

Regimen



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EDITION TEN

STRIVE STUDENT HEALTH INITIATIVE

FUTURE: "WHAT ARE WE DOING?"

Change in Plain Sight

Eye examinations and examining with the eyes.

Trust Me, I Saw It on the Internet

Combatting misinformation in the information age.

Are we taking nutrition for granted?

Climate change, rising temperature and the effect on our one food source.

Preventing More Than Pregnancy

The future of women's contraception.

PCOS to PMOS

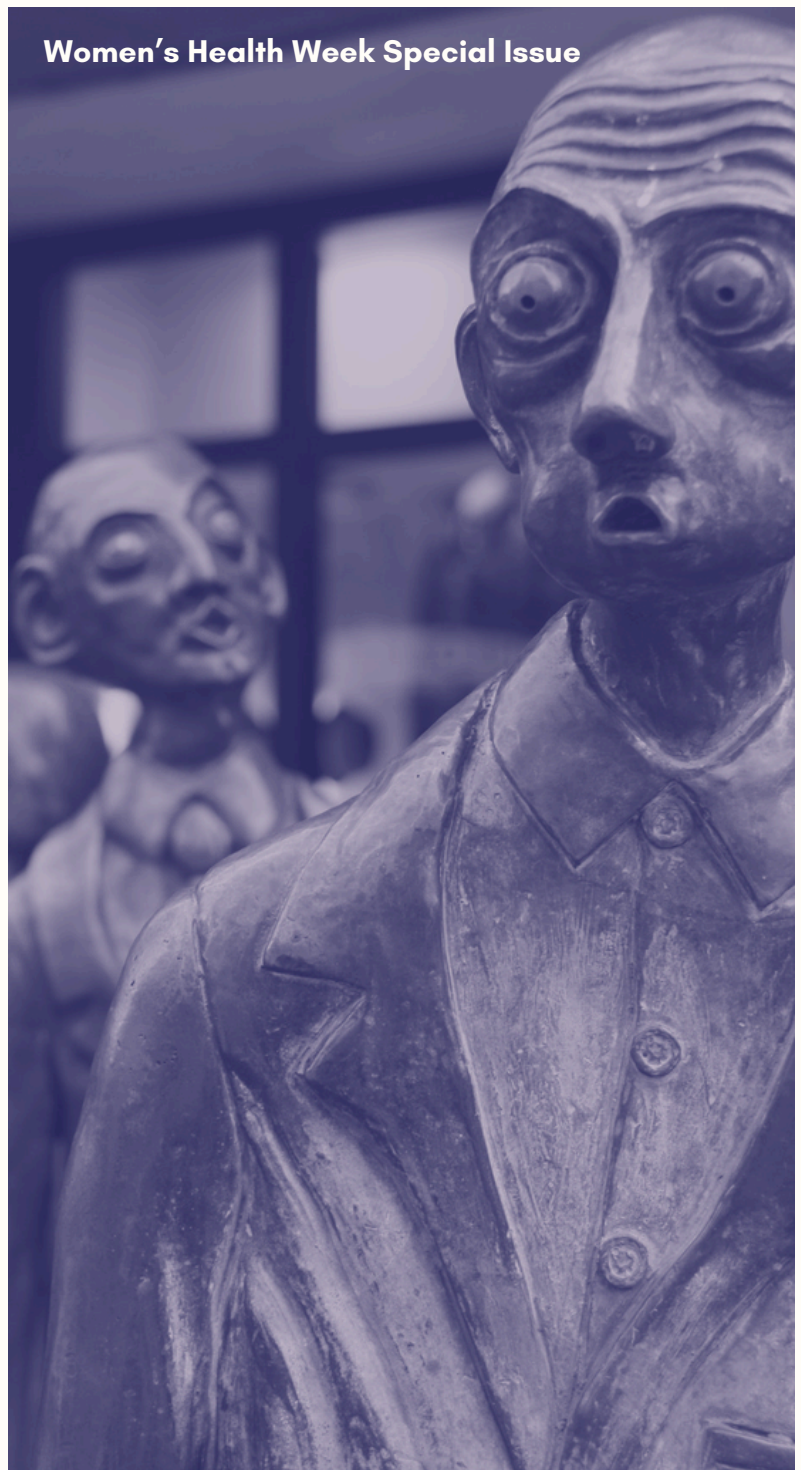
More than a name change.

Less reaction, less talk, less action

Who cares about reproductive rights?

Clinician's Compass Part II

Women, choice and care at the end of life.



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Foremost, we acknowledge the lands we live and learn on, the unceded land of the Wurundjeri Woi-wurrung and Bunurong Boon Wurrung peoples of the Kulin Nation. We pay respects to their Elders: past, present and emerging.

About Us



Strive is a student-led organisation and initiative for public health in the community.

Strive runs various community outreach initiatives delivering health education and helping individuals to make informed decisions about their health. We have delivered a range of impactful programs, including community workshops, student conferences, and Strive Clinic, the first student-run clinic in Australia.

We are proud of our strong volunteer base composed of health-conscious students.

Our initiatives allow students to engage with primary healthcare through workshops and programs. We aim not only to give back to the community, but to build skills such as teamwork, leadership, and project management.

Regimen is our periodical publication, created as a platform for students to reach and extend their emerging voices to others.

WELCOME TO THE Future

What comes next is never entirely unknown. Its beginnings are already here—in what we discover, what we question, and what we choose to change.

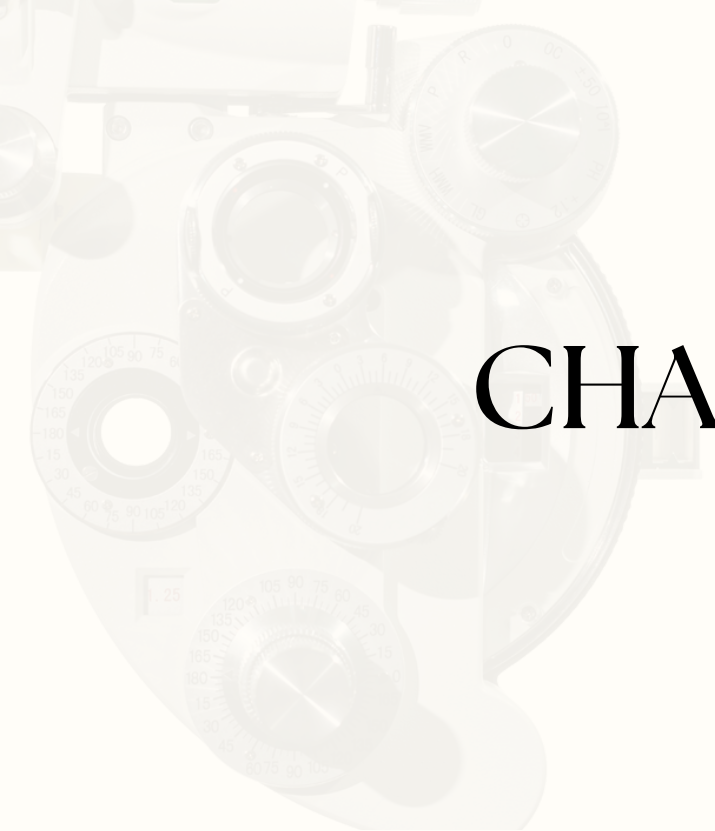
WHAT ARE WE DOING?

In this edition, our writers look forward with the awareness that the future is hard-fought in the present. Increasingly, it seems to pose more questions than promises of security or equity for all. It can be difficult to imagine, much less negotiate, what a fair future for all might look like.

It is no coincidence, here, that issues at the forefront of women's health were submitted to us, and that they feature so confrontingly in this edition.

To simultaneously mark **Women's Health Week**, we have brought the respective pieces together in a dedicated section, represented in purple—a colour long associated with women's rights and with the values of justice, dignity and loyalty to the cause.

Through the passion and intelligence of all our writers, we hope this edition reflects something of the growing presence of women in the healthcare workforce, who care for people across genders, disciplines, generations and communities.



CHANGE IN PLAIN SIGHT

By Khushi Kumbar

Before I began studying optometry, I thought routine eye examinations were mostly about finding the right prescription.

After all, that's what most of us imagine, right? A patient sits behind the phoropter, reads a chart of blurry letters, compares one lens against another and leaves with a stronger pair of glasses. It seemed like one of the simplest encounters in healthcare.

I was wrong.

It took surprisingly little time for me to realise that routine eye exams aren't really about correcting vision. They're about recognising change.

One of the earliest lessons in optometry is that some serious eye diseases rarely announce themselves. Glaucoma, often described as the silent thief of sight (Qi et al., 2025), can irreversibly damage the optic nerve long before a person notices any change in vision. Diabetic retinopathy follows a similarly deceptive course, with early disease potentially developing before noticeable changes to vision occur (Shukla & Tripathy, 2023).

That is why routine eye examinations matter – they are not designed simply to respond to symptoms (NEI, 2025).

They exist because waiting until change becomes obvious often means waiting too long.

Every routine eye examination begins with a remarkably simple assumption: Things change.

The Greek philosopher Heraclitus is famously associated with the idea that “no man ever steps in the same river twice” (Graham, 2023). His point was not simply that rivers flow, but that change is the only true constant. Everything is continuously becoming something else.

Without realising it, routine eye examinations begin with the same assumption: No eye returns exactly as it was before. A prescription may have shifted ever so slightly. The optic nerve may appear subtly different. Tiny retinal haemorrhages may have appeared where none existed before. Individually, these changes seem insignificant. Together, they tell a story.

What surprised me most, however, was not how easily these changes could be detected through careful examination. It was how easily they could be missed by the person living through them (NEI, 2025).

Patients rarely wake up one morning unable to see.

Gradual changes in vision can be remarkably easy for the person experiencing them to overlook, partly due to the fact that our brain can quietly adapt to change. Yesterday's vision becomes today's normal, until today's normal quietly becomes tomorrow's expectation.

**This was when I realised
that seeing is not the
same as noticing.**”

Routine eye exams are, in many ways, examinations of time.

Every retinal image is compared with the one that came before it. Every visual field is interpreted alongside previous results. Every review quietly asks the same question: What has changed?

Not because clinicians expect catastrophe.

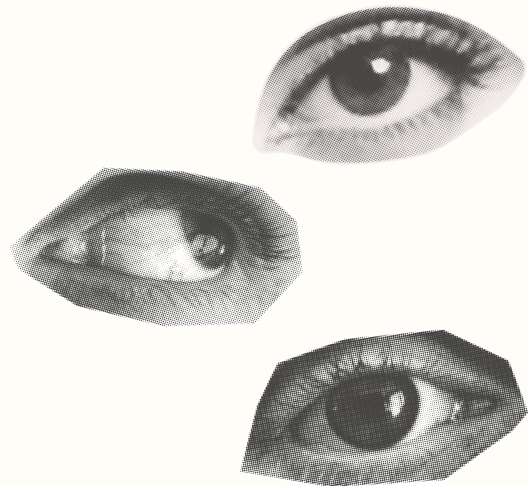
But because they understand that the most important changes are often the hardest to notice.

Sometimes those changes can preserve sight. Sometimes they provide the first clue to something much larger. The retina provides a unique, non-invasive view of the body's microvasculature, meaning retinal changes can also offer clues about systemic conditions such as diabetes, hypertension and cerebrovascular disease (Lee et al., 2025).

Somewhere along the way, I began wondering whether this way of thinking extends beyond the consulting room.

We often imagine the future as a destination waiting somewhere ahead of us. Yet, routine eye exams suggest something different.

**The future rarely arrives
all at once.**



It accumulates quietly, one unnoticed change at a time.

The habits we normalise, the assumptions we stop questioning and the problems we learn to live with rarely transform our lives overnight. Their consequences accumulate.

Perhaps that is why the future often feels surprising – not because it happened suddenly, but because we failed to notice it while it was unfolding.

**Perhaps the future is
simply where unnoticed
change eventually
becomes impossible to
ignore.**

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TRUST ME, I SAW IT ON THE INTERNET

The Mis-information Age

By Apshita Farah

Apparently coffee causes cancer. Wait, no, it prevents cancer. GMOs are secretly rewriting your DNA. Chlorophyll water will detoxify everything your liver apparently forgot to. Vaccines come conveniently loaded with complimentary microchips. Your phone is listening to your thoughts, 5G is making you sick, and according to one convincing comment section, birds aren't real.

Welcome to the internet.

Never before has the democratisation of knowledge been so widespread, yet it has also become increasingly difficult to distinguish misinformation from harmless internet nonsense. The same infrastructure that has expanded access to verifiable scientific research, medical advice and government recommendations has also widened the channels through which misinformation can circulate.

The World Health Organization (2020) terms this phenomenon an “infodemic”: a mix of accurate and misleading information that can accompany a disease outbreak. COVID-19 provided an uncomfortable demonstration of how misinformation can erode trust in science and health authorities, encourage people to disregard expert guidance, and promote unverified treatments that place population health at risk (Bernardin & Perez-Acle, 2025). Bernardin and Perez-Acle's (2025) modelling shows just how little misinformation it can take to cause disproportionate harm: even a modest influx can amplify its spread and worsen the overall severity of an outbreak.



The bad news is “Evidence currently suggests...” is rarely as clickable as “THEY DON’T WANT YOU TO KNOW THIS.” An analysis of approximately 126,000 stories shared by three million people found that false information travelled significantly farther, faster, deeper and more broadly online than the truth (Vosoughi, Roy, & Aral, 2018). Their findings show just how easily misinformation can compete with, and potentially drown out, even the widespread circulation of factual information.

So, what can the average person do to verify their news sources and avoid inadvertently contributing to the spread of misinformation?

A useful approach is the SIFT method: Stop, Investigate the source, Find better coverage, and Trace the claim back to its original context (Kampen, 2023). In practice, that means four fairly simple steps.

First, stop. If a headline immediately makes you alarmed, frightened or desperate to forward it to the family group chat, don’t share it yet! That burst of strong emotion is a good cue to slow down and ask yourself what assumptions or biases you might be bringing to what you are reading.

Second, investigate. Where did the claim actually come from? WHO (2021) emphasises the importance of credible, science-based sources when accessing health information online. Consider the author’s expertise, potential affiliations and conflicts of interest, and biases.

Third, leave the page. Search the claim elsewhere, looking for corroborating or contradicting reports from other sources. It may sound counterintuitive, but one of the best ways to evaluate a website is to stop looking at the website itself!

Finally, trace it backwards. “Scientists have found...” is not a source. Which scientists? What study? Was it conducted in humans? Has it been peer reviewed? How large was the study? And most importantly, does the viral post actually reflect what the researchers concluded, or have the claims been stripped out of their context and misconstrued into something much more dramatic?

Figure 1
SIFT Approach



Note. From A SIFT Lesson Plan: Critical Skills for Navigating Media, by M. Guhlin, 2024, TechNotes Blog (TCEA TechNotes).

But individual vigilance is only one part of the solution. We cannot place the entire burden of navigating the digital information space solely on the public.

COVID-19 also exposed an important responsibility for scientists, researchers and public-health institutions. In a complex crisis, scientific evidence can emerge and change rapidly, all the while uncertainty remains. The Organisation for Economic Co-operation and Development (OECD) (2023) notes that the pandemic brought scientific debates occurring in the public health domain into far greater public view. As evidence developed in real time, preliminary findings, differing expert conclusions and uncertainty easily became a source of public confusion (OECD, 2023).

This makes responsible science communication all the more important. The OECD (2023) identifies six core principles for communicating science responsibly: transparency, inclusivity, integrity, accountability, freedom and autonomy, and timeliness. This means scientists should communicate not only what a study found, but also what it did not find; how certain its conclusions are; and what limitations shape its interpretation. Science is rarely a collection of definitive final answers, and communicating those uncertainties transparently is part of communicating the science itself.

The goal, then, is not simply to make evidence available, but to make credible evidence understandable, transparent and trustworthy. Responsible communication bridges the gap between science and society while supporting public trust and evidence-based decision-making (OECD, 2023).

In the end, good science communication may not be as catchy as a conspiracy theory, but it has the undeniable advantage of being true. Making that truth understandable is a shared responsibility, and when misinformation is only a click away, a little scepticism can make all the difference.

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ARE WE TAKING NUTRITION FOR GRANTED?

By Jin Yan

Dear Citizen of the Earth, picture this — it's finally the end of the workday and you are heading home. You decide to stop by the local grocery store to get some goods for dinner that night. You pick up some tomatoes, greens, protein, and pasta for a delicious home-cooked meal.

Now, imagine a world where the climate is even more turbulent than it is today, pests and diseases are common, populations are overwhelming, farmers are losing their jobs, and fresh produce prices are skyrocketing. Under these intersecting conditions, you may very well lose the privilege of whipping up a delicious and nutritious home-cooked meal.

This is the world I foresee in the indefinite future. It is a future that will affect our children or our children's children. Maybe this future exists one thousand years from now, but it is still one that concerns our descendants.

Given that global warming is already causing \$20 billion crop losses per year, it's no wonder that

extreme weather events
are the biggest perceived
threat over the next 10
years (Le Page, 2026; WEF,
2026).

In 2025, 35.5 million children were acutely malnourished across 23 countries (UNICEF, 2026). Recent heatwaves, which would have been virtually impossible 50 years ago, were the hottest and most humid ever (Luhn, 2026), so the number of lives affected by food insecurity will continue to grow, unless each one of us starts to care a little more about the risks of agricultural fragility on public health, whether that is enforced by political will or otherwise.



Extreme heat stumps horticulture growth and damages foliage, causing widespread crop losses and increased wildfire risks. That means for every 1°C of warming, staple crop yield can decline by 4 to 10% (FAO & WMO, 2026). High temperatures not only harm crops, but also livestock.

“ Heat stress is responsible for reduced productivity, weakened immunity, reproductive issues, and chronic disease onset and mortality (FAO & WMO, 2026).

Underwater, marine heatwaves trigger mass mortality events, leaving fish no other choice but to migrate from their original habitats in search of cooler areas. Agricultural workers will confront higher risks of heat-related illnesses and death from prolonged heat (FAO & WMO, 2026).

Moreover, climate change may shift the geographical tolerance of crops, betraying pre-existing agrifood systems and workforces. While this would create around 200 million hectares of high-latitude, climatically available cropland by 2100, labour, skills, working conditions, land and credit access, mechanisation, infrastructure, finance, and institutions will have to catch up (Triantafyllidou, 2026). Unless worker productivity rises significantly, land cultivation will remain a prominent struggle in future years. Extreme heat is severely undermining food security, including food production and incomes that 1.23 billion people depend on (FAO & WMO, 2026). Although climate adaptation is essential, we all have a role to play in climate mitigation.



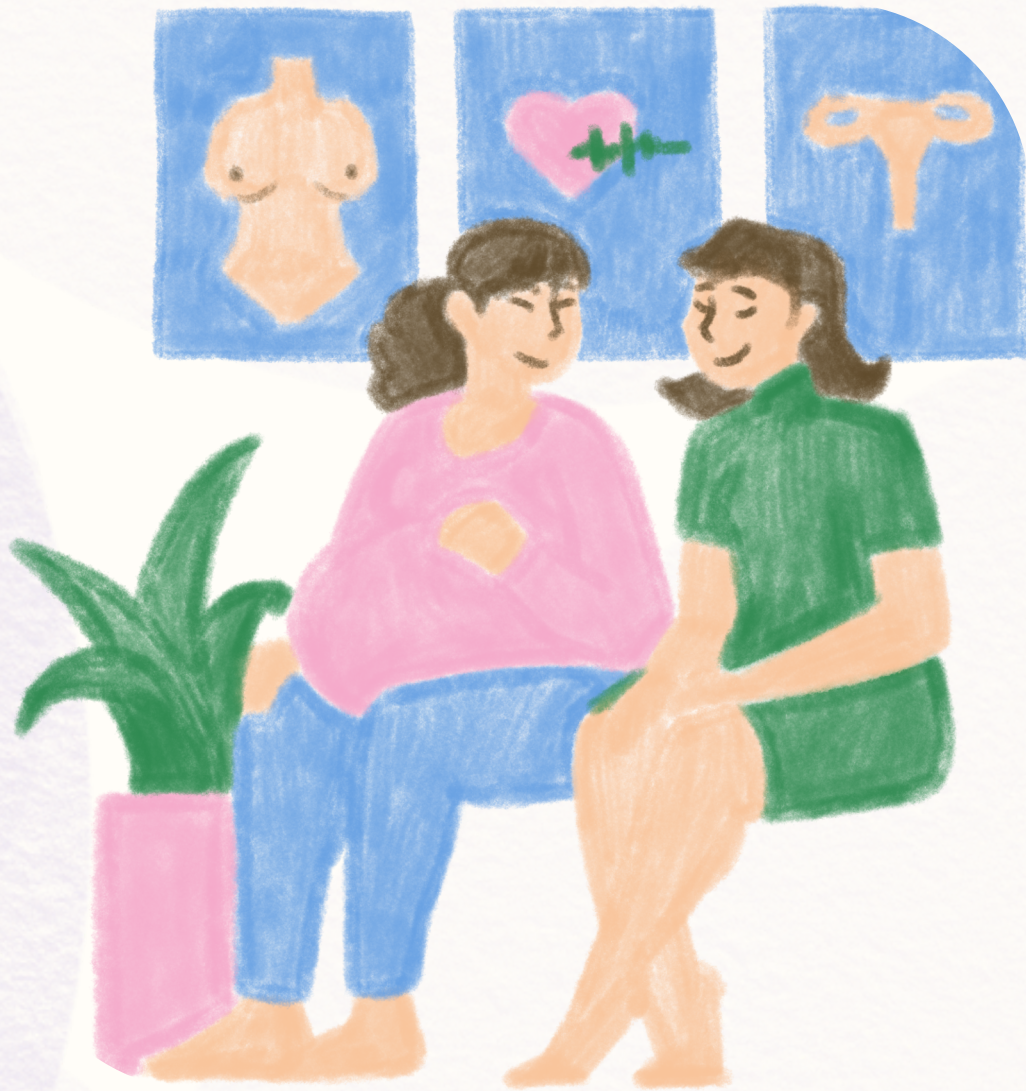
While political and industrial action is crucial to large-scale impact, there are ways to fight climate change in your everyday life. Effective lifestyle solutions already exist, and you know them: emission-free transport, energy efficiency, plant-rich diets, reducing food waste, protecting local forests, supporting the circular economy, and being a conscious consumer (Synenko, 2026).

When you look down at your plate of pasta, it might be hard to imagine a world where such a simple pleasure is unattainable. But this is the case for millions of lives in the present, and potentially your own down the line. Global catastrophic risks like malnutrition and famine can be delayed, but we must start now.

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Women's Health



Week

Special Issue

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PREVENTING MORE THAN PREGNANCY

Exploring the Future of Contraception

By Thuy Anh Vu

Contraception has traditionally been viewed as a means of preventing unintended pregnancy. However, changing lifestyle patterns, delayed childbearing, and a greater focus on preventative healthcare have expanded its role beyond fertility control. Today, contraception intersects with broader aspects of women's health, including cancer prevention, cardiovascular risk, menstrual management, and quality of life. This essay argues that the future of contraception lies in maximising systemic safety, lifestyle compatibility, and patient autonomy through longer-acting methods, safer hormonal technologies, and personalised care across the reproductive lifespan. Access to effective contraception is a cornerstone of public health. (Family Planning/contraception methods, 2025).

The World Health Organization recognises family planning as fundamental to gender equality, education, and economic participation (2025).

Likewise, investments in modern contraception substantially reduce unintended pregnancies, unsafe abortions, and maternal mortality while generating significant social and economic benefits (Adding It Up: Investing in Sexual and Reproductive Health, 2026). Despite these gains, barriers such as limited access, side effects, and high discontinuation rates remain.

One of the most significant drivers of contraceptive innovation is changing reproductive behaviour. Women are increasingly delaying pregnancy to pursue education, careers, and financial stability, meaning many spend decades avoiding pregnancy before choosing to conceive. This extended reproductive window exposes the limitations of short-acting reversible contraceptives (SARCs), such as oral contraceptive pills, which rely heavily on consistent daily adherence.

Long-acting reversible contraceptives (LARCs), including intrauterine devices (IUDs) and subdermal implants, have emerged as a more effective alternative. Because they remove the need for daily compliance, LARCs consistently outperform SARCs in preventing unintended pregnancy while reducing user error (Teal & Edelman, 2021). They also contribute to better maternal and infant outcomes by lowering unintended pregnancy rates. Australian prescribing guidelines similarly recommend LARCs as first-line contraception due to their high efficacy, safety, and suitability for diverse populations (Mason & Black, 2025).

Future developments are also focused on extending the lifespan of existing contraceptive devices. Evidence suggests that modern LARCs remain highly effective beyond their currently approved durations. Guilbert et al. (2025) found that both the 52-mg levonorgestrel intrauterine system and the etonogestrel implant maintain excellent contraceptive efficacy and safety for one to two years beyond their labelled use. Extending replacement intervals reduces healthcare costs, improves convenience, and strengthens contraceptive access, particularly for women in rural or underserved communities.

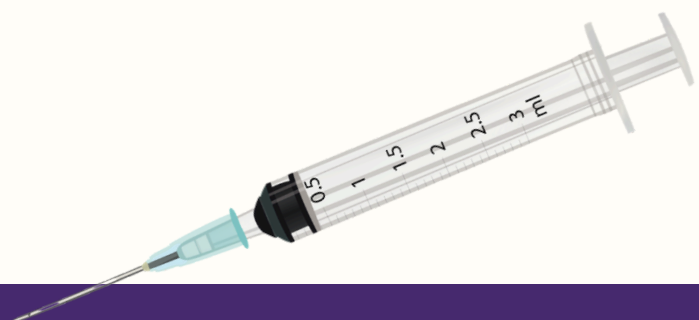
However, extending contraceptive duration alone is insufficient.



The future of contraception must also address concerns surrounding long-term hormonal exposure. Hormonal contraceptives provide important non-contraceptive benefits, including reduced menstrual bleeding and lower risks of endometrial and ovarian cancers. Nevertheless, prolonged use of synthetic hormones may disrupt endocrine balance and has been associated with mood changes, reduced libido, and potential cardiovascular or breast cancer risks (Segarra et al., 2023). These concerns reinforce the importance of continuing research into ultra-low-dose hormonal formulations, tissue-selective therapies, and highly effective non-hormonal reversible contraceptives that preserve natural ovarian function while maintaining contraceptive efficacy (Barton et al., 2023).

Contraceptive care should also evolve alongside women's changing health needs throughout life. During adolescence and early adulthood, the priority is preventing unintended pregnancy while supporting educational and career opportunities. Highly effective, low-maintenance methods such as LARCs reduce user failure and improve continuation rates, although counselling remains essential to address side effects such as irregular bleeding that commonly lead to early discontinuation.

Injections: 12 weeks



As women enter their late thirties and forties, contraceptive priorities shift considerably. Although fertility declines with age, unintended pregnancies carry substantially greater maternal and fetal risks (Van Heertum & Liu, 2017).

Contraceptive selection therefore becomes increasingly individualised, balancing pregnancy prevention with cardiovascular health, metabolic risk, and management of perimenopausal symptoms.

For women over 40, contraception often serves both therapeutic and contraceptive purposes. Low-dose progestogen-only methods and hormonal IUDs provide reliable contraception while treating heavy menstrual bleeding, stabilising hormonal fluctuations, and protecting the endometrium with lower thromboembolic risk than estrogen-containing methods (Emerson & Polyakov, 2024). For women who have completed their families, permanent contraception remains an important option, although it lacks the additional therapeutic benefits offered by hormonal LARCs (Gormley et al., 2021). These changing needs highlight the importance of regular contraceptive reviews throughout the lifespan to ensure methods remain aligned with evolving health profiles.

Ultimately, the future of contraception extends far beyond preventing pregnancy. Advances in long-acting contraceptives, improvements in hormonal safety, and investment in non-hormonal alternatives are reshaping reproductive healthcare into a more personalised, preventative model. By combining effective pregnancy prevention with broader health benefits and adapting care across every stage of life, contraception can become a lifelong contributor to women's health, autonomy, and wellbeing.



Hormonal IUD: 5-8 years*

*Duration varies by device. Graphic based on Mirena (levonorgestrel).

Source for duration of LARCs graphics: Therapeutic Goods Administration [TGA].

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PCOS TO PMOS:

What a name change can mean for the future of Women's Health

By Meher Grover

Women's health has long been understated, underfunded and under-researched. From the exclusion of women in clinical trials to the idea that women are atypical in relation to the male-centric foundation of medicine (Lyne, 2025), the medical industry seems to be years behind in its understanding of the female body. In other words, men's bodies are a template on which our knowledge of women's health is built, rather than viewing women's health as a complete and unique area of medicine. Currently, the medical system treats women's reproductive health as a convenient and isolated add-on to this template. As a result, many conditions confined to this category are extremely misunderstood.

One such condition is Polycystic ovary syndrome (PCOS), recently renamed to Polyendocrine metabolic ovarian syndrome (PMOS).

What is Polyendocrine Metabolic Ovarian Syndrome (PMOS)?

PMOS is one of the "most prevalent endocrine system conditions affecting women of reproductive age" (Singh et al., 2023). Found in 1 in 8 Australian women (Women's Health and Equality Information Hub, 2025), PMOS is incredibly complex, often described by infertility, irregular menstrual cycles, insulin resistance, hormonal imbalance/hirsutism, acne and hair fall (Singh et al., 2023).

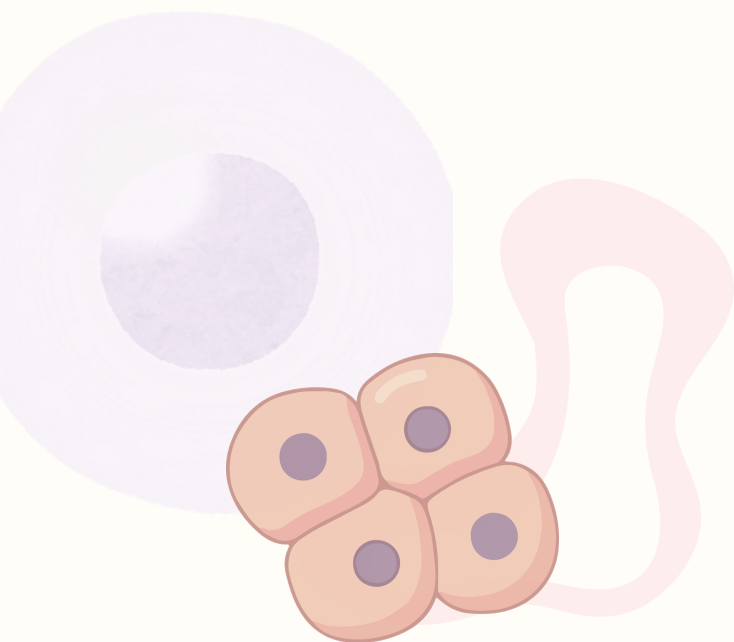
Its scope extends beyond just a reproductive issue, posing long-term health risks, including type 2 diabetes, cardiovascular disease, endometrial cancer, pregnancy complications and uterine issues, among many, if not treated appropriately. While unclear, PMOS is thought to be caused by a combination of genetic, hormonal, lifestyle and environmental factors (Health Direct, 2019). Common treatments include lifestyle changes such as managing weight, diet and stress, and symptom-specific medications to regulate periods, target infertility and ovulation as well as treat hair loss and acne (Mayo Clinic, 2022).

The problem with PCOS and the need for a change

For years, professionals argued that the previous name, "Polycystic Ovary Syndrome (PCOS)" was not representative of the actual condition itself. The name implied that the condition was caused by cysts in the ovaries, an immensely misleading idea. These "cysts" were often mistaken for harmful ovarian cysts, while in reality, they refer to small follicles containing immature eggs, present in all women (England, 2026). This misunderstanding spread into the idea that PCOS was an exclusively reproductive issue, directing focus towards its gynaecological symptoms and completely ignoring the condition's impacts on psychological, metabolic and hormonal well-being (Monash University, 2023).

The many misconceptions tied to PCOS have led to an abundance of hurdles, including; late diagnosis, lack of research and knowledge about the condition among healthcare professionals and the lack of adequate health information and support given to patients. In particular, the wait for a diagnosis can take more than 2 years for many women, even after meetings with multiple professionals and years of dealing with symptoms prior, causing further complications to arise and symptoms harder to manage (Gibson-Helm et al., 2016).

As a condition impacting millions of women worldwide, a change of name was **the first step** to ensuring all such individuals were represented and treated correctly.



The shift to renaming PCOS, directed by Professor Helena Teede,

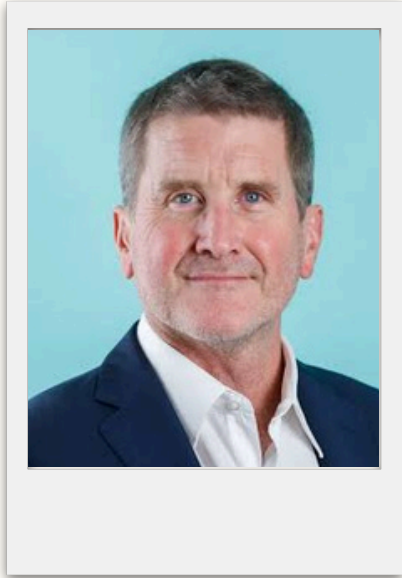


was not straightforward.

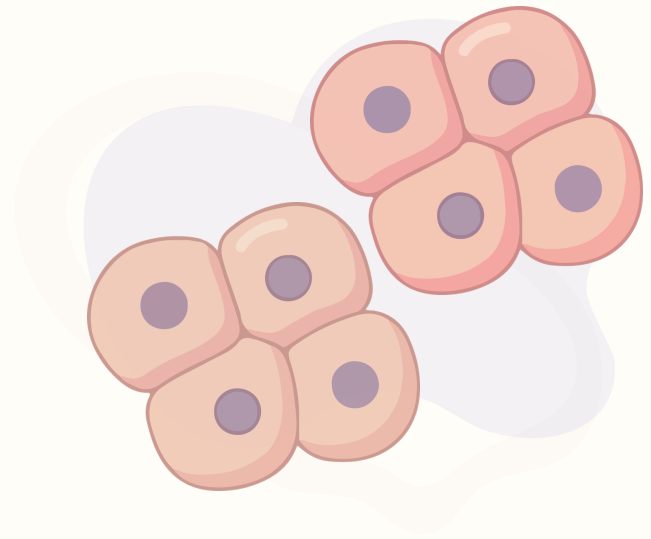
After 14 years of campaigns, research and collaboration among experts and individuals living with PCOS, the new term, PMOS, was endorsed, in what is referred to as a “landmark moment” (Roberts, 2026). This new name appropriately reflects the true nature of the condition, shifting focus away from ovarian cysts and more towards the complex full-body symptoms and systems relevant to the condition (Roberts, 2026).

The name “Polyendocrine Metabolic Ovarian Syndrome” highlights the three integral characteristics of PMOS, including the many hormonal systems that can contribute to or be affected by the condition, metabolic dysfunction in digestive and cardiovascular systems as well as ovarian dysfunction, which allows the name to retain links with reproductive health (England, 2026).

Gynaecologist, Dr Michael Costello



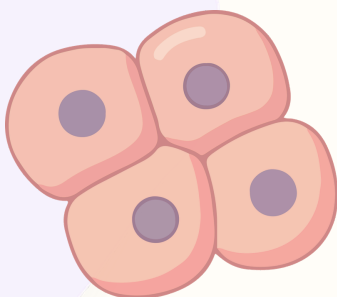
states that, “This change highlights the multidisciplinary care that is required to better support women with PMOS” (UNSW Newsroom, 2026). By accurately defining the condition, our knowledge of PMOS is given the opportunity to grow. Through this emphasised importance and higher possibility of increased funding, this long overdue recognition promises women around the world the higher-quality care that they deserve.



The Future of Women's Health

While this name change symbolises more transparent, accurate and personalised care for women with PMOS, the lengthy and laborious effort it took to make such a critical shift reveals the systemic blind spots that have existed and continue to exist in medicine. It forces us to question, challenge and re-evaluate the frameworks that our current knowledge of women's health has been constructed upon.

This change marks the beginning of healthcare growing to truly understand women, not be intimidated by their complexity. It can inspire similar shifts in other areas of women's health such as endometriosis or menopause and encourages healthcare professionals to continue building a future where millions of women can not only experience the care they deserve, but also understand the intricacies of their own health experiences.



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LESS REACTION, LESS TALK, LESS ACTION

The normalisation of human rights violations.

By Corinne Altieri

If you're anything like me, your preferred method of birth control is abortion.

I mean why would it not be? It's painless and cheap. It's a simple decision. It has no emotional, physical or psychological consequences to consider. It is easily the most rational and viable birth control method out there, right?

Think about it, why would I take a small pill every day or get an injection done every couple of months or ask my partner to wear a condom before sex if I could instead have a medical doctor insert a vacuum inside my uterus and suction out a foetus, or take two pills which would cause me incredible amounts of pain to keep me child-free?

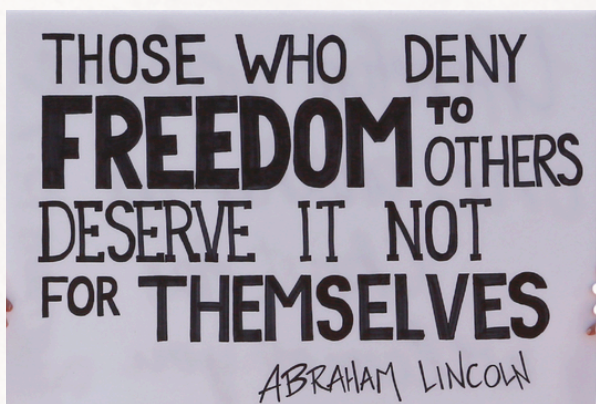
And perhaps the question then becomes, do they want me to be child-free? Irrespective of the circumstances that I am in, the life that I want to live, the family that I want to build.

To me, it feels like there is this never-ending obsession with women's reproductive health freedoms, namely the right to family planning.



It's never quite logically clicked where this fascination and preoccupation came from, and why it persists. The key word being logically. Furthermore, this idea and narrative surrounding how a woman's choice to have an abortion is their 'easy way out' from a 'bad decision'. Or a choice that she makes on a random Tuesday afternoon during her seventh month of pregnancy because she all of a sudden decides she actually doesn't want to be a mother, or worse, doesn't want someone to be a father. There's nothing easy about choosing to have an abortion, and I would argue that most women would rather never have the experience of getting one in their lifetime.

But thankfully, many women will not be able to. Or at least, not easily or safely. Within the first week of his second presidential term, Donald Trump reinstated the Global Gag Rule (GGR), also known as the Mexico City Policy. A policy which restricts funding to non governmental organisations (NGOs) outside of the United States (U.S.) who provide abortion services, including counselling, access to information and referrals to safe and licensed medical practitioners who are capable to perform them, even if these services are provided by using non-U.S. funds (1). Historically, the U.S. has been the largest government donor globally, therefore it is unsurprising that any cuts to these funds would lead to significant and detrimental consequences to those on the receiving end (2). While its initial primary focus was towards controlling abortion services, the GGR also directly impacts these NGOs capability to provide other forms of health services, including access to contraception and treatment to other infectious diseases, such as HIV/AIDS, Ebola and Zika virus (1).



**GIRLS JUST
WANNA HAVE
FUNDAMENTAL
HUMAN RIGHTS**

But it doesn't stop there. As of 2026, the GGR has expanded to restrict all non-military foreign funding, specifically targeting organisations which promote, support and invest in the health care of LGBTQIA+ communities and those who promote Diversity, Equity and Inclusion initiatives (3). All these restrictions and rules which deliberately, blatantly and violently attack human rights and the right to health in the name of 'Promoting Human Flourishing in Foreign Assistance' (3).

Importantly, the weaponisation of foreign aid through the GGR pressures these vital NGOs into having to decide whether to conform to the policy to be able to receive funding to continue to operate and provide other health services or choose to not abide under this policy and risk undermining patient well-being and individuals' access to their rightful sexual and reproductive health care (1, 4). Critically, many of these NGOs are instrumental in providing already marginalised and disproportionately affected individuals with necessary health care services, including health and sex education, which they otherwise would not be able to access (1).

It doesn't take a genius to decipher that making abortion less accessible doesn't stop it from occurring or being sought out. Rather, it increases the number of unsafe abortions performed, leading to increased mortality rates (1). Additionally, the reenactment of such regressive policies enables the continued reinforcement of gender expectations and norms, facilitation of reproductive coercion and perpetration of gender-based violence.

So what now?

Unfortunately, human rights continue to be under attack. People's right to health, right to autonomy, right to information, right to privacy, right to equality and non-discrimination, right to life continue to be under attack. So common and so persistent that desensitisation to these attacks feel normalised.

It's just another thing that's happened. Outrage and concern become a conscious choice people must make because it feels like the world is on fire, because it is.



Less reaction, less talk, less action.

Ultimately, among the populace, the less we react, the less we talk and the less we act, the easier those violations to our fundamental rights become to accept.

I urge you to continue being shaken. To continue making noise, at any scale, to your friends, your family, your neighbours, your community.

Precisely *for* your friends,
your family, your neighbours, your community.

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The Clinician's



Compass

In Conjunction with Women's Health Week

Introduction

In the early 20th century, medical records were often a handwritten note that served only as a memory aid for doctors and healthcare professionals, where their focus lied with eye contact, humour, and physical examination.

Today, the Electronic Medical Record (EMR) is used for billing, legal protection, and quality metrics. Healthcare providers are often forced to act as data-entry clerks to maintain rigorous clinical documentation standards. As a result, the ethical cost is that when staff are tethered to the screen, making patients feel like administrative burden to be processed rather than a person to be heard. This is exactly the kind of dehumanisation we want to address in The Clinician's Compass, Regimen's running feature for 2026.

Mission

To explore how clinicians maintain “ethical mindfulness” and genuine patient connection while navigating the heavy administrative and digital demands of modern healthcare.

To provide aspiring healthcare professionals with a “compass” for the non-technical skills: **resilience, virtue, ethics, and communication**, that are often sidelined in traditional textbooks.

To showcase the diverse roles within the medical ecosystem, highlighting how doctors and allied health professionals collaborate to deliver holistic, patient-centred care.

THE FUTURE FOR THOSE WITH LIMITED TIME

By Ern Syn Lee

How might gender shape a woman's experiences of care at the end of life?

There is a contradiction in the way we care for one another at the end of life. Women disproportionately provide the unpaid care that allows others to remain at home through serious illness. But when women become the ones who need care, the same expectations that positioned them as caregivers can leave them with fewer options (Edwards, 2023; Gott et al., 2020).



Palliative care is sometimes misunderstood as care reserved for the final days of life. Its purpose is broader. Palliative care for individuals can last from days to years. The World Health Organization (2020) defines it as an approach to improving quality of life for people and families facing life-threatening illness by identifying and relieving physical, psychosocial and spiritual suffering. In other words, when someone will live with a serious illness, how can healthcare help them live as well as possible?

That question will become increasingly important in Australia.

Palliative Care Australia (2021) estimates that demand for palliative care could increase by 50 per cent by 2035 and double by 2050. But meeting demand is only part of the challenge. We must also ask who has access to the care they want, and who does not.

One factor that deserves greater attention is gender.

Gender is more than biological sex. It encompasses the socially constructed roles, behaviours and expectations associated with being a woman, man or another gender identity. Those expectations do not disappear when illness begins.

In my literature review examining how gender norms influence women's experiences of palliative and end-of-life care, recurring gendered patterns emerged despite substantial differences in cultural, socioeconomic and healthcare contexts.

Women were often positioned as the “natural” caregivers, expected to provide more physical, domestic and emotional care—sometimes at significant personal cost. But when women themselves became seriously ill, increasing dependence could expose or intensify inequalities already present within their relationships. Women reported financial dependence or withdrawal of support, reduced autonomy and abandonment; in some settings, intimate partner violence was also reported (Kulikowski et al., 2025; Mkandawire-Valhmu et al., 2020).

This complicates what we mean by “choice” at the end of life. Some women questioned whether partners or family could care for them at home, while others preferred formal care to avoid becoming a burden (Ullrich et al., 2019).

How freely can we choose where and how we are cared for when that choice depends on who is available—and expected—to care for us?

These findings do not mean that every woman receiving palliative care experiences disadvantage, nor that men do not provide extraordinary care for partners and relatives (Sutherland et al., 2016). They do, however, demonstrate that healthcare cannot assume the social world outside the hospital disappears when somebody becomes a patient.

Palliative care cannot undo every inequality that came before it. But it can be attentive to them.

It should look beyond symptoms to the relationships surrounding the patient. Who is actually providing their care, should professional support be referred? Who does the patient expect will care for them? Does that person have the support, knowledge and confidence to provide care at home? Are they making decisions according to what they want, or according to what they believe they are allowed to ask of others?

Returning choice to the patient

In Australia, approximately 64% of palliative medicine physicians and 92% of palliative care nurses are women (Australian Institute of Health and Welfare [AIHW], 2026).

It is a privilege to do the work of caring out of professional interest and freedom, rather than obligation. With that privilege comes a responsibility: to recognise when the women in our care have not always been afforded the same freedom, and provide the same attentiveness and care they have so often been expected to give throughout their lives.



The ultimate question, then, is how we support women within their relationships and families when serious illness has transformed those relationships around care, dependence and burden.

For experienced oncology & haematology nurse, researcher and associate lecturer Josalind Wong, part of the answer lies in returning choice to patients.

Choice at the end of life can sound enormous: which treatments they want, who should make decisions if they no longer can.

There may never be a perfectly equal experience of dying. Families, cultures and relationships are too complex for that.

Nevertheless, we must consistently attempt to understand and advocate for our patients.

Josalind remembers the impact of helping someone “feel fresh every morning, spraying on their favourite perfume”, by remembering the little things of life before illness. Simple, consistent acts can preserve something illness can gradually take away.

When asked what the future means in palliative care, Josalind draws on years of compassionate care at the bedside: giving patients and families something to carry forward.

A person's future does not have to end with their life.

Their presence can continue in the memories made each day, the photographs taken with family and moments that give relationships space to exist beyond illness.

These moments allow a partner to be a partner again, a mother a mother, a daughter a daughter— not only a patient, caregiver or burden.

Building the future of palliative care cannot only mean increasing beds, services and workforce numbers. It must also mean understanding who is providing the care, who feels entitled to ask for help, whose preferences are heard, and whose choices are constrained by expectations they have carried for a lifetime.

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CONCLUDING REMARKS

Thank You For Your Readership.

This year's direction and quality have been shaped by the collaboration of the women of Strive. I am in awe of their dedication to bettering the prospects of their communities, and advancing their chosen fields of study.

A special thank you to our writers, our president Elim Tai, our marketing director Sophie Yang and our co-graphic designer Thuy Anh. We look forward to receiving you in our next edition.

Ern Syn Lee, Publications Officer



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