Country program is to:

1. Connect women and their families to their pregnancies through the use of ultrasound.

2. Reduce the need to travel for routine pregnancy ultrasounds.

3. Train local staff in how to use the ultrasound machine for point of care and to perform a basic dating scan in order to facilitate an estimated gestation and due date.

4. Primary and secondary prevention of obstetric complications such as pre-eclampsia and preterm birth.

We are now 18 months into the program, which has evolved to embrace state-of-the-art digital technology. We use a combination of satellite internet (Starlink), web-based practice management software that can be accessed anywhere and the use of cloud-based picture archiving and communication systems (Cloud-based PACS)[1]. The ultrasound images are performed on a portable ultrasound made by General Electrics (GE). We have also integrated artificial intelligence (AI) to improve the efficiency of documentation and reporting. Women can either get their photos printed out or receive them directly on their smart phones.

In the first 12 months, from July 2023 until the end of June 2024, we have seen over 308 women in the Gulf of Carpentaria, with 250 obstetric related visits and 59 women were seen for gynaecology. The majority of ultrasounds performed in the communities were second and third trimester ultrasounds. We were able to perform 28 combined first trimester screenings using the Fetal Medicine Foundation algorithm for both aneuploidy and placental dysfunction, early onset pre-eclampsia. We also perform routine cervical screening at the time of morphology in line with the Preterm Birth Alliance's recommendations. We work collaboratively with the outreach midwifery group practice service, the O&G teams at the base hospital, the local Aboriginal medical services, and the local hospitals.

At least one third of women seen in the Gulf communities in this period, were classified as high risk based on a maternal, fetal, uterine, cervical or a placental issue. Overall:

- 59% of ultrasounds were classified as normal.

- 5% of reviews were related to miscarriage and termination of pregnancy requests.

- 3% of fetuses had a structural abnormality found.

- 7% showed placental dysfunction including late onset placental insufficiency, fetal growth restriction, oligohydramnios, or pre-eclampsia.

- 4% of women were found to have an asymptomatic short cervix. At diagnosis, these women were commenced on progesterone at the time of the ultrasound and were followed up for cervical surveillance at the maternity hospital.

- 8% of women had pre-existing medical conditions, such as rheumatic heart disease, ischaemic heart disease, goitre, and other health issues present at the start of pregnancy.

- 3% of pregnancies were complicated by pre-existing or gestational diabetes, large for gestational age, and/or polyhydramnios.

There are always challenges to overcome with any new program. The unpredictable wet season and multiple cyclones last summer in the north of Australia, resulted in the last-minute postponement of our trips. Despite this, we were able to do catch-up visits and community engagement remained high, as shown in Figure 2.
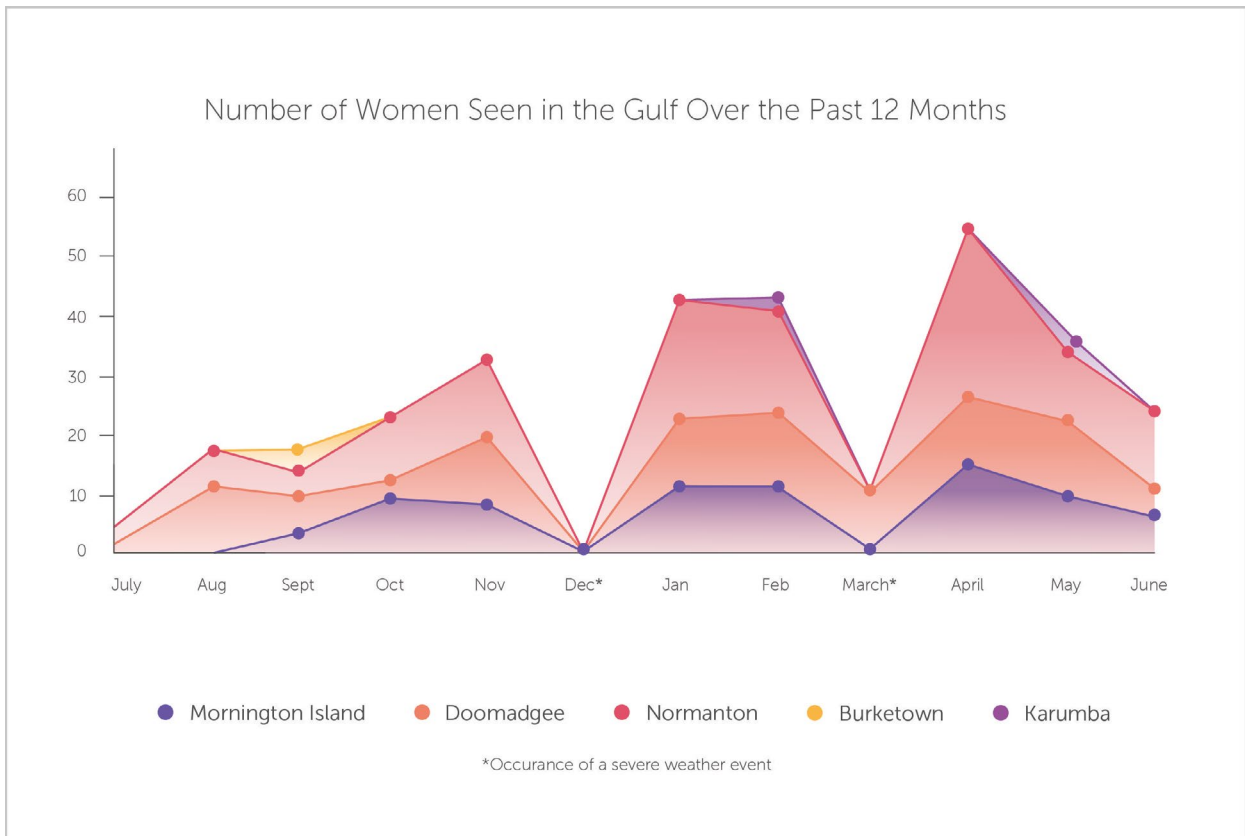
Number of Women Seen in the Gulf Over the Past 12 Months

● Mornington Island ● Doomadgee ● Normanton ● Burketown ● Karumba

*Occurance of a severe weather event

Figure 2. Impact of weather events on patient visits

One of our biggest challenges was poor mobile reception which led to unreliable connectivity to the internet, impacting our ability to upload images to our cloud-based server and perform timely reporting. This has been partially resolved by using satellite technology which provides high speed internet anywhere. Our reporting efficiency will be aided by the advent of a web-based viewpoint in the near future.

In its first 12 months, our program has been estimated to save the healthcare system over $2 million in the transportation of women for routine antenatal care and ultrasound. The cost benefit ratio calculated using the Australian Social Bank Value based on the reduction in parental stress through the Care on Country program is 8.7. This means for every $1 spent on this program, there is a cost savings of $8. Not to mention the benefits of improved outcomes from pregnancy screening and treatment to prevent early onset pre-eclampsia and preterm delivery.

There is no doubt the greatest part of the program is experiencing the delight and excitement generated when a woman sees her baby on ultrasound in their home community for the first time. To be able to share this moment with their children and families has been the highlight for us.

It is such a privilege and honour to meet these amazing families, local staff, the wonderful midwifes and provide access to services such as routine obstetric and gynaecology ultrasound and pregnancy care on Country.

To conclude, the statement from the International Society of Ultrasound in Obstetrics and Gynaecology (ISUOG) summarises our mission to achieve equity in women's imaging. 'All women should have access to ultrasound, that all scan providers are competent and that all O&G conditions are effectively diagnosed'.

Connecting women and their families who live remotely to their unborn baby using the portable ultrasound technology is truly special. We are one step closer to achieving equity and the future of outreach women's imaging is so exciting.

If anyone is interested in the program, we would love to hear from you. Please email me at cecelia@womenshealthcircle.com.au

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The Highs and Lows of Being a Doctor Online

Dr Danielle Jones
MD, BSPsy

Dr Danielle Jones, also known as 'Mama Doctor Jones,' is an obstetrician-gynaecologist and digital health educator. In her article, "The Highs and Lows of Being a Doctor Online," she shares her experiences of navigating social media as a healthcare professional, highlighting both the rewards and challenges of connecting with patients online.

As healthcare professionals, we often meet people at their most vulnerable. While we're trained to offer medical solutions, learning to truly understand and validate the emotional weight of our patients' experiences is a skill that's much harder to master.

I vividly remember an early experience as a medical student, supporting a woman through a miscarriage. No part of my medical education had prepared me to approach this from the perspective of the patient's experience, nor had I been taught how to balance providing acute medical care with the universal need to feel seen, acknowledged and validated. But social media had.

Through my work online, I had read countless firsthand accounts of loss, infertility, birth and medical care surrounding those events. I had been witness to personal recounts of how deeply interactions with medical teams impact our patients and their wellbeing—for better and worse. Without realising it, in the moment, those raw, unfiltered stories people chose to share with me had taught me something textbooks and professors never could: how to meet someone where they are and truly care for patients in the ways they need.

Since that day, my guiding mantra has become: "While I may not be able to make everything better, it is my duty to never be the one who makes someone's worst day worse."

Social media as a space for growth

Social media has become more than just a place to share information; it's where I've learned so much about being a doctor and a person. Each story, comment, and message has deepened my understanding of the challenges and biases that people face, both in healthcare and in life. I still remember the first feedback I received asking me to make my content more inclusive for gender-diverse individuals, and how I had never even once considered that. This blossomed from a simple comment into a passion for expanding the inclusivity of O&G education, not only online but in my real-life education and practice as well.

> *Social media has become more than just a place to share information; it's where I've learned so much about being a doctor and a person.*

Finding my voice, listening to theirs

Social media platforms have allowed me to speak to millions on topics like political interference in healthcare and reproductive education. I've found my footing in discussing ethically difficult topics, pushing back against sexism, and championing patient rights through empowerment and self-reflection within the medical community. My online work is guided by a commitment to "finding my voice, listening to theirs." This simple sentence is a daily reminder to use my voice not only to advocate and teach, but to also listen closely to the words of those who may not have the platform or privilege to speak out.

The power of online communities in healthcare

The digital landscape isn't just for sharing stories; it's also a valuable tool for healthcare. Through social media, I've been able to educate, promote preventive care, and address wellness with a much broader audience. By utilising "edutainment"— a form of education that is presented from an angle of entertainment balanced with empowering, evidence-based education, I've been able to build a truly impactful body of work.

Telehealth may be bringing care into people's homes, but social media has the ability to bring empowerment and advocacy magnitudes greater than I ever could have achieved in clinical practice alone. I see these platforms as essential in providing resources, improving equity of access to health education, challenging stigmas, and building communities that people can lean on.

> *I see social media platforms as essential in providing resources, improving equity of access to health education, challenging stigmas, and building communities that people can lean on.*

Reflecting on the journey

Social media has taught me as much about listening as it has about speaking up. It's a privilege and a responsibility to use these platforms not only for knowledge sharing but also for empathy and support. For medical professionals like myself, it's a place to advocate for positive change in healthcare and to listen to the voices that often go unheard.

I encourage my fellow doctors to consider using social media as a space to share, listen, and learn. How has social media shaped your practice? How does it affect your patients? Let's keep this conversation going, building a more inclusive, empathetic healthcare community together.

So You Want to Become a Social Media Influencer?

Dr Natalie Elphinstone
MBBS, BMedSci, FRANZCOG

Several years ago, we began to see the emergence of patients who consulted the Internet to search for health information, the so-called "Dr Google". More recently, likely accelerated by COVID-19, these internet sources seem to increasingly be social media platforms—where qualifications, research and science may mean very little, but being an "influencer" ensures your voice reigns supreme.

One large study of women in 2019 reported that 96% had used the Internet in search of health information (Covolo, April 2022). Over half (53%) had accessed the internet for health information *after* being seen by a medical professional. Participants primarily cited the need for more detailed and comprehensive information as their reason for doing so. But which sources are they turning to for this information? Lifestyle sites, social media and health blogs accounted for the majority, with only 7.6% of non-healthcare workers seeking information from specialists or hospital websites.

In the Spring issue of the *O&G magazine*, Dr Katie Ryan asked the question, "Should we accept that social media has become an accessible and therefore integral part of health education and be more proactive in joining the chorus of voices in an effort to balance misinformation online?" (Ryan, Spring 2024)

As someone who accidentally created an obstetric social media account that has gained a reasonable following, let me share some of the lessons I have learned in this space.

Check Your Motivations

In 2018, having just entered private practice, I found myself not only thrust into the responsibilities of what that means as a practitioner, but also the challenges that come with starting a business. I designed a logo, made business cards, created a website and a new Instagram profile, simply because it seemed like 'the thing to do' from a marketing perspective. But what to post? What was the message I wanted to share? I had no clue! I started gently, re-posting others' content that interested me or sticking to safe topics such as recognising International Days of significance. Was my content raising health literacy? Maybe. Was it riveting? No.

I quickly learned that my followers responded more when I added a personal touch or shared real-life examples. But without breaking doctor-patient confidentiality it was

hard to know where I was going to get that kind of content. The breakthrough came when a woman asked if she could share her birth story on my page. I hadn't been involved in her medical care, and I ensured that details identifying where she received care were removed. She shared her story, including all the challenges she had overcome, with the goal of inspiring others—and inspire she did! There was an outpouring of support and gratitude from people who connected with her story.

Among all the responses were other women who asked if they too could share their stories. There were stories of harrowing complications and stories of births as victorious as it gets. Women opened up about their post-natal depression, and others shared their grief over their losses. It felt like many were sharing their stories as a therapeutic tool for themselves, but it was also encouraging others who had experienced similar journeys. Additionally, it brought education about the realities of birth to an audience of women who had only ever seen it portrayed in the movies.

I realised this was much bigger than myself or my practice and it became my motivation. My social media platform now focused on combating the false message that birth for can and should look like a serene scene of a woman breathing out her baby in a bath. It was about sharing the full spectrum of what birth might look like—home birth, hospital birth, vaginal birth, caesarean, blood and poop and everything in between. I created a hashtag #100birthstoriesin2020 and I asked for submissions. I had to quickly remove that request after I was flooded with offers and I couldn't keep up!

What I learned through all of this is that the priority was to find my authentic voice. I discovered a topic I was passionate about, one that I had the tools to educate others on, and I learned how to share that message in a way that resonated with my audience.

Establish Boundaries

A major drawback of having a public profile is the keyboard warriors and trolls. I had to figure out how to deal with them and what impact I was going to allow them to have on my life.

At first, I was naïve enough to think that if all I'm doing is sharing women's birth stories in their own words, I couldn't possibly receive any personal abuse. But people love to create drama, and pick fights where they can. I receive a barrage of messages from people who feel they need to show me the error of my ways if I dare to post images of

babies with dummies or being artificially fed. And don't even get me started on what happens if I share stories of women who chose things like a caesarean on maternal request! But worse than receiving hateful personal attacks (fancy being called a 'birth rapist'?) are the hateful comments left for the women who have been brave enough to share their stories.

To combat this, I saw four options. I could turn off comments altogether so no one can say anything, I could read every comment and delete/block those I found inappropriate, I could engage with the haters by responding, or I could ignore them. I usually choose the latter. I believe in the freedom of personal expression, so censoring comments doesn't seem ideal, and engaging with ignorant people making ignorant statements typically achieves nothing. Often, other followers will engage on my behalf, and the fact is that positive comments outnumber the negative ones every time.

As for reading every single comment, I learned long ago to turn off my notifications. The little ding used to stop me in my tracks, prompting me to find out if it was something nasty or nice. I quickly found that this was very bad for my mental health. Reminding myself that I have higher priorities and that I am worth more than my Instagram account was an important step in overcoming this.

Embrace the Opportunities

As my follower count grew, so did the offers and invitations, which wasn't expecting. Initially there was the usual spam and scams that aren't even worth reading. Then there are the offers from health-related products and businesses that want to "partner with me". Maybe these were worth investigating further—after all, there could be a product I wasn't familiar with that might actually be worthwhile for my patients. But it's very unlikely I would ever endorse a product on my social media. In these instances, respond with tact. Lastly, there were invitations to speak or teach,

join podcasts, participate in interviews, and present at conferences. I often say yes to these types of invitations as they allow me to reach a wider audience. You never know what might lead to the next occasion that might effect change.

But more than the personal opportunities my social media profile has provided, its true value lies in its potential to positively impact others on a large scale. In 2021, I posted a birth story from one of my own patients. It was a Maternal Assisted Caesarean. This story not only represented her journey, but also mine as we had worked towards achieving this technique for the first time at our hospital. Her story, and the subsequent Maternal Assisted Caesareans I shared, went viral. I began receiving requests from both women and healthcare providers all over the world asking how they could perform something similar at their own hospitals. I was happy to help in any way I could, and to date, I believe I've impacted at least 11 countries (I've lost count of how many different hospitals) in achieving their first Maternal Assisted Caesarean.

Final Thoughts

In a world where patients are accessing social media for more easily consumable health information but are less discerning about which sources they rely on, I believe it almost becomes a duty of care to show up in this space. However, there are possible personal drawbacks for individuals who do, so be prepared for the battle. Having a clear message, and of course a factually correct one, that you're passionate about sharing is important, and the benefits of effecting change will far outweigh the negatives.

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Book Review: I Choose Elena

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I Choose Elena sat on my bookshelf for a year; I was reluctant to read a book that I knew would be difficult and confronting. When I finally picked it up, I read it in one sitting, and ever since it's been the one book that I've wanted to press into the hands of every obstetrician gynaecologist. Because we've all met 'that woman', but rarely, if ever, do we hear her story told with such honesty and hard-won insight.

Lucia Osborne-Crowley was a high-achieving, extroverted high-school student, training as an elite gymnast, when she was raped by a stranger at age 15. She told no one and attempted to suppress memories of the attack. In the years that followed, she began to suffer from intrusive flashbacks, nightmares and panic attacks. She stopped gymnastics training because she lost her sense of where her body began and ended and repeatedly injured herself. And she developed recurrent, severe abdominal pain and dysfunctional bleeding that led to a merry-go-round of repeated emergency department visits, scans, and laparoscopies.

Osborne-Crowley was eventually diagnosed with endometriosis and Crohn's disease. It was many more years before she was able to acknowledge the role that the rape, and the subsequent suppression of traumatic memories, played in her ongoing mental and physical ill-health.

Osborne-Crowley is a journalist and a lawyer, and she skilfully combines her story with her research into the various factors that played a role in her journey. She delves into our current understandings of post-traumatic stress and how the interplay of the psychological, nervous and immune systems can lead to chronic physical disease—including inflammatory conditions such as endometriosis. She discusses gendered aspects of medical care and the research that shows how women are treated differently than men when they present with pain. She examines the culture of violence in our society and the culture of shame and silence that further traumatises victims of violence, particularly sexual violence.

Osborne-Crowley's descriptions of her many interactions with health professionals make for uncomfortable reading, and it is apparent there are no easy answers. Only once did a doctor ask her whether she had a history of sexual assault; her reaction was to run away and to ignore the follow-up calls that he made. What she sees now, she writes, is that she was presenting to emergency as a traumatised young woman 'whose body was trying to say something her mind could not.' She recognises that no doctor could have helped her while she was trapped by the need to stay silent. *I Choose Elena* is the breaking of silence. The title refers to the support that Osborne-Crowley derived from reading writers such as Elena Ferrante, whose female protagonists have the vulnerability and resilience to overcome their pasts and 'possess their own narratives.'

I Choose Elena is Osborne-Crowley's own narrative, told on her own terms. When she discusses research, it is not an attempt to present a balanced academic review, but rather to show how certain aspects have resonated and helped her to understand her story. As such, *I Choose Elena* offers health workers insights that could never be gained from a textbook or a workshop, or even from an open conversation in a clinical setting, with all its inbuilt imbalances in knowledge and power.

Literature – fiction and non-fiction – has the power to change our perspectives in ways that are startling or humbling or inspiring. In a future edition of the O&G magazine book review, we'd like to make a compilation of texts that have changed the way readers approach or view their work in women's health. If you'd like to contribute, please email: OGmag@ranzcog.edu.au with the name of the book and author, and a brief paragraph on how and why it has affected you.

I Choose Elena by Lucia Osborne-Crowley, Allen and Unwin, 2020.

LUCIA OSBORNE-CROWLEY

'A masterful examination of trauma and finding solace in literature.' —The Guardian

I CHOOSE ELENA

'If you buy one book today let it be this one . . . It moved me to tears and to anger.' —Daisy Johnson, author of Everything Under

Associate Prof Arnold Gillespie AM
1936 - 2023

It is with great sadness that we acknowledge the passing of Associate Professor Arnold Gillespie on 28 June 2023, with some words from Debra Millikan.

At Arnold's funeral, Francis Coombe, President of Voluntary Assisted Dying SA said: "The beauty of Arnold will always be with us. A legacy of love and compassion, of intellectual rigour, tenacity, and high achievement".

Arnold was born in Sydney on 23 September 1936. Even as a primary school student his abilities were recognised, resulting in him attending Sydney Boys High School, a school for gifted students.

At the University of Sydney, he completed a Science degree before commencing Medicine. Post-graduate studies saw him acting as a ship's doctor on his way to the UK to undertake his MRCOG examinations. Before leaving for the UK, he married Dr Nesta McLean. They had been medical students together. Sadly, Nesta died in 1990.

For the MRCOG exam there were two examining doctors. As it turned out, one of them was a mentor of his from Sydney. Professor Devonish Meers from Crown Street Hospital excused himself and that left Arnold alone with Professor John (known as Jack) Dewhurst. After several medical questions Professor Dewhurst started talking about the cricket — that meant Arnold had either done very well or very badly.

Not only had he done well, but shortly after, he was offered a lectureship at the Institute of Obstetrics and Gynaecology at the University of London, taking Arnold down his academic path of research and teaching.

Arnold wrote the seminal paper on the induction of labour using Prostaglandin E2 and up until the week before he went to hospital, he received notifications of its use as a reference in other academic papers.

When he left the UK, he took up a position at the University of Adelaide where his focus became more that of teaching. He was a pioneer in computer assisted learning, travelling again to study more about developing these programs. Postgraduate education became a large part of Arnold's work and he and department colleague Ossie Petrucco learned from luminaries such as Jacque Donnez and Bruno von Herendael, bringing home the knowledge required to introduce gynaecological laparoscopy to Australia.

After retirement in 1999, Arnold travelled to Europe with Deb, his second wife, and they spent three years travelling in a motorhome around Europe and Scandinavia. This had been a long-term goal of Arnold's. Returning home, they then travelled around Australia as grey nomads for 18 months.

As well as serving as Vice President of both the SA Voluntary Euthanasia Society and Voluntary Assisted Dying between 2013-2019, he was National Convenor of Doctors for Assisted Dying Choice for 15 years. During that time, he oversaw the growth of the organisation from a small splinter group to — and I quote — "...a medical advocacy powerhouse that has played an important role in promoting the adoption of VAD legislation in every State of Australia." (Dr Richard Lugg, Doctors for Assisted Dying Choice).

In the 2024 King's Birthday Honours, in recognition of his significant service to medicine, particularly as an advocate for voluntary assisted dying, Arnold was posthumously awarded the Member of the Order of Australia (AM). This recognition highlights his unwavering dedication to advancing medical practices and patient rights, especially in end-of-life care.

A loving husband and father, a caring physician and an enjoyer of life, Arnold was able to use the service for which he fought so long and hard. He ended his life with the assistance of Voluntary Assisted Dying at the Royal Adelaide Hospital on 28 June 2023 with his loving family surrounding and supporting his decision.

A life well lived.

Dr Mukhtiar Sidhu
1937 - 2024

It is with great sadness that we acknowledge the passing of Dr Mukhtiar Sidhu in Brisbane on 8 August 2024.

Dr Sidhu was born in a small village in the state of Punjab, India, in 1937. His family immigrated to Singapore in 1941, where they spent time living under Japanese occupation. Dr Sidhu attended school in Singapore, achieving strong academic results. With great effort and the help of bursaries and scholarships, he was accepted into university. After graduating in 1962, Dr Sidhu began his medical career as a "houseman" at Singapore General Hospital, then moved six monthslater to the maternity hospital Kendang Kerbau (KK).

At the busy Kendang Kerbau Hospital, Dr Sidhu decided to pursue the specialty of obstetrics and gynaecology. In 1967, he left Singapore to complete specialist training in the United Kingdom, working at the oldest hospital in England, St Bartholomew's, and later at Hammersmith. His experience in the high-pressure environment of Kendang Kerbau stood him in good stead throughout his time in the UK. Once his training was complete, Dr Sidhu returned to Singapore to work in the public hospital system.

In 1971, he and his wife Raghbir decided to immigrate to Australia to provide different educational and lifestyle opportunities for their young family. Dr Sidhu accepted a position as the Director of OBGYN at Townsville General Hospital in 1976, becoming the first doctor with an MBBS from Singapore to be accepted for registration in Queensland.

In the 1980s, Dr Sidhu built a successful practice alongside fellow OBGYN Dr Noel Cassells in Townsville, providing care to the community for many years. He moved to Brisbane in 1991, becoming the Director of OBGYN at QEII and Logan hospitals during a period of expansion for obstetric and gynaecology services to meet the growing needs of the community in Brisbane's southside. Dr Sidhu continued as Director at QEII, where he enjoyed combining clinical gynaecological work with the administrative and operational aspects of running a department, until his retirement in 2012 at the age of 75.

Education was deeply important to the Sidhu family. Having benefited from educational and funding opportunities during his early medical career, Dr Sidhu and Raghbir were inspired to "pay it forward" and create opportunities for midwives, doctors, and specialists in obstetrics and related fields. With the aim of improving maternal mortality and morbidity and assisting in fetal surveillance in developing Pacific and Asian countries, they established a grant in collaboration with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. This grant supports OBGYN trainees from developing Pacific and Asian countries to participate in short clinical observerships in Australia and New Zealand. It also funds educational programs and workshops across South and Southeast Asia and the Pacific region. Dr Sidhu and Raghbir hoped that the grant would support a lasting legacy and contribute to enhancing women's and infants' health.

Colleagues remember Dr Sidhu as a respected professional dedicated to the field of Obstetrics and Gynaecology, whose compassionate approach touched many lives. He will be remembered for his ability to foster a sense of unity and purpose, as well as for his warm spirit, generosity, wisdom, sense of humour, and quiet dignity.

Dr Sidhu is survived by his loving wife, Raghbir, and their children, who have been a source of strength and support throughout his life.

Dr Sidhu's legacy will continue to inspire and uplift us, and he will be deeply missed and dearly remembered by all who knew him.