Victorian Medical Women's Society
Newsletter
Founded 1896
Celebrating our history, advancing our future

October 2017 afmw.org/vic Volume 15 Issue 4

# President's Report

## Dr Magdalena Simonis

It is with great pleasure that after two family moves overseas in two years, I am again at the helm of VMWS. An ability to adapt to unexpected events and turns of life is a skill we all possess as human beings, but thankfully our training in medicine has sharpened this especially in us.

As President of VMWS, I am thrilled to be surrounded by a vibrant team of committee members. The team comprises of some of who have been sponsored into key leadership positions, following on from their roles in shadow positions on our committee as students. Some have been with us for decades, and continue to provide their wisdom, energy and direction with passion and focus.

Our student members are our life blood and as graduation from University leads us into becoming fully fledged doctors, VMWS provides another growth pathway for those committed to learning skills required for advocacy at state, national and global levels on issues that matter to the health and well-being of women and children. We continue to uphold the legacy that was established in 1896, which is to support female medical students who then became doctors. We not only offer mentoring and networking for our members but commit to using our skills as doctors in advocating for women and children locally, nationally and internationally through MWIA.

More recently the MWIA President elect Dr Clarissa Fabre, attended our AGM which was held at Ormond College. She gave an excellent presentation and encouraged our younger members to connect with her directly and to participate in international events. In a similar vein, I extend this invitation to our younger and older members to connect directly with myself regarding issues they would like to see VMWS respond to and act upon. Our own Professor Jan Coles delivered the Constance Stone oration and moved us with her personal account of how VMWS has been both her 'medical haven' and a launch pad for research projects, which have developed into international projects. We acknowledged the Master of Ormond College, Mr Rufus Black for hosting our event in such auspicious surrounds and enjoyed one of the most sumptuous and varied buffets we have had at an AGM to date.

In the year that follows, VMWS will continue in its tradition of hosting key events, although my intention is to deepen and strengthen our partnerships with organisations that share similar objects as ours, with a view to enhancing our network, visibility and impact.

## In this issue

## VMWS Committee 2017

| | | |
|---|---|---|
| President | Dr Magdelena Simonis | |
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| | Dr Marissa Daniels | A/Prof Deb Colville |
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| Archivist | Dr Anne Stanaway | |
| | Shadow: Dr Rosalie Cooper | |
| Student Representative – Monash University | Ms Lydia Di Stefano | |
| Student Representative -Deakin University | Dr Rachel Shingaki-Wells | |
| Student Representative – Notre Dame University | Ms Natalie Perera | |
| Student Representative – The University of Melbourne | Ms Tehreem Rawal | |

## Events Calendar 2017/2018

| Month | Date and event | Location (if known) |
|---|---|---|
| November | Saturday 18th, COCO Bushwalk | Dandenong Ranges See flyer below |
| February | Saturday 3rd, Medical Women's Tour of Melbourne | See flyer below |
| March | Thursday 8th, Famous Women in Cemeteries Tour | See flyer below |

## Medicine's ender evolution: How women stopped being treated as 'small men.'

*Associate Professor, Deb Colville – President VMWS.*

Until the turn of this century, there was little sense in Western medicine that gender mattered. Outside the niche of female reproductive medicine, the male body was the universal model for anatomy studies. Clinical trials mainly involved males and the results became the evidence base for the diagnosis and treatment of both genders. Medication dosages were typically adjusted for patient size and women were simply "small men".

Medical academia has also been male-centred, with teachers, professors and researchers being mostly male. Twenty-five years ago, most college boards representing medical specialities around the world were almost exclusively male. But in the last 20 years, mainstream medical research has begun to seriously explore gender differences and bias in academic and clinical medicine. This explicit recognition of gender — along with factors such as ethnicity and socioeconomic status — helps determine how healthy people's lives are likely to be.

And so, the discipline of "gender medicine" (also called sex-specific medicine) was born. Gender medicine centres opened in the early 2000s, textbooks followed and gender modules were introduced into some medical training and curricula.

In 2008, the World Health Organisation issued guidelines on "teaching gender competence". This is the capacity for health professionals to identify where gender-based differences are significant, and how to ensure more equitable outcomes.

Gendered medicine is not only about women. It is about identifying differences in clinical care and ensuring the best health care is provided for all. It is also about ensuring equity of health care access, and about gender equity in the composition and roles in the profession.

**Does gender matter?**

Gender is not the same as sex, which is about biological and physical male-female differences. Gender relates to the social and cultural behaviours we attach to the biological aspects of sex; it is not binary and exists on a spectrum. In medicine, gender impacts how, when and why a person accesses medical care, and the outcomes of that access. For instance, women seeing their doctor for chronic pain often don't feel adequately listened to or supported. In the area of heart health, women are less likely to seek help for a heart attack as their symptoms make it harder to identify. Studies have also found they are not offered potentially beneficial treatments for heart disease at the same rate as men, and have lower survival rates.

In mental health, depression is more common in women and suicide rates are higher in men. The nature of diseases such as heart disease, osteoporosis and lung cancer are different between women and men too, as are their outcomes.

Less well known is that two-thirds of the blind people in the world are women, even when the data is adjusted for the fact women live longer. And as an example of sociological differences that need recognising, women who present with an eye socket fracture, a ruptured eyeball or eye bruise are at risk of dying, not from the injury, but from a further assault by a perpetrator of family violence.

**Improving the evidence**

Clinical trials are the bedrock of medical research and evidence building. Until relatively recently, they were mainly conducted with males for a number of reasons, including availability to participate and concerns about the impact on women's reproductive health, or the impact of menstrual cycles on the

trials. Restricting difference also makes trials cheaper by reducing the required sample size (even though it leads to inaccuracies for various important subgroups).
Women were excluded because they are different, but the results were applied to them because they are nearly the same. And when women and men are included in trials, the results are usually not published separated by sex, so the findings may be inaccurate for all participants.
Even in pre-clinical research using animals, female animals have been excluded to make management and costs simpler, and reduce measurement variation. As a result, large scale clinical trials have yielded findings based on particular population groups. For example, a 1988 study into the use of aspirin to lower the risk of heart attack was based on a six-year trial of 22,000 men.
But change is afoot in trial design. Australia's largest medical research grant body, the National Health & Medical Research Council, for example, has introduced guidelines that require applicants to address gender equity among research participants.

**What are the next steps?**
We need data from clinical trials and population data that is sorted by gender, so knowledge bases can be gradually improved. Generalisations about gender can be both useful and problematic, so careful analysis is needed. We must account for gender in all medical training, and clinical practice. This should apply to not only disciplines that relate to sex hormones such as gynaecology, but also for example orthopaedics and ophthalmology. We need the profession itself to take the lead in encompassing gender diversity in our community. Following the lead of non-medical groups such as the Australian Institute of Company Directors, the medical profession needs to introduce targets for diverse representation on all professional decision-making bodies.

Sarah, an Australian medical student in her final year, told me the biological perspective is taught well, but the psychological and social "not so much".
There are broader social and cultural factors that might affect the way a male patient presents versus a female. Medical training on diversity also needs to include people who are transgender or who identify as non-gender conforming. As Sarah said:
"We talk about inequalities in terms of males and females, but gender diversity isn't mentioned at all. I shudder to think of the barriers and obstacles you might face in training if you were transgender or non-gender conforming. I haven't heard anyone raise that."

## Event Report: Annual Queen Victoria Hospital Memorial Service, September 10th 2017.

*Dr Anne Stanaway – Archivist, VMWS.*

On the second Sunday of September each year, the Welsh Church holds a memorial service to commemorate the foundation of what later became the Queen Victoria Hospital, fondly known as "the Queen Vic".The original health service was founded and staffed by women to provide medical services for the women of Victoria. The Victoria Hospital and its small dispensary started in The Welsh Church at its St David's Hall, and what is currently a cleaning cupboard, in 1896. This was the initiative of the founders of The Victorian Medical Women's Society, which included Dr. Constance Stone, the first female doctor to be registered in Australia, and the first cohort of women to study medicine in Victoria.

Last year, a plaque recognising the services of the medical women of Victoria in WWI was unveiled. At this 2017 service, it was a pleasure to look at the mounted plaque and contemplate the significant contribution these women made to the war effort and the greater social changes they made towards gender equality.

The memorial service was, as always, an incredibly interesting occasion with a detailed historical introduction to the origins of women's health and the Queen Victoria Hospital. We were all moved and inspired by the guest speaker Brownyn, and her personal accounts of her journey as a woman and a nurse through her years of clinical training (which included some time at the Queen Vic), and as a clinical educator. Bronwyn shared some of the personal and professional challenges she has had to face, and with much resilience, managed to overcome. We were touched by her compassion and advocacy for her patients and inspired by her commitment to her personal values and challenging institutions found lacking in social justice. . We are grateful to Bronwyn for sharing her stories with us. These principles of compassion and caring for others were reinforced by passages and hymns lead by Rev. Sion Hughes, which regardless of one's faith, are of universal importance.

A splendid morning tea hosted by the lovely and hospitable Welsh Church community facilitated many interesting conversations, revealing some of the more personal connections between the Queen Vic, VMWS, and the general community.

Thank you to Rev. Sion Hughes and the Welsh Church for welcoming the broader community to celebrate this important step in the social development in Australia - recognising the strength of women in our community and also the ongoing need to provide appropriate community services. We look forward to attending next year.

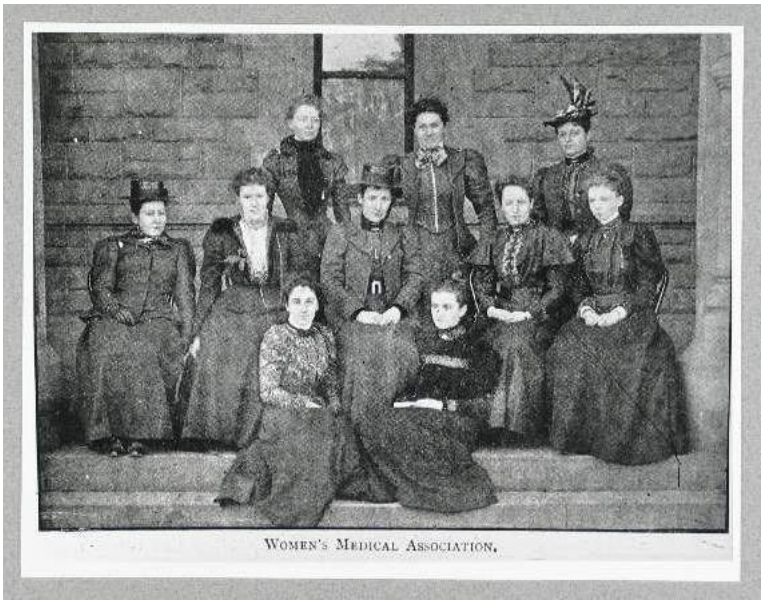
## Thankyou!

Thank you to the following people for their valuable contributions to the VMWS archives:
Heather Peden, Kath McKay, Rosalie Cooper, Jenny Brown, Christine Paton

# Photo Contributions – VMWS 2017 AGM

Top Right: Left to right: Dr Magdalena Simonis, President VMWS, Dr Clarissa Fabre, MWIA President-Elect, Assoc Prof Deborah Colville Immediate Past President, VMWS, Dr Marjorie Cross, AFMW Secretary

Some of the committee members who attended the AGM this year, taken in the same location as the photo of the first members of the VMWS back in 1896 on the steps of the old pathology building of the Elisabeth Murdoch Building - one of the earliest university buildings used for medical studies in Australia.



# Reflections from the moral high ground: on doctors advocating for veganism

*Ms Charlotte O'Leary, Monash University*

*The following piece has been shortlisted for the Doctus Project 2017 Writing Competition. Charlotte has just completed a Bachelor of Medical Science (Honours) in bioethics (University of Oxford) and is now intercalating from her medical degree to undertake a MSc Public Health at London School of Hygiene and Tropical Medicine.*

We live in an era of mixed messages about nutrition, not least from the public health community. A healthy diet was all about minimising saturated fat, until sugar was labelled the new silent killer. We have a turbid relationship with salt, and the often-opposing voices from the media and public health experts do little to clear the air. Add in the influence of the lucrative health food industry and you might believe that you're unhealthy without expensive super foods and supplements with every meal.

Then there is the pervasive influence of 'big food' that subconsciously influences everything you put in your mouth: it's the marketing that makes you crave a Coke on a hot day, and the terrifying forces behind a child's desire for a Happy Meal. Determining what is healthy for us, our families and our planet is not straightforward. Deciphering the science from the fad is equally challenging for the medical profession.

One diet emerges as an all-encompassing solution. Few ethicists or environmentalists would deny that a vegan diet is the most sustainable, planet friendly and ethical choice. With a bit of care, a vegan diet can also provide more than adequate nutrition for humans. Can veganism fix our broken food systems, our struggling planet Earth, our moral foibles and our obesity crisis? And if so, surely it is the imperative of the medical profession, as advocates for health and rights, to espouse the vegan lifestyle.

This notion, whilst initially appealing, is untenable on several grounds.

Vegans display a determination and dedication that most envy, and some despise. They know what is right and what is sustainable, they know what their body needs and how to get it, they always have a snack on hand and they can afford to go the extra mile to a vegan friendly grocer. Above all, vegans show that they have their life together, and they can see the bigger picture.

However, within our current cultural and social climate, veganism is an extreme choice. The vegan goes without, appearing to give up everyday comforts for a greater, often intangible good.

Advocating for an extreme choice runs an unacceptable risk of alienation. For some people, quitting smoking is seen as an extreme choice, despite the conclusive evidence that tobacco is destructive to health. To others, reducing alcohol consumption to a safe level is seen as an extreme choice. For 60% of Australians, taking 30 minutes out of every day to be physically active is an unattainable goal. Even for the large proportion of people living with chronic disease, around 50% struggle to adhere to lifesaving treatment recommendations, and many others find attending check-ups and monitoring their health excessively obtrusive. While these fundamental health behaviours remain a burden for everyday Australians, it is hard to imagine veganism being an accepted ideology.

In many settings, substitution and reduction of animal-based products is a healthier and more acceptable message than elimination. For some people, the idea of encouraging at least some meat free days in the

diet seems like a grotesquely infantile step towards the end of speciesism and unsustainable eating. But for many people this would require significant adjustment. For the motivated individual, substituting dairy for soy might be an acceptable challenge. Reducing processed meats and trying lean chicken might be the most achievable goal for someone else, and will still have a positive environmental and health impact. The role of the doctor, just as in any other aspect of patient-centred care, is to empower patients to make realistic changes, not to dangle lofty goals that are estranging and disheartening.

Doctors are in a privileged position with knowledge, influence, financial security, and respect and trust from the broader community. The true challenge for the doctor comes in being relatable, to be treated as an equal and to understand the struggles of the everyday person. Advocating for extreme changes when many people struggle to achieve the basics of healthy living in an "infobese" environment is not a sensible approach, and doctors risk doing more harm than good to an extremely important cause.

*The views and opinions expressed in this article are those of the author and do not necessarily represent those of the Doctus Project.*

***(link http://www.doctusproject.com/2017/10/08/against-advocating-for-veganism/)***


## Adele's Big Zip! What you do for good conversation!

*Dr Adele Storch, Medical Officer: Headspace Youth Early Psychosis Program – Alfred Psychiatry*

*Social Secretary: VMWS.*

Dr Adele Storch is participating in an upcoming charity event – the AMP Big Zipper – in which she'll be jumping off the 47 storey AMP building in Sydney on a zip-line to raise money for The Conversation (not-for-profit, independent media group) to support their reporting of mental health and women's health issues.

> *"When it comes to making change, it all starts with a conversation. And not just any conversation, but quality, research driven, balanced, and sometimes tough conversations about the things we shy away from.*
> *As a doctor working in mental health, I am especially passionate about reducing the stigma surrounding mental illness. As a female doctor, I am also passionate about women's health and females in leadership. These are some of the topics that we need to talk about!*
> *The Conversation provides quality, thought provoking and educational information to the public. It does not shy away from the tough topics. This is why I am taking this huge crazy leap for The Conversation!*
>
> *A little MORE conversation means a little more action - sorry Elvis! "*

Help Adele raise money for this worthy cause:

https://amp.goodcompany.org/au/fundraising/The-AMP-Foundation-Big-Zipper/Adeles-Big-Zip-What-you-do-for-goodConversation

## No female physican should have to feel that her gender is a factor limiting her success.

*Annonymous Physician. The October 11, 2017. Taken from www.kevinmd.com/blog/2017*

> *A father and a son are in a car accident. The father dies instantly, and the son is taken to the nearest hospital. The doctor comes in and exclaims, "I can't operate on this boy!"*
> *"Why not?" the nurse asks.*
> *"Because he is my son," the doctor responds.*
> *How is this possible?*

I first saw this riddle in a Washington Post article in October 2016.I was four years out of residency, and for the first time in my career, had started to feel like I wasn't treated quite the same as the male physicians that made up the majority of my group. I read the riddle over and over again, but couldn't figure out the answer, so I scrolled down. The boy's mother was the surgeon. s a female physician searching for validation of how I was feeling, even I couldn't come up with the answer that the surgeon was a woman.

I made it through medical school, residency, and fellowship without ever feeling like it was harder to succeed as a physician than my male colleagues. Even as the only female in my residency class, I never experienced (or at least recognized experiencing) gender bias. The nurses I worked with were some of my closest friends. I was successful at emergency medicine, and I felt like any feedback I received was constructive and fair. Then I joined a group where almost every other doctor was an older male. Suddenly nurses were questioning my every order. Suddenly I was being told that I wasn't confident enough or approachable enough. Suddenly I felt like my career was spiralling around me and I didn't know how to fix it.

I was asked to meet with the leadership of my group. There had been some ongoing complaints from the nursing staff about my confidence and approachability. There were no specifics. There were no concerns about my medical care. Initial suggestions to fix this were to bring candy and to try to ask more personal questions. When that didn't work, I was asked to work with a physician coach, spending hours of unpaid time trying to fix a problem that no one could seem to identify. Nobody in my group had any specific examples. Nobody in my group had witnessed anything firsthand. I was told by multiple colleagues that it was difficult to succeed here as a female, that females in the past had failed and moved on. I watched as some (thankfully few) of my older male colleagues communicated by yelling, while it was considered defensive when I kindly explained the thought process behind my orders when my care was questioned. I watched older male surgeons breeze through the emergency department, belittling everyone in their path. Where were their physician coaches? I was putting in countless extra hours, learning to make little adjustments in my interactions, to apologize for difficult orders, to acknowledge concerns before explaining my clinical decision making, while they yelled and belittled without consequence.

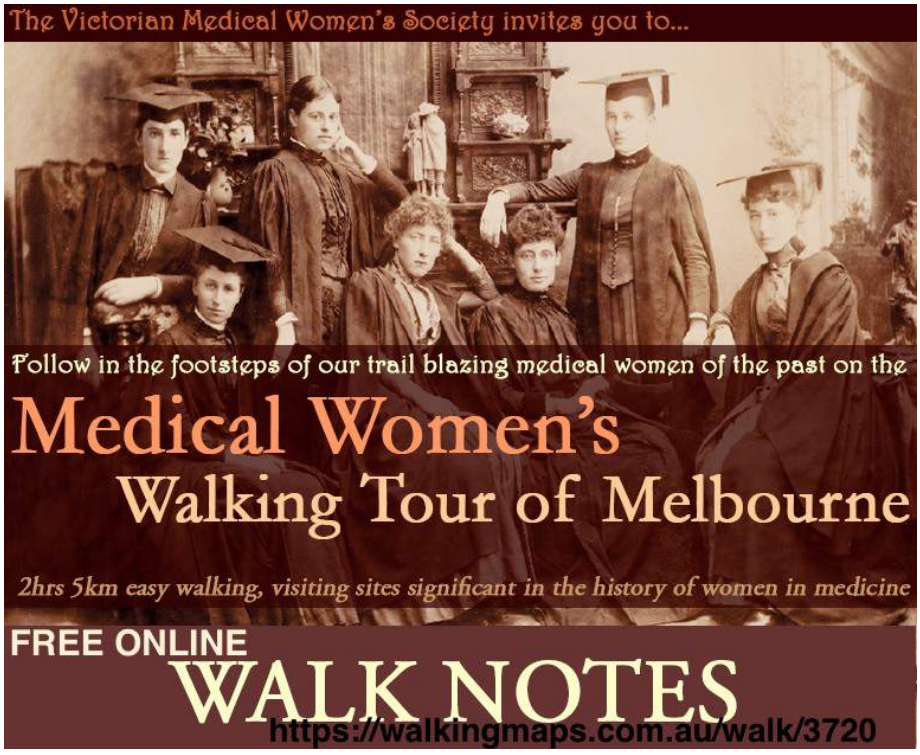
In the end, I'm a better doctor and communicator because of it. I persevered (or, as a supportive colleague put it, was "tenacious AF"), and I succeeded. I became a partner in my group. Everyone has room to improve, and working with a physician coach helped me become a better version of myself. But something inside had changed. I became a partner, but I didn't become an equal. Part of me realized that even those who supported me felt it was okay to tell me "females have a tough time succeeding here." The reality is I'm not the only female physician who has ever felt this way. This problem is so much bigger than my own experience.


Women now make up almost one-third of practicing physicians, and half of today's medical students are female. Despite this, recent studies have shown female physicians are still less likely to be introduced as "doctor" by their peers.30 percent of female doctors report they have been sexually harassed in the workplace.77.9 percent of physician mothers have felt discrimination in the workplace. The average pay gap between male and female physicians, after adjusting for other factors affecting compensation (age, experience, specialty, faculty rank, and measures of research productivity and clinical revenue), is $19,878 per year. In some fields, like neurosurgery and cardiothoracic surgery, the discrepancy is as large as $44,000 per year. Airlines don't believe African-American females can be doctors. They apparently don't believe white, Asian, middle eastern, etc. females can be doctors either.

And I still can't put my name on this article for fear I'll lose my job.

It's bad enough that in 2017, we still have to tolerate patients calling us "sweetie" and asking if we're old enough to be their doctor. It's bad enough that even though studies suggest that female providers have lower mortality rates and have more patient-centered communication styles than male providers, patient satisfaction scores don't reflect this. But what do we do when our own colleagues fail to recognize their own gender biases? No female physician should ever have to feel that her gender is a factor limiting her success. We need to create environments where we recognize our biases and work to address them. We need to do better. It's 2017, and we shouldn't have to remain anonymous anymore.

*The author is an anonymous emergency physician. This article originally appeared in FeminEm.*



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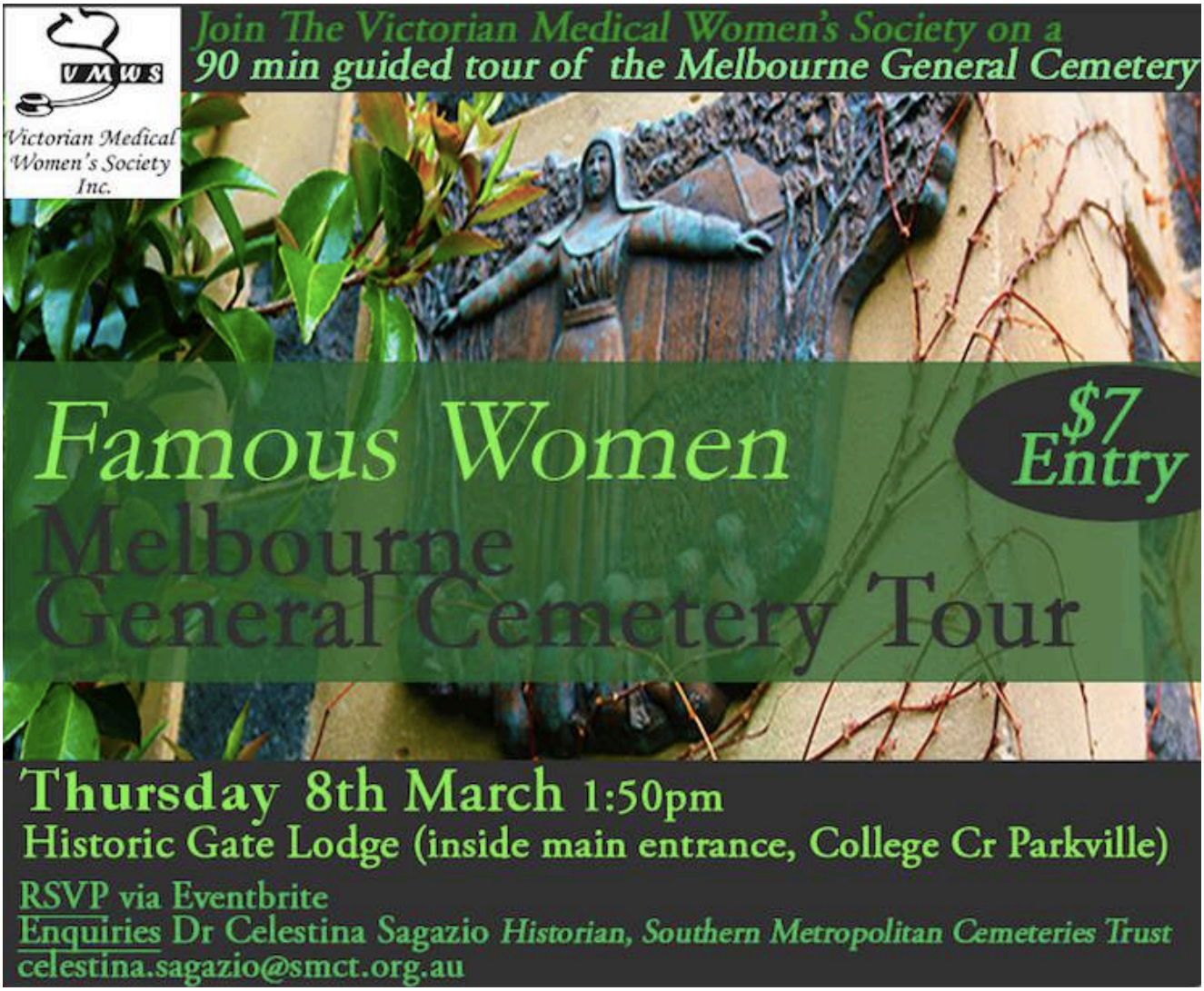


## Obituary: Margaret Henderson 13/11/1915 – 16/08/2017

*Dr Rosalind Terry, August 29th, Trinity Chapel*

I am very honored today to be the speaker on behalf of the medical community. I first met Margaret in 1969 during my 5 years as a biochemist at the RMH working nights and weekends while I did medicine as a post grad student.

Margaret also began her university life as a science student in Perth and transferred to Melbourne in her second year winning a scholarship to study medicine. She graduated in 1938, sharing the exhibition in surgery, and was a resident medical officer at RMH, then in Lonsdale St.

This followed over the years with a MD, work as a GP in Ivanhoe, researcher and serving with the Australian Military Forces with the rank of captain. From Dec 1945 to 1947 she was based in Perak, Malaya

responsible for medical direction and administration of the Red Cross medical unit based there. This involved many visits to villages, mostly in an area associated with tin mining and with many Chinese immigrant workers. Malnutrition and malaria were very common problems seen.

Following Malaya she spent time in London, where she saw a large number of tuberculosis cases. Despite on arrival having wished for a surgical position,that wasn't a possibility at that time for a female. During her London time she obtained fellowship of the Royal College of Physicians. Many TB cases were also seen in Switzerland where she covered for a friend. From London she applied to RMH and was notified by letter that she had been appointed to an honorary outpatient position, being the first female to hold this role.

En route home by ship she performed an emergency appendicectomy with another medical passenger giving the anaesthetic and the captain killing the engines.

Back at RMH an appointment to the senior medical staff, caring for inpatients, followed, again the first female in this position. In the 1960s specialisation began within the field of medicine. Whilst Margaret considered herself more of a general physician she “accidentally” began specialising in respiratory medicine as no one else was doing it, and of course, benefited by her great experience with TB in Malaya and London.

When I was her resident in 1974 I remember well a man with an obvious, severe, respiratory problem and unusual chest XR appearance. Margaret was determined to make a diagnosis and after a pleural biopsy, made a diagnosis of mesothelioma, the first case diagnosed in Victoria (but from memory a few had recently been diagnosed in the asbestos mining area of Western Australia).

In addition to her work at RMH, Margaret served as honorary physician to the Queen Victoria Hospital, as medical officer to Janet Clarke Hall and also provided outstanding service to the management committee of the Royal District Nursing Service for 18 years.

Known for her brilliance, tenacity and perseverance in a male-dominated field of medicine, Margaret was awarded the Order of the British Empire in 1976 for services to Medicine. In 2012 Melbourne University awarded her the degree of Doctor of Medical Science honoris causa.

On my return to Australia in 1990 I renewed my friendship with Margaret through the Victorian Medical Women’s Society and remember many enjoyable occasions when I would drive her to and from events and we would discuss how medicine had progressed and remember events from my RMH years.

In 2014 Margaret agreed to give to annual Constance Stone oration to the Victorian Medical Womens Society. It had been decided in discussion with Margaret the format should be me asking her questions about her career rather than expecting her to write a speech. The president, Deb Colville , and I visited her at home in Kew and video recorded me asking her the questions and her thoughtful answers. All this was unnecessary as on the day she did a magnificent job sitting at the centre of the large group and answering on the spot. The video was never required.

I was so fortunate to be able to visit Margaret several times in Epworth during her final hospital stay and say my farewells and thank her for the assistance she had been to decades of doctors, especially female ones.

I shall end with something I wrote many years ago for an address about my medical life. I quote “General medicine in Margaret Hendersons' unit taught me how to mix medical knowledge with common sense and a feeling for people as probably few people learn it”
Rest in peace Margaret.

## Meet the Committee

Each newsletter features some of our fabulous committee members, so you can get to know your representatives.

### Dr Rachel Shingaki-Wells

*Student Representative, Deakin University*

Rachel Shingaki-Wells is a VMWS student representative in her final year at Deakin University in Geelong. Her interests are science-based medicine, the influence of pharmaceutical industry marketing on doctors and 35mm film photography. Prior to studying medicine, Rachel studied molecular biology at The University of Western Australia and went on to do a PhD in plant biochemistry. Rachel has a wide array of interests, including obstetrics and gynaecology, anaesthetics, and gastroenterology. Next year, she'll be working at Monash Health as an intern.

### Ms. Irene Bryan

*Student Representative, Melbourne University*

Irene is a final year medical student at The University of Melbourne. She is passionate about LGBTIQA+ health, gender equality, education and caring for the environment. Irene has been a student member of Victorian Medical Women's Society for two years and will take on her first official role with VMWS as co-Shadow Treasurer this year.

Before studying medicine, Irene worked as a physiotherapist. She specialised in Geriatric Aged Care and enjoyed the challenging work of managing chronic pain and treating those with dementia. Irene is excited to use her physiotherapy experience as an intern at Alfred Health next year.

Like many in her generation, Irene is an avid overseas traveler. To date she has visited twenty-six countries and, much to her parent's dismay, is looking forward to adding Chile, Peru and Columbia to the list this summer. Notably, she spent two years in Berlin where kindergarten teaching helped her hone her German skills. When in Australia, Irene enjoys playing B-grade women's hockey, spending time with her Doberman Asha and weaving colourful wall-hangings from recycled wool.

# The Victorian Medical Women's Society Inc.

## Membership Invoice 1 July 2017 – 30 June 2018

ABN 67 120 250 797 - Inc A0061560B
(MEMBERSHIP PERIOD IS FROM 1 JULY TO 30TH JUNE)

***Membership Eligibility:*** *Full membership is open to registered female medical practitioners (FMP); non-registered FMPs can join as an associate member, and Student membership is open to female medical students.*

***(NOTE: this invoice becomes a tax receipt upon payment, please retain the top section for your records)***

| Full | Rural (>100km from GPO) | Senior/Retired (>65yrs) | Post-grad Yr1-2 | Student |
|---|---|---|---|---|
| $200 | $100 | $150 | $110 | $60 |

☐ **Donation: $_____**

*Please complete and send the bottom section of this form to the VMWS Inc. via email or mail.*

### 1. PLEASE TICK WHICH TYPE OF APPLICATION YOU WISH TO REQUEST:

☐ **I am a applying for new membership.** Please complete the Membership Declaration and make payment.
☐ **I am changing my membership category.** Please complete the Membership Declaration and make payment
☐ **I am renewing my membership.** Only renewal payment is required.

### 2. MEMBERSHIP DECLARATION:

I wish to become a member of the Victorian Medical Women's Society Inc., and will support the purposes of the Association and agree to comply with the Rules of the Association (available here).

**Signature:** _____ **Date:** _____

### 3. MEMBERSHIP DETAILS

Membership Type: _____ Duration: _____ Amount: $_____

Title, First Name & Surname: _____

Alternative Surname (if applicable): _____

Mailing Address: _____

Phone: _____ Date of Birth: _____

Email: _____ Intern Year: _____

Specialty/Area of Practice: _____ Year of Graduation: _____

Car-pooling: Potential driver: □ Potential passenger: □

***NOTE:*** When you join the VMWS you get 3 memberships for the price of 1!: the Australian Federation of Medical Women (AFMW) and the Medical Women's International Association (MWIA). You will automatically be subscribed to all three mailing lists and your email address may be shared with other AFMW members.

***VMWS newsletters are distributed electronically, unless you request otherwise.***

**4. Membership Payment: CHQ** to **Victorian Medical Women's Society**. **Post:** VMWS Secretariat, PO Box 252, East Melb VIC 8002; **Electronic Transfer** to Victorian Medical Women's Society; **BSB: 033 089**; **Act No: 297664**. Credit Card/PayPal: Log on to www.afmw.org.au/vic use the DONATE button, choose PAY WITH A CARD for details or use your account. Please ***include your name*** in the ***transfer info.*** *Refer to www.afmw.org.au/vic for our privacy policy.*

**Donations are gratefully received. Please advise if you wish for your donation to be used for a specific purpose.**