



vicdoc

MAGAZINE OF THE AUSTRALIAN MEDICAL ASSOCIATION (VICTORIA) LIMITED OCTOBER 2015

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VIOLENCE
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TRANSGENDER
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- ✓ greater access to education and promotion of doctors' health and wellbeing in Victoria
- ✓ collaborative events and activities of interest for the Victorian medical profession
- ✓ stronger advocacy on the key issues impacting our local medico-legal and medico-political landscape
- ✓ complimentary professional medical indemnity for eligible post graduate doctors at next renewal*
- ✓ 50% premium reduction off MDA National's professional indemnity for eligible doctors in specialist training at next renewal.*

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Commission statement

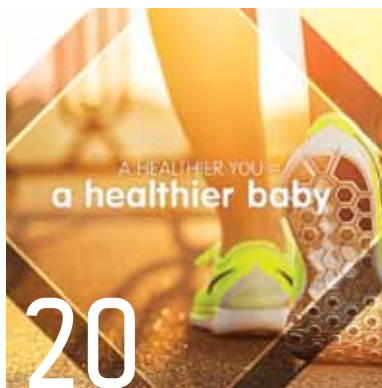
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AMA Victoria continues to evolve

Strategic Plan

A constant theme over the past 12 months has been, undeniably, that it has been a year of change. As our society evolves, so too its health challenges. AMA Victoria must evolve to meet these new challenges. We have a proud and rich history, developed over the past 150 years. We are exceptionally positioned to build on that dedicated history. However, we must always be willing to renew our commitment to the medical profession and to the health and wellbeing of all Victorians.

Earlier this year, AMA Victoria held a search conference where a large group of members, non-members and stakeholders came together. The result was the development of a new purpose which reflects the AMA that members of today would like it to be. Our new strategic direction was subsequently formulated, and defines our role in terms of outcomes focussed on the health of those we serve.

The purpose for AMA Victoria is to *amplify doctors' contribution to the health and wellbeing of all Victorians*. The future role of AMA Victoria today has changed in style and is now more aspirational, more about improving the life of Victorians.

Our purpose will be achieved through four linking pillars.

First, by creating a vital and vibrant community of medical practitioners. A strong vibrant community which is well-equipped to tackle the health problems of our society.

Second, by wisely using our powerful and trusted voice to develop and advocate policy that improves the health and wellbeing of all Victorians.

Third, by learning through listening, connecting and collaborating; by leading members, the medical community and society on all health matters. We are smarter together than we are apart.

And fourth, by serving our members – assisting members at every stage of their career; making it easier for doctors to focus on medicine and the wider medical community.

I am extremely proud of our vision. Our challenge is to bring that strategy into operation. AMA Victoria is committed to ensuring that everything it does proclaims and resonates with this vision. It is important that we aspire to achieve those outcomes, presenting ourselves as that viable solution to doctors today, doctors tomorrow, and Victorians as a whole.

We are indeed well placed to connect and lead doctors in a way that makes doctors proud to be a part of AMA Victoria and achieve a healthier future for all.

End of Life Submission

After extensive consultation with members, including via member surveys and feedback, a policy forum and discussion, and a vigorous Council debate, AMA Victoria made a submission to the Victorian Parliament's Inquiry into End of Life Choices.

AMA Victoria has called for legislation that protects doctors who provide necessary palliative treatment to patients who are

in a terminal phase of a terminal illness. While this treatment is intended to relieve suffering and pain, it may have a secondary consequence of hastening death. Doctors practising good medical practice in these situations fear, and are at risk of, persecution in this regard, and thus legislation is needed.

AMA Victoria urges the enactment of legislation to provide legal certainty to medical practitioners in connection with the accepted clinical practices of:

- double effect, where the administration of treatment or other action intended to relieve symptoms may have a secondary consequence of hastening death; and
- non-provision of futile care, where medical practitioners are generally not obliged to provide treatments that are considered futile.

While these practices are ethically acceptable practices by the medical profession, many doctors are concerned that they are not adequately protected by the law. As such, patients may not be receiving the care they wish to have at the end of life because medical practitioners fear prosecution.

AMA Victoria requests the following principles, which are consistent with South Australian law¹, to be incorporated in new Victorian legislation to rectify this legal uncertainty:

1. the protection relates to measures directed at maintaining or improving the comfort of a person who is, or would otherwise be, in pain and distress (to be defined as "palliative care");
2. there must be an existing doctor/patient relationship;
3. the patient is in the terminal phase of a terminal illness;
4. the protection relates to a medical practitioner or his/her agent if the medical practitioner is responsible for supervising delegated care;
5. the protection relates to the provision of palliative care (as defined above) or the non-provision of futile medical treatment;
6. there is no civil or criminal liability if performed in accordance with good medical practice and with the intent of relieving pain or distress.

This submission was considered, informed by members, debated by Council, and discussed at length by the Board. I am of the view that this legislative change, along with binding advance care directives and greater funding for palliative care, will improve aged care in Victoria. AMA Victoria will continue to advocate for these changes.

The full submission can be viewed under the policy section of our website.



Dr Tony Bartone
President
AMA Victoria

1. Section 17, Consent to Medical Treatment and Palliative Care Act 1995 (South Australia).

AMA Victoria leads and amplifies doctors' contribution to the health and wellbeing of all Victorians.

Connect & Lead

Uniquely positioned to build on 150 years of dedicated service, AMA Victoria connects and leads to achieve a healthier future for all.

Our purpose is achieved by:

Vibrant Community

Creating a vital and Vibrant Community that is more together than apart.

Connecting, supporting and growing a strong and vibrant medical community that is future-ready and can solve society's problems.

Collaborating and continuously learning to ensure AMA Victoria is the leading, respected voice in health.

Powerful and Trusted Voice

Using our Powerful and Trusted Voice to improve the health and wellbeing of all Victorians, now and in the future.

AMA Victoria works across the whole system to develop and advocate policy that improves the health and wellbeing of all Victorians, both now and in the future.



Learning and Leading through listening, connecting and collaborating with members, the medical community and society on all health matters.

We are smarter together than we are apart; we lead by collaborating across the whole system to address the purposes, concerns and circumstances of members and all Victorians for better health.

Here to Serve our members, and the wider medical community, so as to address the greater needs of society.

Assisting members at every stage of their career.

Connecting and leading in a way that makes doctors proud to be a part of AMA Victoria.

Learning and Leading

Here to Serve

New Cabinet allows renewed lobbying

On Tuesday 15 September, Australia's fourth Prime Minister in five years was sworn in. Much of the media commentary on this change has focussed on how it happened, who is out and who sided with who. For the AMA, it is integral to focus on who is in and how best we can influence change for the benefit of members, and the health of the community.

While Sussan Ley remains Health Minister, there is now a Rural Health Minister, a new Assistant Health Minister, and a cohort of new Chief of Staffers and Senior Advisers to work with.

The issues that affect AMA Victoria members' working day crosses between State and Federal government decisions. While AMA Victoria deals predominantly with the Victorian Government, and AMA Federal the Commonwealth, our input on the GP co-payment, the Fringe Benefits Tax exemptions, Medicare Locals/Primary

Health Networks and COAG decisions (such as the review into medical internships) requires us to be across all changes in Canberra.

Deviating from my usual column which details AMA Victoria's services, activities, wins and events, this edition is simply to inform members on the new Cabinet, Assistant Ministers and Outer Ministry (as I am yet to see a newspaper article that has done this!).



Frances Mirabelli
CEO
AMA Victoria

Cabinet

The Hon Malcolm Turnbull MP
Prime Minister

Senator the Hon Nigel Scullion
Minister for Indigenous Affairs

Senator the Hon Michaelia Cash
Minister for Women, Minister Assisting the Prime Minister for the Public Service, Minister for Employment

Senator the Hon Arthur Sinodinos AO
Cabinet Secretary

The Hon Warren Truss MP
Minister for Infrastructure and Regional Development, Deputy Prime Minister

The Hon Josh Frydenberg MP
Minister for Resources, Energy and Northern Australia

The Hon Julie Bishop MP
Minister for Foreign Affairs

The Hon Andrew Robb AO MP
Minister for Trade and Investment

Senator the Hon George Brandis QC
Attorney-General, Leader of the Government in the Senate

The Hon Scott Morrison MP
Treasurer

The Hon Kelly O'Dwyer MP
Minister for Small Business, Assistant Treasurer

Senator the Hon Mathias Cormann
Minister for Finance, Deputy Leader of Government in the Senate

The Hon Barnaby Joyce MP
Minister for Agriculture and Water Resources

The Hon Christopher Pyne MP
Minister for Industry, Innovation and Science, Leader of the House

The Hon Peter Dutton MP
Minister for Immigration and Border Protection

The Hon Greg Hunt MP
Minister for the Environment

The Hon Sussan Ley MP
Minister for Health, Minister for Sport

Senator the Hon Marise Payne
Minister for Defence

Senator the Hon Mitch Fifield
Minister for Communications, Minister for the Arts, Minister Assisting the Prime Minister for Digital Government

The Hon Christian Porter MP
Minister for Social Services

Senator the Hon Simon Birmingham
Minister for Education and Training

Outer Ministry

The Hon Mal Brough MP
Special Minister of State, Minister for Defence Materiel and Science

The Hon Jamie Briggs MP
Minister for Cities and the Built Environment

Senator the Hon Fiona Nash
Minister for Rural Health

The Hon Michael Keenan MP
Minister Assisting the Prime Minister for Counter Terrorism, Minister for Justice

The Hon Stuart Robert MP
Minister for Veterans' Affairs, Minister Assisting the Prime Minister for the Centenary of ANZAC, Minister for Human Services

The Hon Paul Fletcher MP
Minister for Territories, Local Government and Major Projects

The Hon Luke Hartsuyker MP
Minister for Vocational Education and Skills, Deputy Leader of the House

The Hon Steven Ciobo MP
Minister for International Development and the Pacific

Senator the Hon Richard Colbeck
Minister for Tourism and International Education, Minister Assisting the Minister for Trade and Investment, Deputy Leader of the House

Assistant Ministers

Mr Ken Wyatt AM MP
Assistant Minister for Health

The Hon Michael McCormack MP
Assistant Minister to the Deputy Prime Minister

The Hon Darren Chester MP
Assistant Minister for Defence

Senator the Hon Concetta Fierravanti-Wells
Assistant Minister for Multicultural Affairs

Mr Alex Hawke MP
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The Hon Alan Tudge MP
Assistant Minister to the Prime Minister

Senator Anne Ruston
Assistant Minister for Agriculture and Water Resources

Senator James McGrath
Assistant Minister to the Prime Minister

The Hon Karen Andrews MP
Assistant Minister for Science

Dr Peter Hendy MP
Assistant Minister for Productivity

Mr Wyatt Roy MP
Assistant Minister for Innovation

Senator the Hon Scott Ryan
Assistant Cabinet Secretary



**President's
Reception**
10 September 2015
Zinc Federation Square



Outdoor dining smoking ban



AMA Victoria welcomes the State Government's announcement that smoking will be banned in outdoor dining areas from 2017.

"Victoria is the last state in Australia to ban smoking in outdoor dining areas. Victoria used to be a leader in tobacco action and this important change is long-overdue," AMA Victoria President, Dr Tony Bartone told media outlets.

"AMA Victoria calls on the Victorian Government to apply the smoking bans in all commercial outdoor dining and drinking areas – courtyards, laneways, rooftops, balconies, street tables and beer gardens.

"This needs to apply to all premises – regardless of whether food is sold or not. Drinking and smoking is just as harmful as eating and smoking.

"We are talking about the health of all Victorians here. Smoking in outdoor dining areas affects not just the health of patrons, but also the health of all the employees who work at these venues," Dr Bartone added.

Good complaints management

Our last edition included an article by the Health Services Commissioner, Dr Grant Davies, which detailed the principles of good complaints management. The Victorian Equal Opportunity and Human Rights Commission (VEOHRC) can assist health services and training organisations with these issues and can be contacted on 1300 292 153.



Do you have a story to tell?

AMA Victoria welcomes contributions to *vicdoc* from members. Would you like to write about something significant you or someone you know has achieved in the medical world? Do you have an opinion on a current issue that you're keen to get off your chest? Or do you simply have an idea for a story? Contact *vicdoc* Editor, Barry Levinson on (03) 9280 8722 or BarryL@amavic.com.au



Section of General Practice invite you to the 2015

Section of General Practice

AGMDINNER

Monday 26 October

6.30 pm–9 pm

RACV City Club

501 Bourke Street
Melbourne

GUEST SPEAKER

Dr Peter Harcourt,
AFL Medical Director

**Issues for doctors looking
after elite athletes**



Section of Psychiatry invite you to the 2015

Section of Psychiatry

AGMDINNER

Thursday 29 October

6.30 pm–9 pm

RACV City Club

501 Bourke Street
Melbourne

GUEST SPEAKER

Professor Michael Ackland,
Deputy Chief Health Officer

**Public Health in Victoria –
a Chief Health Officer's
perspective**

AMA Victoria forms alliance with MDA National

AMA Victoria is forming a strategic alliance with MDA National to enhance advocacy on local medico-legal and medico-political issues, and optimise education and support for Victoria's medical profession.

AMA Victoria President, Dr Tony Bartone, said the alliance formalises AMA Victoria's ongoing collaborative relationship with MDA National.

"AMA Victoria is confident this alliance will deliver additional value to our members, we are thrilled to announce that MDA National is now the organisation's premium medical indemnity provider," Dr Bartone said.

MDA National President, Dr Rod Moore, said the alliance solidifies MDA National's position as AMA Victoria's premium medical indemnity provider.

"We are delighted to launch this alliance which features multiple benefits for MDA National and AMA Victoria members," Dr Moore said. These include:

- greater access to education and promotion of doctors' health and wellbeing;
- stronger advocacy on the key medico-legal and medico-political issues;

- collaborative events and activities of interest;
- complimentary professional medical indemnity for eligible doctors in training;
- professional indemnity premium reductions for eligible doctors in specialist training programs.

For more information about MDA National see page 2.



War and Peace - what now?

A one day conference for health professionals is being held in Melbourne on Saturday 31 October at Trades Hall, Carlton, presented by the Medical Association for Prevention of War.

Speakers include:

Julian Burnside AO QC: Australia's approach to asylum seekers - we must do something, but what?

Dr Phoebe Wynn-Pope: Banning the bomb - current achievements and next steps

Dr Richard Di Natale: A constructive role for Australian foreign policy

Professor John Langmore: Australia's place as a peacemaker - past and future

Nic Maclellan: Peace and conflict in the Pacific Islands - future trends and opportunities

Dr Sue Wareham OAM: War and civilians

Dr Andrea Phelps, M. Psych (Clinical), PhD: PTSD and moral injury in veterans



For more details visit mapw.org.au

RSVP to Phyllis Campbell-McRae on eo@mapw.org.au or (03) 9023 1958.



You are invited to attend the

AMA VICTORIA MASTERS

TUESDAY 17 NOVEMBER 2015
Kingston Heath Golf Club
Shotgun start at 1 pm.

THE DAY INCLUDES:

18 holes, entry fee, pull carts, practice balls, course maps and rules, light lunch buffet on arrival, on course drinks.
Golf Format: Ambrose

ALL INCLUSIVE PACKAGE:

AMA Victoria member and guest \$80 each
Non member \$300

RSVP: t: (03) 9280 8722 E: reception@amavic.com.au



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Specialist family violence services

Domestic Violence Victoria outlines what they are and how they can work with medical practitioners

Recently I answered a distraught call from a woman experiencing family violence. Christine (not her real name) had been physically and psychologically abused by her brothers for 30 years. Her elderly father, living with one of her brothers, was now also being abused. Christine was palpably terrified for her own and her father's safety and she urgently needed a service to help her. She had just disclosed her experience of family violence to her GP, who referred her to Domestic Violence Victoria (DV Vic) for help.

DV Vic is the peak body for women and children's services in Victoria. We do not provide specialist family violence services. We could only refer her on to a service in her area. Christine will have to tell her painful story over again

for the third time. She may decide that it's too hard; she may feel that there is no one who can help her; she may feel let down by the system that is there to protect her. And that is before she has even made contact with a specialist family violence service.

I tell this story to highlight the critical role of medical practitioners in the early detection and response to family violence. It is well established that women often (around one in five according to NSW research¹) first disclose family violence to their doctor. Recognised as a trusted source of information and confidante, general practitioners are in the front line in responding to family violence, making it absolutely critical that their responses are appropriate and effective. We know

that best practice in responding to disclosures of family violence includes non-judgemental listening and validation, an initial safety assessment, appropriate referrals and continuing care. In some cases, mandatory reporting may be required if child abuse is suspected. In Christine's case, the doctor in question didn't have the necessary information at hand to refer her directly to specialist services in her area, resulting in a circuitous and more stressful process which may or may not have led to appropriate support.

As a community we are increasingly aware of the prevalence and impact of family violence. Consequently, general practitioners will see more and more patients who are affected by it. The Victorian Royal Commission is



focusing much needed attention on family violence and systemic responses in this state. There is now a real opportunity for medical practitioners and specialist family violence services to work together to ensure that women and children affected by family violence receive the best response and support possible.

General Practice and specialist family violence service: partnerships for early intervention

Effective responses to family violence must include a comprehensive and consistent approach to early intervention – capitalising on the opportunities to engage women and children experiencing family violence before their situation reaches crisis point. This is the point where specialist family violence services can develop responsive partnerships with doctors to build capacity, strengthen referral pathways and develop more effective interventions for women and children.

The primary healthcare setting is recognised as an invaluable site for opportunistic interventions with both women and children experiencing family violence. General practitioners are commonly the first point of disclosure because of the trust relationship women have with their doctors and also because, for many women, a visit to the doctor may be one of few permissible external contacts. Research shows that women in this situation visit their doctors more frequently than other women, and children experiencing family violence also present more often to health services.² So much depends on the response women receive when they first disclose or seek support to leave a violent relationship. Evidence shows that if a woman's first contact, whether it is with friends or family or services, is met by an uninformed response, they can be reluctant to seek support again, significantly increasing their risk of harm.³

First responses to women and children should ensure that:

- she will be believed and her experiences taken seriously;
- her rights will be upheld and her safety protected;
- she will not be judged or experience any disadvantage if she chooses to



return to her violent relationship; and

- she will have accessible options and will be supported to make safe changes for herself and her children.

The critical role that the medical profession plays in the early detection, intervention and treatment of women and children is highlighted in the resource *Supporting patients experiencing family violence*, recently developed by the AMA and the Law Council of Australia. In setting out some general information about family violence, the resource acknowledges the complexity of family violence and appropriate responses to it. This important work can be enhanced and supported by partnering with specialist family violence services in developing effective interventions with women and children.

What is specialist family violence practice?

Collaborative partnerships are built on a shared understanding of respective skills and practice bases. Family violence services provide a specialist response to women and children experiencing family violence in two core areas: comprehensive risk assessment and safety planning; and advocacy and support for women as they traverse the complex legal and social support systems required for separation. The risk of harm to the woman and her children escalates following separation, making specialist support and safety planning critical at this time.⁴

The specialised skills, knowledge and practice of family violence work has developed over time in response to evidence-based practice and emerging theoretical models within a framework

of broad principles.⁵ Understanding the nature and dynamics of family violence and the lived experience of the women and children who suffer it is the underpinning of effective responses. This knowledge informs the specialist practice of family violence workers, as well as the variety of abusive behaviours that constitute family violence – physical, psychological, emotional, financial and sexual abuse. Importantly it includes an understanding that intimate partner violence is overwhelmingly perpetrated by men against women and provides a gendered analysis of the impact of overt and coercive power and control within abusive relationships. This helps to explain the complex dynamic that makes it difficult for women to leave violent relationships, and why women often return multiple times before they finally leave.

Risk assessment and safety planning

Specialist family violence services are underpinned at every point of contact with a client by ongoing risk assessment and risk management processes. In a family violence context, risk management is a dynamic process. Risks change over time, can shift suddenly and are usually outside the woman's control. This means that her journey throughout the service system is unlikely to be linear. Specialist family violence services provide a continuous response of ongoing risk assessment, safety planning and risk management so that services are responsive to the woman's and her children's safety needs at any point in the process.

Specialist family violence practitioners are uniquely trained to undertake

this sophisticated risk assessment and management. This approach is embedded in the Family Violence Risk Assessment and Risk Management Framework (known as CRAF) which is based on three pillars:

1. evidence based individual risk factors;
2. the victim's own assessment of the level of risk to herself and other family members; and
3. the practitioner's judgement based on a sophisticated understanding of the context and dynamics of family violence.

This process involves a conversation through which an individualised safety plan is developed that integrates police and other services as required. The woman's assessment of her own risk and that of her children is pivotal to this process and it is adaptive to the woman's needs at the time. For example, if she wants to stay or to leave the relationship. As the woman is most at risk of harm when she leaves or is planning to leave a relationship, these conversations must be nuanced and skilfully conducted.

Specialist family violence service delivery is based on a trauma-informed approach. This is a strengths-based approach to understanding and responding to the impact of trauma on women and children. It draws on an understanding of the neurological effects of trauma and the range of adaptive responses and patterns, conscious and unconscious, developed to cope. The need for physical, psychological and emotional safety of women and children is prioritised along with their need to establish a sense of control in their lives.

In summary, the key elements of trauma-informed specialist family violence practice are:

- a safe environment;
- a strengths-based framework that

creates opportunities to rebuild a sense of power and control;

- taking time to build trust through information sharing and mutually agreed boundaries; and
- an understanding of the impact and responsiveness to the impact of family violence-related trauma, which means that women and children who have experienced violence are not blamed or pathologised for the ways that they manage their traumatic stress. It supports women and children to understand why they feel and behave in certain ways.

Advocacy and support

Specialist family violence services provide women with a range of support options appropriate to their needs at the time, wherever they are on the journey away from family violence. They work on the principle that no contact with women is wasted; that every opportunity to talk about their experience breaks down the process of denial or minimisation that is inherent in the family violence dynamic. Specialist family violence services work with women to facilitate access to various options that may increase their level of safety, and provide information and support that allows women to make decisions about their future. Most women require information and time spent discussing their situation to understand how the dynamics of family violence impacts on their options. Some women have multiple and complex needs such as mental health or substance abuse issues and family violence services will work with them to manage these, sometimes with the assistance of other specialist services.

Additionally, family violence specialists' comprehensive knowledge of the system enables them to support and advocate for women and children as they navigate the complexities of child

protection, liaison with police, courts, and immigration issues. Often women face practical barriers to finding safety and require assistance with income support, financial advice, education, housing or employment. As the only professionals within the family violence system focusing exclusively on women and children and their experience of violence, family violence workers can provide assertive advocacy throughout the process.

Conclusion

The complexity and time demands involved in responding to family violence necessarily require a specialist practice. While medical practitioners have a key role to play, particularly in facilitating early detection and interventions, they do not have the time, resources or specialised skills to support women and children through the journey of leaving family violence. Family violence specialists can work collaboratively with medical professionals to increase their knowledge and understanding of family violence and to inform their knowledge of referral pathways and appropriate services. They are a valuable resource for the medical profession – doctors cannot be the experts on every presenting issue that presents, but specialist family violence workers can support them to ensure that the first response women and children receive from a trusted source, their doctor, is informed and sensitive. The journey out of family violence is always hard and can be slow, but every supportive and informed contact along the way means that women and children are a step closer to safety.



Fiona McCormack
Chief Executive Officer
Domestic Violence Victoria

1. Spangaro, J & Zwi, A. A 2010 *After the Questions: Impact of Routine Screening for Domestic Violence in NSW Health Services*, School of Public Health and Community Medicine, University of New South Wales
2. For example, Hegarty, K, Gunn, J, Chondros, P & Taft, A 2008, Physical and social predictors of partner abuse in women attending general practice, *British Journal of General Practice*, vol. 58, pp. 484–487.
3. For example, Bagshaw, D, Chung, D, Couch, M, Lilburn, S & Wadham, B. 2000 *Reshaping Responses to Domestic Violence: Final Report*, University of South Australia, Adelaide wesnet.org.au/wp-content/uploads/2012/07/PADV-Reshaping-responses.pdf, pp 33-36
4. Barrett Meyering, I 2012 Staying/Leaving: Barriers to Ending Violence Relationships, *Australian Domestic & Family Violence Clearinghouse*, UNSW adfvfvc.unsw.edu.au/PDF%20files/Fast_Facts_7.pdf
5. For a comprehensive overview, see *DV Vic 2015 Specialist Family Violence Services: The heart of an effective system*. Submission to the Victorian Royal Commission into Family Violence dvvic.org.au/images/DV%20Vic%20Submission%20to%20the%20Royal%20Commission%20-%20Specialisation.pdf
6. Kezelman, C. 2013 "Trauma-informed practice: how important is this for domestic violence services" Newsletter 52, Autumn, *Australian Domestic and Family Violence Clearinghouse*, UNSW, Sydney adfvfvc.unsw.edu.au/documents/Newsletter_52

Submission on the *Health Services (Conciliation and Review) Act 1987*

AMA Victoria responded to the Department of Health's request for feedback on the *Health Services (Conciliation and Review) Act 1987*. Our primary focus was on the scope of the Office of the Health Services Commissioner (OHSC).

Unregistered practitioners

Over the last decade, there has been a significant increase in the number of unregistered 'health' practitioners using medical equipment (i.e. lasers) or recommending health remedies (i.e. disease cures, weight loss, pain relief). These unregistered practitioners are outside the scope of the Office of the OHSC and AMA Victoria supports an amendment to the 'health service' definition.

The *Health Services (Conciliation and Review) Act 1987* currently defines 'health service' to include any of the following:

- a. *Medical, hospital and nursing services;*
- b. *Dental services;*
- c. *Psychiatric services;*
- d. *Pharmaceutical services;*
- e. *Ambulance services;*
- f. *Community health services;*
- g. *Health education services;*
- h. *Welfare and social work services necessary to implement any services referred to in paragraphs (a) to (g)*
- ha. *therapeutics counselling and psychotherapeutic services;*
- hb. *laundry, cleaning and catering service, where those services affect health care or treatment of a person using or receiving a service referred to in this definition;*
- i. *Services provided by chiropodists, chiropractors, osteopaths, dieticians, optometrists, audiologists, audiometrists, prosthetists, physiotherapists and psychologists*
- j. *Services provided by optical dispensers, masseurs, occupational therapists and speech therapists*

- k. *Services provided by practitioners of naturopathy, acupuncture and in other alternative health care fields;*
- ka. *Services provided by Chinese herbal medicine practitioners, acupuncturists and Chinese herbal dispensers;*
- l. *A service prescribed as a health service for the purpose of the Act – and includes any services provided by the Department of Health and the Secretary to the Department of Health;*

While paragraph k refers to 'other alternative health care fields', the definition needs to be amended as many new (and potentially dangerous, harmful and/or unethical) services do not claim to be a 'health' service, for example tattoo removal and laser hair removal are not health related. Therefore, the legislation needs to include services that are primarily concerned with changing the human body (physical appearance, physiological functioning, and psychological and mental outlook).

AMA Victoria recommends amending the legislation to include:

- kb. *Services provided by an individual, business or organisation that intends or claims (expressly or otherwise) to change the human body (physical appearance, physiological functioning, psychological and mental outlook).*

Under this new definition, unregistered health practitioner services should include, but are not limited to: alternative therapies (such as homeopathy); complementary medicine and therapies (such as massage); herbal, natural and/or mineral medicine/remedies/ingredients (such as 'salt therapy'); the hair and beauty/cosmetic sector; the tattoo sector (including removal); weight-loss, diet, allergy, intolerance services; fertility and pregnancy services; fitness, strength and conditioning services; psychological and mental services (such as hypnosis, mindfulness).

Registered practitioners

As stated in AMA Victoria's 2012 submission on the OHSC, extensive regulations currently apply to registered health practitioners and these provide a strong safeguard for the public. These regulations and requirements are monitored and enforced by AHPRA (by law, the OHSC must inform AHPRA of any complaint they receive against a registered health practitioner). There should be no more regulations imposed on registered health practitioners.

By increasing the OHSC's scope to include unregistered practitioners, the function (and power) of the OHSC will be improved. The OHSC must be able to impose sanctions on unregistered health practitioners who have been found to have caused harm.

OHSC reports

The OHSC must identify trends and implement the necessary changes in an efficient manner. The rise of unregistered health practitioners, and the harm that some do, has been an issue for many years. AMA Victoria hopes that any future trend or new 'health' practice will be within the realm of the OHSC's powers; and if it is not, then swift change is required to ensure public safety. The public must be protected from unregistered health practitioners.

Furthermore, the OHSC should publish quarterly reports that detail the nature of the complaints and identify the major health services, and large clinics (in a de-identified manner), so that trends and ongoing issues are transparent and can be acted upon.

To read the full submission see the policy section on our website.



Felicity Ryan
Media & Public Affairs
Officer



Chasing a cure for Motor Neurone Disease

It's no secret that funding for medical research is critically short. So it was a dream come true when the Florey's Dr Brad Turner spoke to a community group and unwittingly attracted the attention of a scout who would radically change his future – and hopefully the lives of people living with Motor Neurone Disease (MND).

Dr Turner is renowned for his community outreach activities and his relentless quest to cure MND. As the head of the Florey's MND group, he recently spoke to an Inner Wheel Club in Pakenham, enthusiastically describing his work to the group and outlining a project he believed promised great hope for a new treatment. This alerted Rotary Pakenham and a short time later, a phone call arrived from a trustee of a philanthropic foundation, recommending he submit a research proposal as quickly as possible.

A few days later, Dr Turner was told he would receive \$3 million over five years, thanks to the Stafford Fox Medical Research Foundation, a fund that does not accept requests but, rather, seeks worthy projects and invites applications.

"This could change the course of MND. Until now, I haven't had the funding to achieve it. It is truly, utterly amazing," Dr Turner said.

It is a relentless disease, with nerves controlling movement (motor neurones) degenerating and rapidly wasting muscles. It strips away the independence of people living with it, who

lose their ability to walk, feed themselves, talk and breathe. The average lifespan from diagnosis is 27 months. So the need to find effective treatment is urgent.

The grant will allow Dr Turner and his team to fast-track some significant findings they made last year, using a form of gene therapy to substantially increase the lifespan of MND mice. The research builds on previous work he has done at Oxford University, looking at a gene involved in a childhood form of MND called Spinal Muscular Atrophy (SMA).

Children born with the condition are missing a gene and become weak at six months and die within two years. Significantly, Dr Turner found the gene was also missing in MND mice and in tissue from patients.

He experimented by putting the gene back in the MND mice – with dramatic results: the lifespan of the mice increased by two months. MND mice usually only live for four months. The process of replacing the gene also measurably saved motor neurones.

"The sad thing about MND is that by the time people are diagnosed with it, 50% of motor neurones are gone so that they are already at crisis point," Dr Turner said. "We want to prolong a person's lifespan and save their motor neurones – they are the two key objectives for an effective treatment."

For the next phase of research, the Florey's team will collaborate with Flinders University scientists using a specially devised tool

– a gene therapy – to deliver the SMA gene to motor neurones in the brains of mice.

Once the team has demonstrated that the tool brings about the same effect in the mice – a two-month increase in survival – they will adapt it to a clinical trial in humans.

“Conventionally, a clinical trial can take 10 to 15 years to happen but in the case of MND it can be sooner due to accelerated approval and fast track status of promising drug candidates. Within five years we could potentially have something.”

Dr Turner said the MND patients he talks to are heartened by the findings and particularly by a graph showing the prolonged lifespan of the mice.

“When people are diagnosed with MND they know precisely what it is, they know the course it will take and that they often have no or little hope. Part of their hope comes from the knowledge that people in lab coats are beavering away working on their disease, passionately, and as a fulltime commitment – and that actually lifts their spirits.”

Dr Turner will continue to share his work with the public – going out to speak to interest groups and hosting an annual ‘Ask the Expert’ day when patients and their families hear talks and see demonstrations of lab techniques.

“They love it!” he said, “And they ask some impressive questions.”

The 36 year-old has researched MND for more than a decade and has succumbed to the Ice Bucket Challenge four times. “When I first read about MND, I thought ‘it’s tragic and terminal’. Then I thought ‘I need to help solve this.’ I tell people that I have a lifelong commitment to work on this disease.

“The Florey’s a great place to work. It has prestige. It’s unique. I don’t know of many places that are working on so many neurological disorders under the one roof. That means great collaboration.

“At the start of my PhD, people would ask ‘is there going to be a cure?’ and I’d say I wasn’t sure. Now I tell people that it’s not a matter of ‘if’ but ‘when’. An effective treatment or cure is on the horizon.”



Florey Institute of Neuroscience & Mental Health

Motor Neurone Research

The Turner lab seeks to unravel the molecular pathogenesis of MND, also called amyotrophic lateral sclerosis (ALS). Dr Turner’s team employs a combination of biochemistry, cell and molecular biology to study motor neurone pathogenesis in cell culture and mouse models, seeking to identify and understand the primary mechanisms underlying motor neurone stress and injury in MND, while translating discoveries into candidate biomarkers and effective therapeutic targets.

The group is particularly interested in the molecular determinants of protein misfolding, mistrafficking and accumulation within neurones and harnessing endogenous cellular protective mechanisms to combat protein misfolding.

A further area of investigation is the therapeutic action of survival motor neurone (SMN) protein for MND. Here the team found that its restoration slows disease onset and improves motor neurone survival in a mouse model of MND. This approach is being extended to SMN gene therapy in other mouse models of MND, while developing new therapy approaches for efficient and sustained SMN gene delivery.

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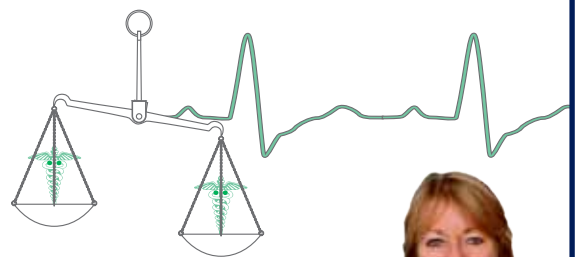
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Learning about transgender patients

Over the last three years, trans and gender diverse (TGD) people seem to be everywhere. From Caitlyn Jenner to stories of young people and their families forging ahead, through to articles about actress Ruby Rose identifying as non-binary, suddenly this issue is more prominent in society. So what happens when someone with this life experience presents at your practice?

First, let's be clear about who we are talking about. TGD (sometimes transgender) is used as an umbrella term for anyone whose gender identity and/or expression differ from society's expectations, based on how the person is recorded at birth, given that person's body. So to give one example, Caitlyn Jenner (known to some as the 1976 Olympic decathlon champion and others as a member of the Kardashian family) was assigned male at birth, yet her innate sense of gender identity is female. She now expresses herself in ways society describes as feminine. Other people may not identify as either women or men, and fall under the term 'non-binary'.

As people become more comfortable expressing their identity, the likelihood of a TGD person visiting your practice is increasing. With the aim of providing the most respectful, dignified and best service possible, and this means an approach of individual centred care - a different path for every patient to achieve this aim - what are some general guidelines to follow? For some, this may seem to be incredibly obvious, but sadly we've had too many stories from TGD people that reflect the opposite, so here are a few tips.

Use the name, pronouns and labels/definitions used by your patient. If

someone says, "I'm Jim and I'm a trans man", or "I'm Kim and I use 'they' as a pronoun", go with that. But if the patient doesn't give any indication it is perfectly ok to ask. For example, "I'd really like to be respectful, what pronouns if any do you use?" If you honestly believe you know someone's preferred pronoun and get it wrong the first time (it won't always be he or she), just apologise and move on from there. Be aware that many people identify simply as women or men, not as TGD.

Be affirming. If a patient 'comes out' for the first time, replying, "I'm really honoured you've disclosed that to me" is positive. Saying, "What do you want to do that for?" or to a young person, "You're too young to know about that," can be extremely harmful.

Also be aware that bodies can differ from the two 'expected' versions of male and female. If it is necessary for a patient to remove their clothes during a consultation, being aware of this can prevent shock or alarm. Virtually all trans men are unable to add a phallus for a range of reasons. Only 25-30% of trans women who permanently affirm their gender identity as women have lower surgery. This also has medical implications: trans women need prostate checks and trans men need pap smears and, in some cases, breast screening for their whole life. However, many TGD people avoid medical examinations due to past negative experiences. It is important to be aware that terms you might be accustomed to using when describing people's bodies can be interpreted as misgendering and offensive. Ask patients which terms they use to describe their body parts. For example, a man of trans experience

might find the terms 'vagina' and 'clitoris' offensive and instead use terms such as 'frontal opening'.

Finally, ask if it's ok to touch certain body parts. For example, a trans woman who is yet to have surgery may have an extreme dislike of her birth genitalia and touching could cause distress. An understanding of this will go a long way to making your patient feel comfortable.

There is much talk about prescribing hormones as part of a TGD person's journey, but in reality hormones are just another pharmaceutical and involve the same degree of skill and professionalism as any other.

TGD issues also need to be considered by other practice staff. Being the most knowledgeable health professional goes to waste if the rest of your practice is not included. Consider issues such as phone conversations. Hearing a deep voice and saying, "Good morning sir, how can I help you?" will most likely lead to a disconnected call if the caller happened to be a trans lady. Other issues to consider are having inclusive forms and gender-neutral toilet options.

Ultimately, consulting with TGD patients is simply about using your existing skills and fleshing out good practice management, thereby giving great service and retaining patients. For more information, including details of group training, contact enquiries@transgendervictoria.com



Sally Goldner
Transgender Victoria
Executive Director



Representing general practice IR interests

The AMA Victoria Workplace Relations unit has multiple dealings with our general practitioner members on a daily basis, providing support and advice on staff management issues, such as performance and discipline, defending unfair dismissal applications and award entitlements.

We've been working hard representing the industrial interests of our GPs. Here's an update on some recent issues.

Enterprise Bargaining Agreement (EBA)

A newly AMA negotiated EBA will deliver an 18% pay increase to GPs employed by CoHealth, a new community health practice serving the inner north and west. Other key conditions include two weeks' paid study leave, a \$6000 bonus, the ability to purchase additional annual leave and a guarantee that contractors will be offered employment so that they can access the benefits. It has been a complicated process because CoHealth was an amalgam of three separate entities, each with different conditions. AMA Victoria is now in the process of registering the EBA under federal law.

Managing GP redundancy

In late July, St Vincent's GP employees were advised of their pending redundancy and intention to be offered re-engagement as contractors. Members requested our involvement. AMA Victoria was quick to address the poor communication and the negative implications of what was a rushed process and we ensured St Vincent's placed a proper value on their GPs. We represented the different needs of GPs arising at each affected site, forced substantial amendments to what was an unfair and very poorly drafted contract offer, successfully (for some sites) advocated for increases to the originally offered fee split and in some cases improved redundancy payouts.

Contract issues

We are regularly advising members on the appropriateness of their offered employment or contractor agreements relating to their work at a practice or for in-patient public hospital services. Beyond reviewing the contract for any perceived unfairness, AMA Victoria can also consider the percentage of billing and other pay arrangements, span of hours, on-call ratios and the meaning of restraint and intellectual property clauses.

This year there have been several cases where AMA Victoria has represented members subjected to debt recovery by their previous practice. In some cases, we have been able to reduce alleged overpayment claims by tens of thousands of dollars by uncovering errors, for example, employees being subjected to GST and not receiving the full value of their superannuation or their aged care billings.

Trainee issues

There have been multiple occasions this year where we have worked to equip trainees with the insight and knowledge they need to progress their careers. Recent issues for some trainees include:

- alleged bullying by practice staff;
- failing core competency requirements;



- being subjected to unfairness through selection processes; and
- deficiencies in exam techniques.

In these cases, AMA Victoria has been acknowledged by the training providers and practices as an important, influential stakeholder who can broker solutions and crystallize what issues need to be resolved.

For all industrial issues, whether you are a practice owner, an employee, contractor or trainee, AMA Victoria is here to help. Contact Workplace Relations on 03 9280 8722.



Andrew Lewis
Senior Industrial Relations Adviser

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Legal requirements for doctors witnessing powers of attorney

Often people making an enduring power of attorney have ailing health and/or mental capacity and are particularly vulnerable to exploitation. Appointing an enduring power of attorney enables that person to appoint someone they trust to manage their financial and legal affairs if they become incapacitated.

The *Powers of Attorney Act 2014* (Vic) has introduced changes to Victoria's power of attorney laws which take effect from 1 September 2015.

The previous 'enduring power of attorney' and 'enduring power of guardianship' will be consolidated into one enduring power of attorney, who will have powers to make decisions regarding financial and/or personal matters. This includes, for example, financial decisions about how to invest money, or personal decisions about where a person lives.

A general power of attorney (which stops as soon as the principal loses capacity) will be known as a non-enduring power of attorney.

The *POA Act* also introduces a supportive attorney appointment, who will not make decisions on behalf

of the principal but will support the principal to make their own decisions, including by collecting information, communicating or assisting the principal to communicate, or by doing anything to give effect to the principal's decisions.

The *POA Act* does not alter enduring powers of attorney (medical treatment), which is regulated separately under the *Medical Treatment Act 1988*.

What is the doctor's role in appointing powers of attorney?

A person who wishes to appoint a power of attorney must be over 18, and must possess capacity to make the decision to appoint. Doctors are often called on to perform the complex task of assessing a person's decision-making capacity.

The *POA Act* makes a clear statement that a person is presumed to have capacity unless there is evidence to the contrary.

Certificate

Witnessing an enduring POA requires more than simply witnessing the signature of the person appointing the

enduring POA.

Section 125A of the *Instruments Act 1958* requires a witness to an enduring POA to sign a certificate confirming that:

- the person making the enduring POA signed it freely and voluntarily in the presence of the witness; and
- at the time, that person appeared to the witness to have the capacity necessary to make the enduring POA.

The witness has a statutory duty to make an independent assessment of both issues required by the certificate before signing it. Medical practitioners may incur liability if they fail to discharge this duty. How this risk can be avoided is discussed in detail in the members-only section of our website amavic.com.au

On the Legal Services Fact Sheets page, click on the link to Witnessing Powers of Attorney in Victoria - Legal requirements for doctors. You will also find a number of other useful legal fact sheets in this section.

(Last reviewed May 2015)

Medicare rebate freeze must end

An election is almost certain to be held by September next year, and the Federal Government is facing difficulties on several fronts, including health policy.

While many in the Government believe its health policy woes disappeared with the disposal of the GP co-payment, the reality is the Medicare patient rebate freeze remains a big electoral headache. The freeze remains Government policy. The AMA and others will work to have it abolished before the election. It is bad health policy.

It is important that people - especially politicians seeking re-election - understand the rebate goes to the patient. Only in the case of bulk billing does it go directly to the doctor.

The freeze is based purely on reducing health expenditure, rather than investing in patients' health. The government has failed to consider the consequences.

For a long time, the Medicare rebate has been indexed in such a way that it has failed to keep pace with the value of the services provided, let alone the cost of providing those services. Indexation of GP rebates was delayed by eight months from November 2013 until July last year. Then, after the Medicare rebates were eventually indexed by 2%, this year they were frozen until 2018.

As wages and other practice costs rise - and we expect more from general practice - the costs of providing services will be passed on directly to patients. There will be an increased burden on those patients as there will be a growing out-of-pocket cost to accessing quality healthcare.

The Government portrays doctors as only being concerned about indexation in terms of their incomes, but this argument is false. This is about the viability of practices in socially disadvantaged areas. It is about the ability of doctors to provide the type of healthcare we expect from our GPs. It is about whether they can employ the practice nurse or invest in the equipment that helps them provide the patient with better healthcare. The freeze to indexation is a direct attack on general practice.



This is not AMA rhetoric. It is what GPs all over the country are saying to the AMA and to their patients.

The indexation freeze will also have a significant impact on the affordability of non-GP specialist services. It has been a cynical exercise that has shifted more costs onto vulnerable patients, and it is starting to undermine the effectiveness of the private health insurance system.

Gaps for specialist care don't just have an impact on services such as surgery. The failure to index has had a profound impact on the accessibility and affordability of services for patients needing to see a psychiatrist, a cardiologist or a dermatologist. In many instances, these will be patients with chronic and complex diseases. They need the care of many specialists.

Normally each year, as the Medicare schedule is indexed, so too are the private health insurers' schedules. The freeze has meant private health insurers have had to make a decision on also freezing their schedules, or indexing and

absorbing the extra costs.

Some private health insurers, such as Medibank Private, have chosen not to index their known gap schedule. As a result, there is likely to be a growing number of doctors who will choose not to participate and instead charge a gap.

Government measures that reduce the value of private health insurance by increasing out-of-pocket expenses - or putting upward pressure on health insurance premiums - undermine our private sector. This puts more pressure on our public hospital system and the effects flow back to general practice. That's not good for anyone.

(First published in *Medical Observer* 25 August 2015.)



Professor Brian Owler
Federal President
The AMA

Obesity and reproductive outcomes

'Your Fertility' is a government funded, national public education program to improve knowledge about modifiable factors that affect fertility and pregnancy health. Each year, in the first week of September, its 'Fertility Week' campaign focuses on one of the factors affecting fertility. In 2015 it highlighted the impact that being overweight can have on fertility.

Obesity is one of the great public health challenges in contemporary high-income societies. Awareness of many of the adverse health consequences of obesity is growing and the role of prevention and health promotion to reduce the prevalence of obesity is increasingly being recognised. But the impact of obesity on fertility and reproductive outcomes is less well known.

Prevalence and causes of obesity

A healthy BMI for adults is between 18.5 and 24.9 kg/m². A BMI between 25–29.9 kg/m² is classified as overweight and BMIs of 30 kg/m² and over as obese. It is estimated that more than half of Australian women and men of reproductive age are overweight or obese.¹

People who are overweight or obese often feel bad about this and in part this is due to the stigma attached to obesity.² Therefore, health professionals' advice about the health effects of obesity needs to be non-judgmental and supportive. Furthermore, recommended weight loss goals should be achievable, the timeframe to reach those goals realistic, and ongoing support provided to those who commit to weight loss.

Obesity and reproductive outcomes

Most people want and expect to have children sometime in their life³ but may be unaware that obesity reduces their fertility and the chance of having a healthy baby.⁴



Preconception obesity

Studies show that the health of a baby at birth and into adulthood is affected by the health of the parents even before conception.⁵ One of the factors that contribute to a less favourable environment for eggs and sperm is obesity. Consequently, getting into shape and striving to be in the healthy weight range before conception will significantly improve the odds of having a healthy baby.

Obesity and fertility

Obesity can cause hormonal changes that interfere with ovulation and reduce fertility. As a result, obese women on average take longer to conceive than women in the healthy weight range and are more likely to experience infertility.⁶ In men, obesity

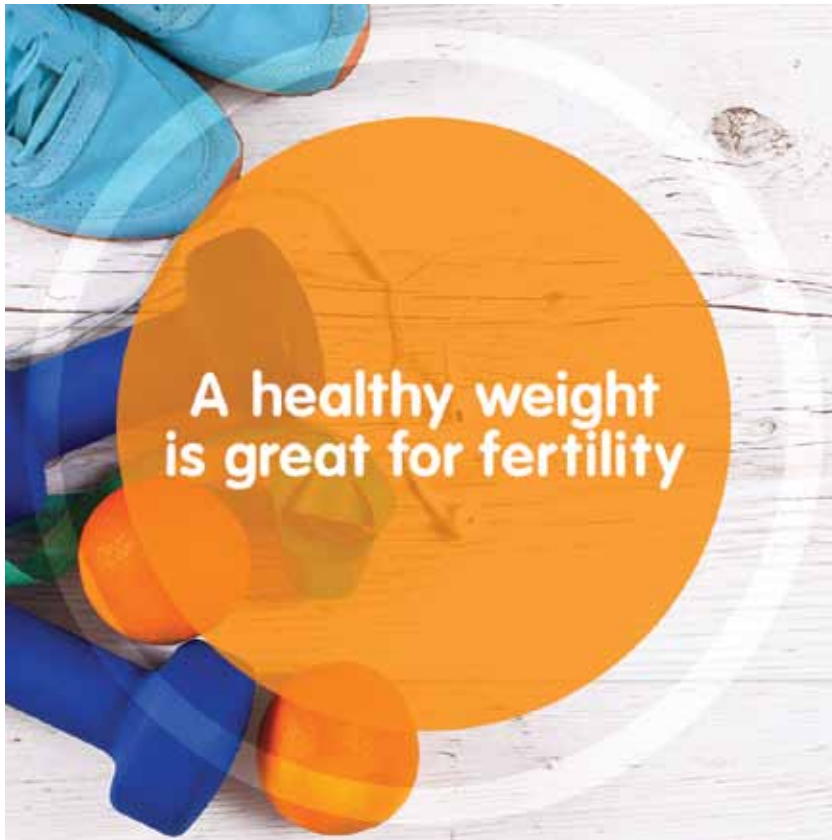
is associated with lower fertility. This is likely due to a combination of factors including hormone problems, sexual dysfunction and/or other health conditions linked to obesity.⁷

Among infertile couples who use assisted reproductive treatment (ART) to conceive, female and male obesity reduces their chance of achieving a pregnancy.⁸

Obesity and pregnancy health

Compared with women in the healthy weight range, overweight and obese women are more likely to develop gestational diabetes, pregnancy induced hypertension, and preeclampsia; experience miscarriage and still birth; have induced labour; and be delivered by caesarean section.⁹

MOST PEOPLE WANT AND EXPECT TO HAVE CHILDREN SOMETIME IN THEIR LIFE BUT MAY BE UNAWARE THAT OBESITY REDUCES THEIR FERTILITY AND THE CHANCE OF HAVING A HEALTHY BABY.



Obesity and the new baby

Overweight and obese women are more likely than women in the healthy weight range to have a baby weighing more than 4.5 kilograms at birth (macrosomia),¹⁰ and who is at increased risk of future childhood and adult obesity and all its associated health problems.¹¹

The good news

While the facts about obesity and reproductive outcomes can seem daunting, there is some good news. In obese women, even a modest weight loss of 5-10% improves their chance of conceiving¹² and dietary and lifestyle interventions that limit pregnancy weight gain can improve outcomes for both mother and baby.¹³ Also, men and women are twice as likely to make positive health behavior change if their partner does too.¹⁴

What you can do

GPs and other primary health practitioners have a crucial role to play

in educating people of reproductive age about the known risks of obesity on reproductive outcomes.

People who plan pregnancy are motivated to do everything they can to have a healthy baby. This is a good time to promote the benefits of weight loss before conception for those who are overweight or obese and explain the importance of limiting pregnancy weight gain.

Lastly, encouraging partners who want to have a baby to tackle losing weight and increasing physical activity together, will potentially improve their chances of achieving this goal.



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Treatment Authority



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The benefits of an early diagnosis of dementia

Dementia is an increasingly common condition, with 342,000 Australians living with it and almost one million people expected to have the illness by 2050. Although there is no known cure, awareness and early diagnosis are crucial to improving the lives of people with dementia.

It can take two to three years from the time symptoms are recognised until a diagnosis of dementia is made. This is because the symptoms many not always be obvious to the person or their family and friends. Early symptoms can include memory problems, confusion, difficulty managing everyday activities and social withdrawal. As people may mistakenly assume that such behaviour is a normal part of the ageing process, symptoms may develop gradually and go unnoticed.

An early diagnosis provides answers

An early diagnosis can make it easier to find ways to help someone with dementia maintain their independence and enhance their quality of life. Changes in memory and thinking ability can be worrying and identifying the cause of these symptoms can bring relief to people and their families. Not only does an early diagnosis provide time for a person with dementia and their family to adjust, it also allows them to play an active role in making decisions regarding their future treatment.

Healthcare professionals can help

Healthcare professionals play an essential role in early dementia detection. General practitioners are often the first point of contact for people with dementia, as well as their families. By being aware of the resources available to assist with an early diagnosis, GPs can make a real difference to the lives of people with dementia.

GENERAL PRACTITIONERS ARE OFTEN THE FIRST POINT OF CONTACT FOR PEOPLE WITH DEMENTIA.

Alzheimer's Australia can help

Alzheimer's Australia provides a range of information, practical advice and support services that can help healthcare professionals and their patients understand the many aspects of living with dementia. Most services of Alzheimer's Australia are provided at no cost, including the early-intervention 'Newly Diagnosed' and 'Living with Memory Loss' programs, the National Dementia Helpline and the Detect Early website.

Detect Early

The Detect Early campaign was created to improve awareness about Alzheimer's disease and other dementias and to provide



resources to help healthcare professionals make a real difference to the lives of people with dementia and their carers. The detectearly.org.au website features help sheets containing advice, common sense approaches and practical strategies on the issues most commonly raised about dementia.

GPs can access the GPCOG, an RACGP-accredited screening tool. It takes less than four minutes for patient assessment and only two minutes to interview the caregiver. The website also provides GPs with information on the early signs of dementia and advice on how to assist their patients who may be concerned about dementia. CPD points can also be gained for accredited dementia learning.

Alzheimer's Australia

Alzheimer's Australia is the charity for people with dementia and their families and carers. As the peak body, it provides advocacy, support services, education and information.

detectearly.org.au

National Dementia Helpline: 1800 100 500



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Launching AMA Victoria's DiT Mentoring Program

On 19 September, AMA Victoria had the pleasure of launching its inaugural 'Doctors in Training (DiT) Mentoring Program', with the first cohort set to commence their 'mentorships' in December.

The program was launched by the President of AMA Victoria's DiT Subdivision Committee, Dr Enis Kocak (pictured) at the 'Next Steps' DiT Conference and is a significant new service provided by AMA Victoria to its DiT membership.

The initial program will be structured as a pilot and will involve 10 pairs who will come together in a mentoring partnership for 12 months. If the pilot is successful we plan to expand the program within the next 12 months, with a second intake commencing in April next year.

Why is the DiT Mentoring Program being launched and what is its purpose?

The DiT mentoring program has been established in direct response to concerns raised by the AMA Victoria DiT Sub-Committee, as well as by the broader AMA Victoria membership who are current and prospective DiTs. The program is specifically designed to support the mentoring needs of DiTs as they assess career options and navigate the ever-changing health services landscape.

The program is unique in that it sits outside of a mentee's current workplace and/or training environment. The intent being to create a safe, confidential and supportive environment in which frank and robust discussion can occur to assist mentees to think about, and to respond to, career and professional development opportunities and challenges, in order to reach their potential and achieve their professional goals.

In engaging the program, mentees will benefit substantially by accessing the knowledge and experience of more



senior AMA members in a one-on-one mentoring format. There will also be opportunity to participate in small group events over the course of the mentorship on topics relevant to personal and professional development.

What is mentoring?

Mentoring is a dyadic psychosocial intervention in which a more experienced individual is brought into a close relationship with a less experienced person in order to provide, support, guidance and opportunities for career, social and professional development.

Two models of mentoring: sponsorship & developmental

1. Sponsorship - A progressive model of mentoring designed to support the mentee to get from position A to B. It is more specific and structured and is underpinned by particular goals / issues / gaps that the mentee would like to address within a timeframe, with the support of a mentor.

2. Developmental - A more holistic model of mentoring where the mentor aims to help the mentee develop new skills and abilities. The mentor

acts as a guide and a resource for the mentee's growth, which can be at both a professional and personal level.

Becoming a part of the pilot program

Mentees

The pilot program is designed to be available to DiTs in years two through to five after graduation (HMO2-HMO5). You must be a current AMA Victoria member, have full registration and be able to participate in the program for its 12-month duration (Nov 2015 – Nov 2016). We would hope that those who partake in the program as mentees would have aspirations to one day take up a role as a mentor.

Mentors

We have a small pool of volunteer mentors who have already committed to this pilot program, however, we would like to add to this group and are seeking expressions of interest from current AMA Victoria members who have an interest in developing their professional mentoring skills.

To be a part of the program, you must have full registration, be a senior

registrar or consultant, be passionate about medicine, committed to your particular area of practice and be familiar with the training pathways and requirements for your area of practice. Most importantly, you value the opportunity to share your passion and commitment with a junior doctor.

You may or may not already have experience as a mentor, or have been involved in the education and supervision of junior doctors. We will provide induction and guidance in relation to the role.

How to apply or express interest

Applications for the roles of mentees and mentors can be submitted via our website amavic.com.au/mentoring

All applications must be submitted by Friday 23 October 2015 to be assessed for suitability. Any enquiries regarding the pilot can be emailed directly to mentoring@amavic.com.au



Mardi O'Keefe
Careers & Pathways
Coordinator



Kay Dunkley
Peer Support Program
Coordinator

AMA VICTORIA MENTORING PROGRAM

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Community Grants

In 2014, AMA Victoria awarded Community Grants to four Doctors in Training (DiT) projects. Thanks to all of the groups who submitted an application. After an update from two recipients in the June-July edition of *vicdoc*, we now hear from the other two on the great work they achieved.



Water Well Project

The Water Well Project has been busy this past year delivering health literacy sessions throughout Melbourne and Geelong to migrant, refugee and asylum seeker communities. In 2014, we delivered 45 sessions throughout Melbourne and were recognised in the Department of Health Victorian Refugee and Asylum Seeker Health Action Plan, and as finalists for the Melbourne Awards for Community Contribution. This year, we have expanded to the Geelong area.

With the help of an AMA Victoria DiT Community Grant, we were able to reach 10 different community groups and run 13 sessions, specifically on healthy eating and nutrition: teaching community members about good nutrition combined with the importance of exercise, to reduce the risk of diabetes and cardiovascular issues.

Our education sessions are tailored specifically to each group and run in an informal and interactive session. In particular, sessions run with parenting groups have the objective of providing practical tips for sustainable healthy eating, food preparation and how to

ensure adequate nutrition for growing children. In groups with younger members and students, our aim is to engage participants in interactive games around health and nutrition, and invite them to take control of their own health.

Examples of the exercises used include 'The Traffic Light Game', which involves large green, orange and red paper circles fashioned as traffic lights for the participants to place food products according to their health value - healthy/everyday foods (green), in-moderation foods (orange) or 'sometimes' foods (red). Another popular activity is measuring out teaspoons of sugar contained in well-known products such as soft drinks (11 teaspoons always surprises people).

2014 and 2015 have been very successful campaigns. The community representatives have described the sessions as "fabulous" and "very informative". The overall feedback from our nutrition sessions has been that we have positively impacted on the health and wellbeing of these communities. For more information about our work, visit thewaterwellproject.org

Community Based Health Project

Community Based Health Project (CBHP) is a partnership between University of Melbourne students with a passion for global health, and a primary healthcare service led by Dr Moses Kharat, based in the rural Indian region of Buldhana, in the western state of Maharashtra. The Australian branch provides assistance to CBHP India through fundraising, project planning and engaging with communities.

This year has seen further development of CBHP India's activities in the health sector and community life. The project continues to expand, taking on two new project villages, training village health workers, and providing regular mobile health clinics and community liaison.

An exciting milestone included opening the Videya Niketan English School, a low-cost English-medium preschool for children from slum and village backgrounds. It aims to provide a safe, supportive learning environment for disadvantaged children and families, and to encourage value and participation in ongoing education.



CBHP Australia also facilitated the launch of the Early Education Child Sponsorship program in January, to support children to attend the school. Another 10 volunteers spent a month in Buldhana for the Volunteer Immersion Program, assisting at clinics and schools, surveying and evaluating field projects and participating in community life.

We are now seeing students from diverse educational backgrounds joining our team, and as a result, we are able to expand our reach and the way we address primary healthcare issues from Australia. This year has seen us achieve charity status and launch our corporate sponsorship program. For more information about our work, visit communitybasedhealthproject.org

The Inaugural 2015

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We are seeking nominations which recognise the actions and achievements of General Practitioners who identify with a disability who go above and beyond what could be reasonably expected, and in doing so, encourage aspirations and ideals of high standards and values.

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Closing date October 23rd 2015




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Please cc judith.robertson@supremecourt.vic.gov.au

How group singing promotes health and wellbeing

As a GP, I see patients with complex conditions seeking solutions for healthier and happier lives. While doctors can provide treatment for diseases, becoming active and creative within one's community on a regular basis is a powerful tonic. I believe group singing is a very effective way to enhance wellbeing, charging up hearts, lungs and minds for better health and brighter futures.

Many people have been told that they cannot sing, or they feel self-conscious and afraid of making mistakes. Their voices have been silenced and they are missing out on excellent health benefits.

I am involved with the inspirational *With One Voice* social inclusion program. Each week, their choirs unite people of all ages and backgrounds for singing and supper. They bring together CEOs, doctors, lawyers, teachers and retirees with migrants, youth-at-risk, job seekers and those suffering from depression and disabilities.

The *With One Voice* program has been operating for six years, in which time it's touched the lives of thousands of participants, their families and networks. A recent research project in collaboration with Swinburne University and *beyondblue* showed participation greatly contributes to enhanced wellbeing and reduced stress, depression and anxiety.

Through the cross-community networks created at the *With One Voice* choirs, over 200 people have been assisted to find work experience and jobs, and hundreds of participants have been connected to community services and medical practitioners they otherwise would not have accessed, particularly in relation to mental health and chronic illness.

The study also highlighted that one of the most valuable parts of the program is the opportunity to meet with diverse people on a level playing field, create new relationships and give back to others – often emotional support and simple kindness.



In her 2013 article 'The Benefits of Music for the Brain', Dr Sarah Wilson (School of Psychological Sciences, University of Melbourne) concludes that, "Music participation provides a powerful tool to enhance learning for people of all ages because of its widespread effects on the brain and its ability to induce experience-dependent neuroplasticity."

I would encourage medical professionals to consider referring vulnerable patients with mental illness or social

disadvantage to *With One Voice*... and to consider it for themselves also.

For more information on *With One Voice* and singing groups, visit creativityaustralia.org.au



Dr Sharon Woolf
GP

1. Branigan E, Barker C, 'The Power of Song: an evaluation of the *With One Voice* program', Swinburne University's Centre for Social Impact, February 2015.

Monthly wrap

The Eastern and Southern subdivision member forums were the first two to be held in August, with Jim Doumakis, owner of JOSE Health Informatics, providing advice on medical IT networks.

A good attendance at both forums ensured a flurry of questions during and after Jim's presentations, as he demystified the world of medical IT networks, covering the main components, types available, security,

a case study and accreditation requirements, including compliance-relevant standards.

In Horsham, the Wimmera subdivision was also well attended, with a number of members and visiting RMOs - who usually miss their own subdivision meetings - travelling some distance to hear guest speaker, Dr Mark Pilbeam from St John of God Pathology.

Dr Pilbeam's presentation "Blood and Iron" provided an overview of the metabolic processes, the causes and effect of iron deficiency and overload, as well as providing an update on new developments in the diagnoses and management of iron status.

We thank our sponsors JOSE Health Informatics and St John of God Pathology.



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Time: 8.00am – 5.30pm

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Thursday 15 October**JILL HENNESSY MP DINNER**

Time: 6.30pm – 8.30pm

Venue: Park Hyatt, 1 Parliament Square, Melbourne

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Thursday 22 October**NORTHERN SUBDIVISION
DINNER MEETING**

Speaker: Jim Doumakis

Topic: Medical IT Networks (Demystified)

Venue: C H James, 86 Station Street, Fairfield

Time: 6.30pm – 8.30pm

Sponsor JOSE Health Informatics

Monday 26 October**SECTION OF GP AGM**

Speaker: Dr Peter Harcourt

Topic: Issues for doctors looking after elite athletes

Venue: RACV Club, 501 Bourke Street, Melbourne

Time: 6.30 pm–9 pm

Thursday 29 October**SECTION OF PSYCHIATRY AGM**

Speaker: Professor Michael Ackland

Topic: Public Health in Victoria - a Chief Health Officer's perspective

Venue: RACV City Club

501 Bourke Street, Melbourne

Time: 6.30 pm–9.15pm

To RSVP: T: (03) 9280 8722 or E: reception@amavic.com.au

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Holding the Man

A significant amount of anticipation has met the film adaptation of *Holding the Man*. Based on Timothy Conigrave's 1994 memoirs of the same name, Timothy and John's love story has a firm place in the gay canon. After penning a successful theatrical adaptation, playwright Tommy Murphy returns to Tim and John's story for the big screen.

The film – directed by Neil Armfield – had its world premiere at the closing night gala for the Sydney Film Festival in June and was the centrepiece gala at the Melbourne International Film Festival (MIFF) in August.

For those yet to read it, the book is turbulent and gut-wrenching. I remember reading it when I was in my first year at university following a recommendation from a new friend I had recently met in the queer lounge on campus.

Like many others, reading the book was a rite-of-passage as I began to articulate my own gay identity. *Holding the Man* has been a pivotal text in the formation of an Australian gay identity. It intimately follows Tim's 15-year relationship with John Caleo, the star of the school football team. Their story begins at Melbourne's Xavier College, where their high school romance is filled with sneaky pushes, love letters and secret rendezvous at night. This theme of forbidden love is made even more obvious through Tim's role in the school production of *Romeo & Juliet*.

Tim and John's years at Xavier College are lovingly captured in the film with their youthful infatuation adapted from key passages in the text, from Tim writing on John's pencil case in class to the dinner party where they share their first kiss.

Early into the film, Armfield cuts to a later stage in their relationship, a transition that is particularly disorienting for the viewer. We learn that they have been together for 15 years and are both HIV positive. This devastating announcement is a harbinger for what's to come for their relationship.

Casting actors to play characters in their teens through to their 30s is



always going to be a difficult task. The film does manage to transition Ryan Corr's Tim and Craig Stott's John smoothly through the 15 years of the story. Their chemistry is palpable, which is imperative in order to convey the deep bond these two men had.

It's important to note how funny the film is. Quite a few lines sparked laughter in the Sydney crowd, when I saw the film there. As John and Tim argue at a movie date, John complains that all he really wanted to do was see the film *Nine to Five* as he'd heard it was very funny.

There is a charming, Australian irreverence to these characters, which balances out the impending heartbreak – a personal, Australian perspective of the HIV/AIDS crisis of the 1980s.

Adapting a much-loved text is always a delicate task as the audience – familiar with the source material – can be fiercely protective. This is a story that is held incredibly dear to those that read the book. As shattering as reading this book was, Conigrave's work was a beautiful text that was informative during my early years at university. Many friends have similarly recounted to me how important this book was for them as they grew up.

The film adheres to the original text closely with key passages recreated in the film: Pepe's dinner party, various sexual encounters and Tim calling John and asking, "Will you go round with me?"

It also places a significant emphasis on the high school period with the final, devastating turn of events not being as drawn out as they were in the book. The book provides a distressing amount of detail at how totally destructive the disease was to the body during the crisis. The level of detail provided in the book was at times overwhelming – I could only ever read it in short bursts.

There is an affective power when one revisits a text such as *Holding the Man*. Sitting in the screening during the closing scenes – with an audibly sobbing audience – the sheer emotional toil the book had on me returned, particularly when the photographs of the real Tim and John appear before the closing credits.

It's important that the emotional weight of this tragic period is told to younger Australians, and particularly gay Australians. If ever the devastating effect of AIDS in Australia was going to be told to a mainstream audience, *Holding the Man* has the potential to be that film.

(First published on *The Conversation* 10 August 2015) theconversation.com/au



Stuart Richards
Researcher and Tutor
in Screen and Cultural
Studies at University of
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