Since 2007, Australian Medical Council accreditation standards for medical schools have included an explicit focus on Indigenous health.

The standards specify that medical schools use the educational expertise of Indigenous people, and have effective partnerships with Indigenous organisations and communities.

Importantly, medical schools are also required to have an Indigenous health curriculum that includes study of the history, culture and health of Indigenous Australians. The AMC has endorsed the nationally consistent Indigenous health curriculum that was published by Medical Deans Australia and New Zealand in 2004.

Dr David Paul, a senior lecturer at the Centre for Aboriginal Medical and Dental Health at the University of Western Australia (UWA), says this increased recent focus on Indigenous health within Australian medical schools means that there are substantial opportunities for doctors, both Aboriginal and non-Aboriginal, to get involved in Indigenous health education.

“It’s quite a new field, internationally as well as locally … lots of educators are needed to teach the curriculum”, he says.

Dr Paul says the Indigenous component of the UWA curriculum aims to ensure that medical students are well prepared to see Indigenous patients.

“We’re trying to give students an understanding of the context – the culture, the history of colonisation, the contemporary circumstances and how all of that impacts on the health of the community”, he says.

The curriculum also focuses on the specific clinical needs of Aboriginal people, and strategies to meet these needs. For instance, students consider whether screening programs should start at a younger age for Indigenous patients, or if medication should commence earlier.

Dr Paul says his greatest professional satisfaction comes from seeing students “start to get it” over the course of their 6-year undergraduate medical program.

“It’s fantastic watching them shift their level of understanding and engagement”, he says.

He also draws satisfaction from the fact that a number of UWA graduates now work in Aboriginal medical services or in Indigenous medical education roles, (see Registrar Q+A, page C2).

Dr Paul, who recently won a leadership award from the Leaders in Indigenous Medical Education (LIME) network, began teaching medical students when he was a GP in an urban Aboriginal Medical Service in WA in the early 1980s. From there, he worked in Indigenous health policy and research before taking the position at UWA.

Dr Louis Peachey, one of Australia’s
It’s always assumed that Aboriginal people are special and different, and while I do think we’re special, yes, I don’t think we’re that different.

Training as an educator in Indigenous health

Several universities and other organisations offer courses and training that are relevant to Aboriginal and Torres Strait Islander health. The Australian Indigenous Health InfoNet (www.healthinfonet.ecu.edu.au) includes a comprehensive list of courses, not all of which are specifically aimed at doctors. Options range from a Masters of Public Health with an Indigenous focus, to medication management training for Aboriginal health workers.

Many of Australia’s medical schools also now have Indigenous health units, many of which also offer specific units or courses in Indigenous health. Registrars can also commonly access placements in Aboriginal Medical Services through their specialty college.

State-based Rural Workforce Agencies also offer courses and activities.

Sophie McNamara

Registrar Q+A

Dr Shirley Godwin, senior lecturer in Indigenous Health, University of Notre Dame, Fremantle, WA

Why did you decide to become a medical educator?
Before I began studying medicine, I worked in Aboriginal health research. It grew on me that the key to improving Indigenous health outcomes was education. Not just patient education, but also what the patients could teach the doctors. Within the health sector, there was a lot of talk about capacity-building of Indigenous students, but at medical school I realised that a lot of the other students needed capacity-building to deal with Aboriginal patients. From first year medical school I started to think about the influence of Indigenous medical education and how we could translate that into outcomes.

How did you get involved in Indigenous medical education?
When I graduated from the University of Melbourne in 2010, a job came up with the University of Notre Dame. I'm a Bardimia Yamatji woman from Western Australia so it was a chance for me to pursue my interest in education and go back to where my mob is from.

What does the job involve?
The job of the Aboriginal health team is to develop the Indigenous health medical curriculum and embed it across the 4 years of the course. The aim is for students to achieve a set of foundational skills to use with Indigenous patients. We don’t expect students to be experts, but hopefully they will come out feeling comfortable with Indigenous patients. Also, it’s all based on delivering holistic, patient-centred medicine, so if you get it right for Aboriginal patients you will get it right for all your patients.

We also develop strategies to recruit and retain Indigenous students, facilitate partnerships with community organisations and local Aboriginal people and provide a strong Indigenous presence on campus.

What advice do you have for other young doctors interested in this career?
There’s a lot of talk nationally about the development of Indigenous medical education as its own specialty so it’s a good time to get involved. Aboriginal people need to be at the centre of the process, but we can’t do it on our own. I would encourage students to take up every opportunity. Medical school is very intense and it can feel like all the focus is just on getting through, so it’s important to be aware of other career development opportunities.

Students could make contact with the Indigenous health team at their medical school, choose Aboriginal health electives, take up tutoring, or get involved with mentoring programs.

It’s also important for doctors to know that if they pursue this career they won’t be out on their own. There are plenty of supportive people and organisations such as the Leaders in Indigenous Medical Education (LIME) network and the Australian Indigenous Doctors’ Association.
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Specialists in medical recruitment
Associate Professor Peter O’Mara reflects on his career as a GP and medical educator

Associate Professor Peter O’Mara is president of the Australian Indigenous Doctors’ Association. He is head of the Discipline of Indigenous Health at the University of Newcastle, and a director of the Wollotuka Institute, which consolidates all Indigenous activities at the university. He continues to practise clinically as a GP at an Aboriginal Medical Service in Forster, NSW.

“I left school in year 10, and got what was the best job available in the small town of Cessnock in the Hunter Valley, which was a job in the coalmines. I was a fitter machinist, and it was a well paid job and a secure industry. Although I had always been interested in how the body works, I thought medicine was for doctors’ children or rich people. I never thought someone like me could give it a shot.

I was quite happy working in the mines, but that all changed after I sustained a lower back injury in a serious motor vehicle accident. I returned to work after 6 weeks and tried to do the things I’d always done, but it was so difficult. I had been known as the strongest bloke in the mine and I did lots of kickboxing and cross-country running, so I expected to go back and do the heavy work again. It was really tough, but I knew I had to look for something else to do. I thought I’d have to study, use my brain.

I did a matriculation course, which got me into a Bachelor of Arts at the University of Newcastle. I studied psychology, sociology and biology, because I thought I’d like to become a clinical psychologist. Although I don’t like talking to big crowds, the thought of sitting down one to one with people and making a positive impact on their lives was attractive to me.

One day I was home studying, when I sat down for lunch in front of the television. Ray Martin was interviewing the first two Indigenous doctors to graduate from the University of Newcastle, Louis Peachey and Sandy Eades. I was taken aback — ‘what, they’re Aboriginal doctors?’... They just seemed like really normal people, and I thought ‘wow if these guys can do this, maybe I can too’.

So the next week, I was straight down to the faculty, read all the information packs until I knew them word for word, then applied for medicine, got accepted and the rest is history.

I’m a GP in Forster and I also helped set up a bulk-billing clinic in Port Macquarie. I hear a lot of our medical colleagues complaining, but I felt honoured to be a doctor. People take you into the deepest parts of their lives, and you do get to make a positive impact in their lives. Compared to the university work I do, the verification is obvious. For instance, someone’s depressed and you initiate treatment and see the improvement. At university, the rewards are very long term.

The main role of the Discipline of Indigenous Health is to get Indigenous students in, make them good doctors, and get them out the other end. But it’s also about making non-Indigenous health professionals competent in dealing with Aboriginal people. And you really see the change. It’s fairly well known now that when you train doctors to work well with Aboriginal people, you make them better doctors overall, for everyone. They’re less judgemental; they’re more independent and have a greater understanding of people’s histories outside their own cultural systems.

To work well with Indigenous patients you can’t just be a great communicator, you also need a solid core of medical knowledge overall. There is also a skill set around clinical issues that particularly affect Indigenous people. It’s about scanning for proteinuria at higher rates, not accepting such high levels of blood pressure, and looking out for diabetes in everyone.

I will be AIDA president until October, when I will have spent about 4 years in the job. Some of the things we’ve achieved as a team at AIDA include creating a collaboration agreement with the Medical Deans to install an Indigenous health curriculum in every university across the country. I’ve also just signed an agreement with the Confederation of Postgraduate Medical Education Councils, who look after junior doctors’ training. I also chair an Indigenous sub-committee with the Committee of Presidents of Medical Colleges, where we are making inroads to ensure that all specialist colleges have training positions for Indigenous doctors, and, most importantly, that they train all doctors to competently deal with our people.

The bottom line in all these activities is improving the health of Indigenous people. We’ve made fairly significant progress into ensuring that all doctors who work in this country know the health issues facing Indigenous people and how to deal with those. There are not many jobs where people you’ll never know, and they’ll never know you, will have improvements in their lives because of things you’ve done. It’s incredibly rewarding.

Outside of medicine, I try to prioritise time with my family, but finding that balance is one of the battles as well. We’ve got a cattle farm, and I’m a lead singer and drummer in a rock ‘n’ roll blues band, plus I’m kickboxing and bodybuilding again now. When my presidency with AIDA finishes I’ll have more time for all those things.

Despite the work with AIDA and the university, the highlights of my career are my patients and their thanks and the relationships I have with them. I know there’s all that big stuff but for me it often comes back to just being a doctor and finding it rewarding everyday.”

Interview by Sophie McNamara
The crime doctors
Forensic physicians practise at the intersection of medicine and the legal system

A typical workday for Dr Morris Odell might involve being cross-examined in court regarding a medical opinion, attending a crime scene, then later assessing and collecting biological samples from an assault victim.

Dr Odell is one of Australia’s few doctors practising full-time as a forensic physician.

His work at the Victorian Institute of Forensic Medicine (VIFM) involves anything where forensic medical services are required for people in contact with the legal system.

Clinical forensic physicians work with living people, compared with forensic pathologists who focus on autopsy work.

Dr Odell says the main output of the VIFM is medicolegal reports, opinions and statements.

Dr Odell works closely with the police, including assessing people who have been arrested to determine if they are fit to be interviewed — a responsibility that carries heavy consequences.

He also does a lot of work in “traffic medicine”, including assessing fitness to drive among people with neurological or other medical problems, or analysing crash injuries to determine who was driving the vehicle.

Before studying medicine, Dr Odell worked as an electrical engineer, so he also has a particular interest in electrical injuries. For instance, he advises the Victoria Police electronics laboratory, which tests Tasers that have been involved in a death.

Dr Odell’s first experience of forensic medicine was during an elective with Victoria Police when he was a medical student at the University of Melbourne. He was involved in work such as assessing the health of people in custody, and acute psychiatric work.

“I found it very interesting and thought it would be a fascinating area to work in”, he says.

He qualified as a general practitioner, but pursued his interest in forensic medicine by working part-time as a medical officer with the police, and later travelling to the United Kingdom to complete one of the few postgraduate qualifications in forensic medicine available at the time.

Back then, clinical forensic medicine was a service within the police force, becoming part of the VIFM in 1995.

Dr Odell has worked with VIFM since 1996 and says he loves the variety of his job, as well as his interaction with some of the more extreme elements of humanity.

“I like the amazing, unusual and bizarre aspects of the things we see. As a policeman once said to me, ‘we’ve got a ringside seat for the best show in town’.”

Dr Odell says some of the cases, such as homicide or child abuse cases, can be distressing; however, overall he finds his job incredibly rewarding.

“If you hear through the courts that something you have found has been important evidence that’s helped to solve a case, that can be very satisfying … but our job is not to be detectives, it’s to collect evidence that can help the legal system.”

Dr Odell has also found the time to pursue research interests. He is currently involved in a project looking at how to interpret cannabis levels in heavy users of the drug. While detection is straightforward, interpretation presents more of a challenge, he says.

In addition to his role at VIFM, Dr Odell is president of the Australasian Association of Forensic Physicians (www.forensicphysicians.org), which is working towards recognition of clinical forensic medicine as its own specialty or subspecialty.

“We do have some unique features that define us as a specialty. Forensic medicine has its own body of knowledge, for example, and its own specific journals.”

The group has already completed the time-consuming task of developing a training curriculum, which includes an academic component through Monash University’s Master of Forensic Medicine course.

Dr Odell teaches in this course, and also runs short courses through the Association.

Forensic physicians come from a variety of backgrounds, but are mostly GPs or emergency medicine doctors. Others come from a sexual health, infectious diseases or paediatrics background. Dr Odell says the field is not well suited to new medical graduates, but rather doctors with broad clinical experience.

He says working in the field has made him appreciate that forensic issues can emerge in virtually all areas of medicine.

“The variety of things that surface is infinite. There is no limit to the human experience. That is one of the things that intrigues me about the work that I do.”

Sophie McNamara
Breaking down the budget
How will the superannuation changes hit your nest egg?

It’s been buoyed by the mining boom and battered by the global financial crisis, but Australia’s patchwork economy will be back in the black if the government can claw back billions of dollars.

In the Federal Budget handed down in May, the government identified $33.6 billion of savings over the next 5 years, some of which will come from high-income earners such as doctors.

In two key superannuation changes, wealthier workers will have to pay more tax when they make super contributions, and the government has deferred a deal that would continue to allow older workers with less than $500 000 in super to contribute up to $50 000 per year.

Despite the extra changes, superannuation remains a tax-effective strategy for high-income earners.

There is also good news for medical practices, with an easing of rules for writing off business assets and a new upfront deduction for car purchases.

Here’s a look at the fine print of the budget, and suggestions for how to manage the changes.

Super contributions capped at $25 000 for over-50s
What’s changed?
People aged under 50 can contribute up to $25 000 to their super fund each year at the concessional tax rate of 15%. Over recent years, people aged over 50 have been able to contribute up to $50 000 to encourage them to top up their balances before retirement. However, the May 2012 budget announced that the $25 000 cap would apply to all workers, regardless of age. The government decided the $50 000 cap would again be made available to workers over 50 with a super balance of less than $500 000 — but not until July 2014. With indexation, this is expected to rise to $55 000.

Similarly, it is expected that from July 2014 the $25 000 cap will have increased to $30 000 through indexation.

What will it mean?
Maximising super contributions is a favourite tax-management strategy for doctors. However, because many are self-employed, they often come late to the superannuation party and often need to maximise contributions later in their career.

The change to the super contributions cap will mean that people aged over 50, on the highest marginal tax rate and contributing the maximum tax-deductible amount into super, will pay an estimated extra $15 750 in tax over 2 years.

Older doctors who earn super contributions from a couple of sources such as universities and hospitals may also feel the effects. If they inadvertently exceed the $25 000 cap, they may have a tax bill. Anything paid into super that exceeds the cap will attract a penalty tax of 31.5% in addition to the 15% contributions tax, giving a combined total that is equal to the maximum taxation rate.

Mr Chris Wren, a financial adviser with Highland Financial, says that even after-tax super contributions (which are capped at $150 000 per year or $450 000 over 3 years for those under 65) may still offer financial advantages due to the lower tax rates on profits made within a super fund.

Mr James Gerrard, a financial planner with PSK Financial services, says the change will also affect doctors implementing transition-to-retirement strategies.

He says this group has been able to swap significant levels of tax-free pension income for concessationally taxed super contributions, so they may have to tweak their arrangements.

For those over or approaching the age of 50 who have less than $500 000 in super, Mr Gerrard suggests super-splitting into a spouse’s account over the next 2 years.

Then in 2014, when the cap returns to $50 000, the doctor’s super balance will ideally be under $500 000 so they can get the maximum tax advantage.

Doctors can place up to 85% of their concessional contributions into their spouse’s account, according to Mr Gerrard.

Contributions tax rises to 30% for high-income earners
What’s changed?
Before the budget, the contributions tax on tax-deductible superannuation contributions was 15% for all individuals. From July 1, this tax increased to 30% for those who earn more than $300 000.

Although all the details have yet to be released, this income is likely to include taxable income, concessional superannuation contributions, adjusted fringe benefits, total net investment loss, tax-free government pensions and benefits and certain foreign income.

However, if an individual’s income excluding their concessional super...
contributions is lower than $300,000, but the inclusion of their concessional contributions pushes their income over the $300,000 threshold, only that part of the contribution in excess of the threshold will be subject to the higher contributions tax.

This change will not affect the 15% tax on earnings within superannuation (and the tax exemption for assets supporting pension payments).

What will it mean?
This measure, of course, makes super a less tax-effective vehicle for those on very high incomes. Those earning $300,000 and over on the highest marginal tax rate of 46.5% were paying up to $3750 tax a year on their concessional contributions. This new measure will see that figure double.

However, even for people in this category, super still attracts a far better tax rate than income (30% compared with 46.5%), Mr Wren says.

“Super contributions within allowable limits still provide tax advantages, so it will still have a place in retirement planning”, he says.

Also, because income and capital gains from super remain at 15% or under (depending on how long an asset is held), super is still an attractive tax structure in which to hold investment assets, Mr Gerrard says. To capitalise on this tax-effective aspect, he suggests that people older than the preservation age of 55 seek advice about starting a transition-to-retirement pension — which brings the overall tax rate on investments held inside the super fund to 0% — and draw down the absolute minimum (which varies depending on your age).

“When you start a transition-to-retirement pension, you usually move the total super balance across to a transition-to-retirement pension and this becomes a second account inside your super account”, Mr Gerrard says.

Once in that pension, the money can earn interest, receive rent and produce capital gains, all tax free, he says.

Meanwhile, you still receive money into your separate super account as usual through salary sacrifice and employer contribution, which continues to be taxed at up to 15% on earnings and gains.

Amanda Bryan

The good news

Immediate deduction for business assets costing less than $6500

What’s changed?
Small businesses (those with turnover of less than $2 million) have had to depreciate business assets costing over $1000 — think diagnostic equipment, computer software and office furniture — over a few years, depending on the life of assets. They could, however, write off assets that cost $999 or less.

As of 1 July 2012, small businesses are able to write off any new business assets that cost less than $6500 in the same year they bought it.

What will it mean for you?
Mr John Fara, an accountant and tax consultant with Fiducia Advisors, says this measure means most practice items will be tax deductible in the year in which they are purchased, improving cash flow and making accounting easier at tax time.

Upfront $5000 deduction for new or used car purchases

What’s changed?
A business owner who buys a new or used car can claim a tax deduction over several years based on the percentage of work-related use. Though this is still the case, as of 1 July, small businesses can also claim $5000 upfront on new or used cars.

What will it mean for you?
If you’re considering upgrading your vehicle, this measure provides an extra incentive. Mr Fara says the additional deduction will be worth $2325 for those on the highest tax rate.
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DEPARTMENT OF HAEMATOLOGY

Clinical Fellow in Haematology
(SpR/ST3+/post-CCT)

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For further information please contact Dr Shirley D'Sa, Consultant Haematologist and UCH Training Programme Director on shirley.dsa@uclh.nhs.uk

Please visit www.jobs.nhs.uk quoting the reference number 309-SC754-MY.

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