Sharing workforce challenges

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Disclosures

- I personally declare:
- Attending this meeting thanks to ASUM and BMUS
- Previously received speaker fees from Philips Healthcare, Radiopaedia and GE Healthcare
- Previously received honoraria from Vagenius Training
- Director of Australasian Society for Ultrasound in Medicine
- Recipient of Australian Government Research Training Program fee offset scholarship and University of Adelaide Research Training Stipend.
- Grant funding from Robinson Research Institute and Wilson Foundation



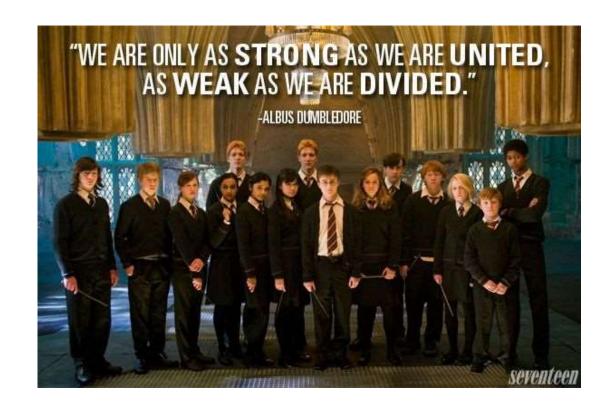
How did I become a sonographer?

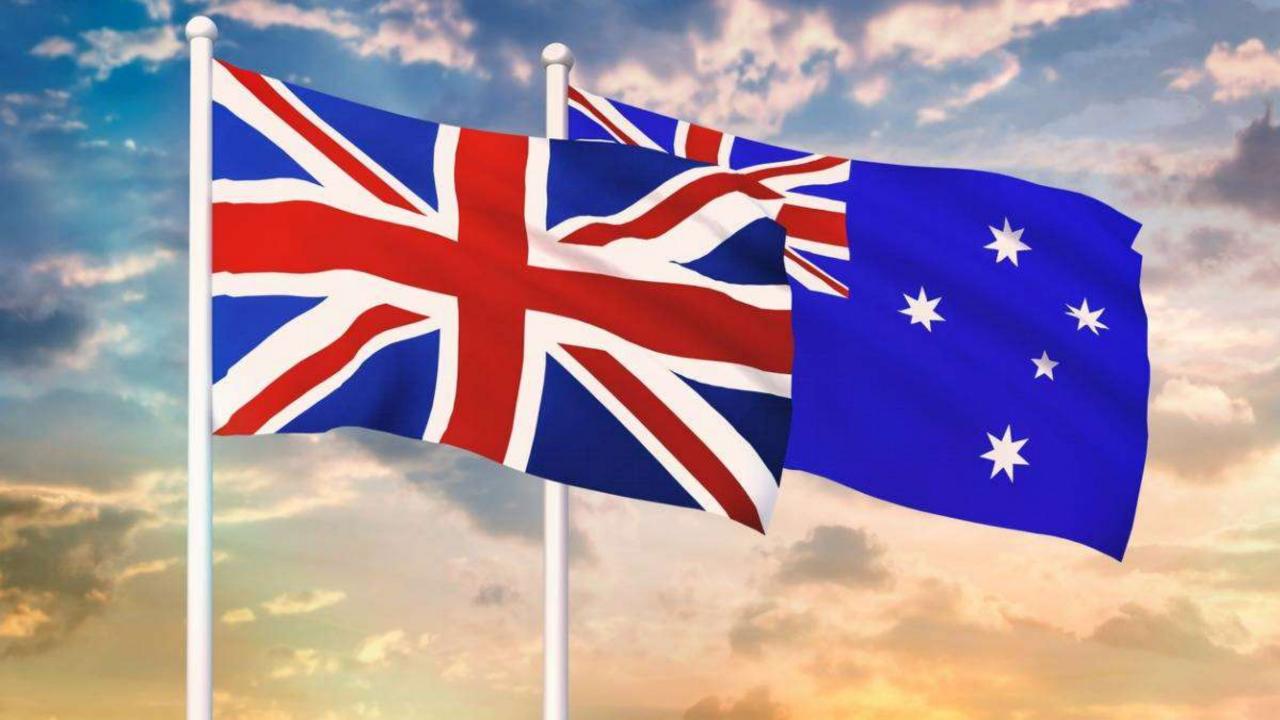




Objectives

- Shared session
- Australia vs UK perspectives
- Evolution of ultrasound practice
- Sonographer registration
- Corporatisation of medicine











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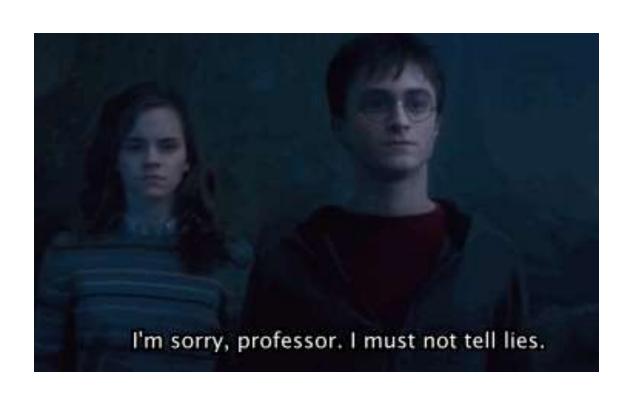






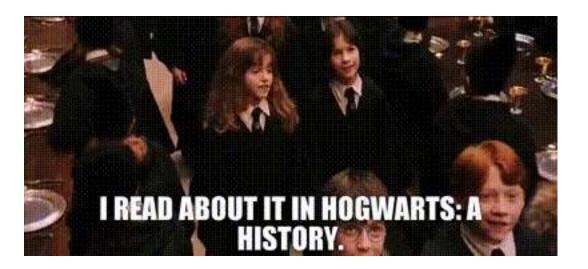


Healthcare Australia vs UK



- Common belief UK and Australia have very similar healthcare systems
- NO WE DON'T!!!!!
- Australia= private (subsidized) and public (free)
- UK= Predominantly NHS (free)

History of ultrasound



1794

• Lazzaro
Spallanzani (Italian biologist)
investigates how bats use echolocation, laying the groundwork for understanding sound waves and their applications.

1880

 Pierre and Jacques Curie discover the piezoelectric effect 1915

Paul Langevin
 develops the first
 working ultrasound
 transducer for
 submarine
 detection during
 World War I,
 demonstrating
 potential of sound
 waves for imaging
 through solid and
 liquid mediums.

1928

 Sokolov suggests using ultrasound for detecting flaws in metals, introducing the concept of ultrasonic imaging. 1940s

• Transition to Medical Applications 1950s: Emergence of Diagnostic Ultrasound

- John Wild and John Reid develop early ultrasound systems to detect tumors in human tissue.
- 1958: Ian Donald and his team publish the first paper on ultrasound use in obstetrics, marking the beginning of fetal imaging.



1960s: Real-Time Imaging

- 1963 Joseph Holmes, William Wright, and Ralph Meyerdirk introduce the first compound contact scanner, enabling more detailed imaging.
- •1966: Development of Bmode ultrasound
- 1969: Development of grey scale imaging

1970s: Widespread Adoption

- Introduction of real-time ultrasound scanners
- Development of more transducers
- Ultrasound machines began appearing in radiology departments
- •Birth of Sonographers
- •1979 first sonography qualification born-ASUM DMU



1980s: Advances in Technology

- Introduction of Doppler
- Endovaginal and endorectal transducers developed
- Digital imaging systems replace analog technology, improving resolution and image quality.
- Sonographers recognized as a professional group in Australia
- •1984: Medicare introduce Australia
- •1985: First "corporate" medical service established

2000s: Miniaturization and Portability

• Development of handheld and portable ultrasound devices, expanding accessibility to point-of-care applications.



•Introduction of Alpowered ultrasound systems, improving diagnostic accuracy and enabling automated detection of abnormalities.







Registration: The Debate Around Professional Recognition

Sonographers not registered professionals in either UK or Australia



Why Registration Matters?



Ensures consistent standards of practice.

Enhances public trust and patient safety.

Protects title

Challenges- Australia

- Current strong effort over several year has hit brick wall
- Administrative burden from government
 - Costly
 - Will only act if public pressure
- Administrative burden and resistance from some professionals.
 - Australia collective agreement sonographer registration is needed
- The cost implications for individuals and organisations.
 - Loss of dual qualified professionals



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Your thoughts?



Corporatisation of Medicine



What's Happening?

- Growth of corporate imaging chains focusing on efficiency and profit.
- Culture of efficiency and corporatisation of public health services
 - Creates systemic changes reducing patient-centered care.
 - Views professionals as "resources" rather than humans



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Challenges for HCPs

- Increased pressure to meet quotas, often at the expense of quality care.
- Limited opportunities for individualised patient interaction or professional growth.
- Lower job satisfaction. Higher risk of burn out



Your thoughts?



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