Child and adolescent psychiatrists work with whole families to treat — or prevent — mental health problems.

One of the most appealing aspects of child and adolescent psychiatry, according to specialists in the field, is the chance to intervene at the earliest stages of burgeoning mental health problems.

In some cases the work of child and adolescent psychiatrists is preventive, stopping mental health problems from developing in vulnerable children.

Dr Sally Tregenza, director of advanced training in child and adolescent psychiatry in South Australia, decided to specialise in the field after enjoying a 6-month placement as a registrar.

“I found there was more of a sense of hopefulness with young people. I liked that early intervention could have a longer impact by preventing mental health problems”, she says.

Dr Tregenza also appreciated that child and adolescent psychiatry is one of the more flexible specialties.”Given that we’re so focused on developing relationships between children and parents or caregivers, it’s quite an understanding profession when it comes to supporting working parents”, she says.

Child and adolescent psychiatrists often work with the child’s family, school and community, in addition to the child themselves. Dr Tregenza says this adds another layer of complexity and challenge to the specialty, which she enjoys.

The specialty also involves considerable interaction with other medical and allied health professionals, such as paediatricians and psychologists, so prospective trainees need to enjoy teamwork. It suits doctors who are interested in understanding development and why we become the people we become, says Dr Tregenza.

“You also need to have a sense of playfulness; working with young children can be a lot of fun”, she says.

Professor Philip Hazell, director of advanced training in child and adolescent psychiatry at the Royal Australian and New Zealand College of Psychiatrists, agrees that working with young people can be great fun. He says the specialty suits doctors who like psychiatry, but who also enjoyed their paediatric terms.

“Most children and adolescents have really interesting stories to tell and it’s enjoyable trying to make a connection with them and understand their experience of the world so far.”

Professor Hazell says child and adolescent psychiatrists need to be dynamic in their interactions with colleagues and patients. He says they also need to be able to tolerate more uncertainty than most other doctors.

“Many of the manifestations aren’t yet fully formed in young people. Often, we’re not quite sure where it’s going and you have to sit with that ambiguity and communicate that to families and...”

Dr Sally Tregenza

continued on page C2
other health professionals”, he says.

Professor Hazell has witnessed tremendous changes in the specialty since he started out in the early 1980s. He decided on the specialty after a supervisor advised him that it was the area of psychiatry where “all the action” would be in the next 20 years. However, not everyone shared this view at the time.

“Back in the early 80s the general attitude was that it was a backwater discipline, that it was just ‘people doing nice things with sad kids’. It wasn’t taken particularly seriously.”

He has enjoyed seeing the accumulation of evidence for childhood mental health disorders and their treatments. Now there is good science underpinning many of the treatments, both psychosocial and pharmacological.

However, scientific understanding is still growing rapidly in the field, which means there are plenty of opportunities for child and adolescent psychiatrists to get involved in research. Professor Hazell says the research community is well connected internationally and very supportive of early career researchers. Two organisations he recommends for their mentoring opportunities for young doctors are the American Academy of Child and Adolescent Psychiatry (www.aacap.org) and the International Association of Child and Adolescent Psychiatry and Allied Professions (www.iacapap.org).

Training as a child and adolescent psychiatrist

After completing 3 years of basic training in psychiatry through the Royal Australian and New Zealand College of Psychiatrists, trainees can enter Advanced Training in Child and Adolescent Psychiatry. Entry into advanced training is based on an interview and completion of all the requirements of basic training. The 2-year advanced training program includes goals such as achieving clinical competency in infant, child and adolescent psychiatry, skills in advocacy on behalf of children, and the ability to show leadership in promoting mental health in children. Professor Hazell says that although entry into psychiatry training is not particularly competitive, it can be difficult to secure a place in some of the more popular training posts.

Sophie McNamara

Perinatal and infant psychiatry

Advanced trainees in child and adolescent psychiatry also need to gain clinical experience in infant mental health. Perinatal and infant psychiatrists work with infants and their families, with a focus on the importance of the attachment relationship between parent and child.

Dr Anne Sved Williams is a perinatal and infant psychiatrist based at the Women’s and Children’s Hospital in Adelaide. She works with pregnant women in the hospital and new mothers in the psychiatric inpatient unit. She is also involved in screening women for antenatal and postnatal depression and managing community referrals from general practitioners and others.

“I love that it’s the earliest intervention in mental health... there are so many important parts of development in the first 2 years of life, so it’s an opportunity to help things go the best way possible”, she says.

Registrar Q+A

Dr Gillian Sanzone, final year trainee in child and adolescent psychiatry, Sydney and Wollongong, NSW.

Why did you decide to specialise in child and adolescent psychiatry?

I really enjoyed the first child and adolescent psychiatry rotation I did as a basic trainee. My supervisors during basic training were inspiring as clinicians, generous with their knowledge and teaching, and very supportive.

Subsequent rotations in this area strengthened my conviction that this was something I really wanted to do. The opportunity to intervene early was enormously appealing, and remains so.

I also enjoyed being part of a multidisciplinary team. I found that, on the whole, people working in this area are passionate and committed to providing the best care possible. It’s also one of the more family-friendly specialties, and part-time work is very well accepted.

What do you enjoy about the training program?

The program involves two mandatory clinical rotations and two elective rotations. This meant I was able to gain good general experiences in the first year of training, while the second year allowed me to develop skills according to my particular interests, such as working with autistic children and infants.

The formal teaching component of the child and adolescent advanced training program is fabulous. The program is detailed, well structured and comprehensive, and the training atmosphere is extremely collegial.

I’m currently working with infants, children and families at Park House Child and Family Clinic in Liverpool, NSW, as well as doing family-based interventions at Child and Adolescent Services in Figtree, NSW.

I find working with children and adolescents very rewarding. The capacity to intervene before problems are entrenched is important, and to help restore hope and function in a young person is extremely satisfying. The nature of the work is interesting, diverse and dynamic, and it readily fits into the biopsychosocial framework.

What do you dislike or find challenging?

Dealing with uncertainty and ambiguity can be confronting. Another challenge is that psychiatry is often consulted as an “end of the line” option for complex problems, and this can carry unrealistic expectations in terms of what we can achieve.

In terms of providing pharmacological treatment, there is often inadequate scientific literature pertaining to children and adolescents. This can make prescribing tricky, because potentially helpful treatment may be withheld or, alternatively, off-label prescribing may be required.

What do you want to do once you’ve completed the training?

I have done lots of travelling in NSW over the past two years, so working a little closer to home is appealing! I hope to keep my experiences broad in the first few years, although I am keen to continue working with younger children, and I would like to hone my psychotherapy skills. Hopefully there will be the opportunity for research too.
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Royal Flying Doctor Service

WESTERN OPERATIONS
Professor Bruce Tonge reflects on his career in child and adolescent psychiatry

Professor Bruce Tonge is an academic child and adolescent psychiatrist, who recently retired after 20 years as head of the Centre for Developmental Psychology and Psychiatry at Monash Medical Centre in Melbourne. He continues research and clinical work. His key research interest is developmental psychiatry, with an emphasis on autism and childhood anxiety and depression.

“I was lucky to have had inspiring teachers while at medical school at Monash. During a clinical placement, we had a visiting teacher from the United States, psychiatrist Professor George Engel. I introduced him to a young man who’d broken his legs in a car accident. I thought it was straightforward, but Professor Engel used open interviewing to discover what was behind the injuries. It turned out the man had become involved in the crash after an argument with his newly pregnant wife. That taught me the important lesson of ‘why now? Why does this patient present to a doctor now? It got me interested in the psychological aspects of disease.

After an internship at the Royal Brisbane Hospital, which stimulated my interest in psychological medicine, I travelled to Great Britain to begin psychiatry training. It was a comprehensive program, including psychotherapy training at the Tavistock Clinic, London. This deepened my understanding of how fundamental early attachment experiences are to ongoing mental health. I also completed a placement with child psychotherapist Frances Tustin, who introduced me to long-term psychotherapy work with children. I then got a senior registrar position in child psychiatry at Cambridge University. In that wonderful academic environment, I mixed with people who were fascinated by child development and were doing early studies on child mental health. That set the scene for my subsequent career.

While at Cambridge, I met a child with school refusal problems. He was quite uncommunicative but warmed to the ‘squiggle technique’, which involves asking the child to squiggle on a page and make something of it. His parents thought their son was having nightmares, so I had the idea of taking the technique a step further. I drew a child sleeping, with a balloon coming out of his head, and asked the boy to draw a picture of his bad dream. He immediately drew two monsters fighting. They were saying bad things to one another and the man monster was hitting the lady monster. I said, ‘I wonder if things like this sometimes happen at home?’ He started to cry and tell me about his witnessing domestic violence and parental conflict. He was not so much frightened about going to school as concerned that he needed to protect his mother. I subsequently wrote a paper on this ‘draw a dream’ technique, and it is now used internationally. John Murtagh even has it in his textbook. It’s a contribution of which I’m very proud.

I returned to Australia in 1976 when I was invited to help establish a child psychiatry clinic at the Austin in Melbourne. I was director of the child and adolescent psychiatry department at the Austin from 1980 to 1987. While there, I began to develop an interest in autism and helped establish autism assessment services across Victoria, which continue to operate today. I was also partly responsible for setting the accreditation standards for child psychiatry, which form the basis of the current standards.

In 1987, I was offered the foundation chair in child psychiatry at the University of Sydney. Around this time, I realised that children with development problems had a significant number of associated mental health problems but we didn’t have a good way of assessing this. My colleague, Stewart Einfeld, wanted to do an MD, so I supervised his doctorate and together we developed a parent-completed and teacher-completed questionnaire about emotional and behavioural difficulties in children with developmental problems. This ‘developmental behavioural checklist’ has now been translated into 21 languages and is used around the world to assess children — and recently adults — with developmental difficulties.

I established the Centre for Developmental Psychology and Psychiatry at Monash University in 1989. The centre provides research and teaching in developmental psychiatry and psychology. A major part of my research interest has been the mental health problems associated with autism. At Monash, we’ve had a series of National Health and Medical Research Council grants for work in this area. We’ve also looked at potential autism treatments. For instance, with my colleague Dr Avril Breton, we have established that education and skills training for parents of children with autism can significantly improve parental mental health, reduce family stress and improve adaptive behaviours in the young people, which persist 2 years later.

With colleagues, I’ve developed a number of psychological treatments based on cognitive behaviour therapy to treat anxiety, particularly presenting as school refusal, and depression, particularly in teenagers. The treatments have been effective, and are now used by other clinicians. One of the things about research, however, is that it opens doors. The next question is how to improve the interventions for those who don’t respond.

Psychiatry, and particularly child psychiatry, has always been a passion. On the surface some mental health problems seem insurmountable, but using the techniques I’ve learnt from others and honed over the years, and taking a family approach, can lead to a significant change for the child. It’s been a privilege.”

Interview by Sophie McNamara
Patient consultations have officially hit the small screen. Encouraged by new Medicare Benefits Schedule (MBS) telehealth item numbers, some generous financial incentives, and affordable technology, practitioners and their patients are embracing the new health delivery model.

The typical video consultation involves a link-up between a patient and their general practitioner (or health worker) in one geographic location, and a specialist in another.

The MBS incentives apply to patients living in outer metropolitan, rural or remote areas. For these patients, a video consultation can provide more timely care and can cut the time, cost and stress involved in travelling long distances for appointments.

But what’s in it for you? For starters, an upfront incentive of $6000 to help compensate for the investment and learning curve involved. Then there are ongoing Medicare incentives (GPs get an extra 35% for each consultation and specialists get an additional 50% of the schedule fee).

There’s also a quarterly volume-based incentive payment, which depends on the number of telehealth consults you’ve conducted.

On top of that are the numerous potential efficiencies. For those already travelling to rural and remote areas to provide outreach services, telehealth can reduce travel time and enable them to see more patients.

And although it’s early days, some practitioners are already using telehealth to tap new sources of patients. For instance, the model suits semiretired doctors who want to work from home.

However it’s worth noting that, like many new delivery models, some of the finer details have yet to be ironed out. Early adopters say that technically and administratively speaking, setting up telehealth is relatively straightforward, but clinical and technical standards remain a work in progress.

Should you choose to proceed, here are some of the challenges you may encounter on your journey:

Finding doctors to connect with
At present, one of the greatest barriers to telehealth is finding other doctors to connect with. Although there are plenty of telehealth projects in the works, these are mostly operating in silos. No central directory is yet dominating — though a handful of organisations are building them.

GP Dr Ash Collins, who has established a telehealth service at his practice in Temora, Central NSW, has created www.myonlineclinic.com.au, a directory of GPs and specialists who provide video consultations.

The Australian College of Rural and Remote Medicine (ACRRM) also has a provider directory as well as a range of support materials to help doctors get started. See: www.ehealth.acrrm.org.au.

But how do you forge telehealth relationships locally? The most logical telehealth targets at this early stage are your current medical networks, which brings us to the next challenge: platform interoperability.

Choosing a video conferencing platform
The main problem here is that different video conferencing platforms are not all interoperable. This means there’s no guarantee that your platform will work with the system used by another practitioner.

To help address the interoperability issue, some companies are building physician communities around specific technology platforms. Australian Telehealth Network (austtelehealth.com.au), for instance, is building up a network of GPs, specialists and aged care providers who can use its video conferencing platform to connect with each other.

Melting away the miles
Dr Geoffrey Boyce recently began offering video consultations to patients, including some located thousands of kilometres away, from his offices in Lismore in northern New South Wales.

He started only a few months ago but has now completed more than 60 video consults and has plans for many more.

“I’ve seen one patient today in Cairns, yesterday I saw someone in Cobar.”

He only accepts telehealth patients from areas that aren’t already being serviced by a visiting neurologist. He bulk bills for telehealth consults so the MBS incentive is a welcome initiative.

He sees a lot of patients with severe epilepsy and Parkinson disease, many on pensions, so bulk-billing allows him to provide them with “a little concession”.

Dr Boyce says telehealth also fits in well with his own financial plans.

“In the next couple of years I’d like to start cutting back on patients. If I can see 10 patients via telehealth each week, I won’t have to use up my superannuation”, he says.

Dr Boyce, who uses Telehealth Solutions Australia’s free platform (www.telehealth.net.au), said the technology set-up and ongoing administration had been straightforward.

“I’m 65 so I understand how anything to do with technology can sound intimidating — but once you do it you realise it’s quite easy.”
For now, though, many of telehealth’s early adopters are using Skype (www.skype.com). Although it’s a consumer-grade product, experts say if your computer system meets security and privacy obligations, it can be a good way to get started. Skype’s deficiencies, however, such as video quality and reliability, mean that most doctors will want to upgrade at some point.

There is another way to get started on a more robust platform without locking yourself in. Telehealth Solutions Australia (www.telehealth.net.au) is a not-for-profit organisation established by occupational health physician Dr David Allen.

Dr Allen developed a platform for his own occupational health operation — a 24-hour injury management service for shiftworkers in large corporations. It’s high definition and secure, and comes complete with training materials. He’s offering it to other doctors free, he says, because of the absence of government-mandated applications that would provide doctors with an interoperable solution.

“Lots of doctors are sitting on their hands and waiting for that to happen and that’s a disadvantage to patients”, says Dr Allen, adding that hundreds of doctors already use the system.

ACRRM has also developed a stack of resources, including a technology directory, to help doctors get started. It offers an online support form to help practices decide which technology solutions best suit their requirements, operating system, bandwidth and budget. It can also provide guidance on potential privacy and security issues.

Preparing for your first telehealth consult
Dr Allen says telehealth does add an extra layer of complexity to the traditional consult, and it can take a while to get used to the technology (see box for his tips).

The logistical complexities involved in connecting two doctors and a patient can be tricky: they all need to be available simultaneously, which involves factoring in two busy clinics with variable waiting times.

Dr Mike Civil, a GP and chair of the Royal Australian College of General Practitioners (RACGP) committee on standards, has firsthand experience of this. To address this problem, his practice, which has been conducting video consults for about 6 months, blocks out time that is devoted to video consults. The task of coordinating the three different parties is done at the front desk.

Dr Civil says after the consult, claiming the MBS telehealth incentive is easy. Doctors who already have a provider number do not need to register. The payments arrive automatically after you submit a telehealth MBS item number.

There are also 11 derived fee item numbers available to specialists. Those who wish to bulk bill their telehealth patients can do so by obtaining a signature or via an email agreement (see more at http://www.medicareaustralia.gov.au/provider/incentives/telehealth.jsp).

Dr Sara Bird, manager of medicolegal and advisory services at Occupational and environmental physician and telehealth advocate, Dr David Allen, offers these tips on preparing for a video consult:

- Practice using the system as much as possible before you go “live” with a patient, and check that it is working a few hours before the consult.

- Determine the best way to examine the patient by imagining they are in same room but behind a glass partition. How would you examine them?

- Have a spare webcam on hand so you can show the patient, GP or other attending health worker how to position it during an online examination.

- Ensure that your background is simple and appropriate: framed degrees or a plain wall is suitable.

- Position a lamp behind your monitor to illuminate you.

- Lock the door and put a sign on it to prevent interruptions.

- If the picture fails, continue the session by phone.

- If the internet connection is poor or variable, slow the visual examination down.

Once doctors are up and running, they wonder why they were so worried about starting

Vicki Sheedy

Meeting your legal obligations
The RACGP has developed a set of telehealth standards and these view the specialist consultation as a “dual consult”, which means each of the clinicians have a degree of responsibility for the management of the patient from the time of the consultation onwards, says Dr Civil.

Though the particular responsibilities need to be clarified by both physicians at the time of the consultation, he says the consultation is actually between the patient and the remote specialist, with the GP or other health worker considered a support person — there to facilitate the consultation.

Legal responsibility would therefore rest with the specialist. The patient is referred to the specialist in the normal way, and the specialist should report back to the patient’s GP in the normal way, says Dr Civil.

Patient records should be made by both parties (as per a normal face-to-face consultation). Generally speaking, video consults should not be recorded — but if, in exceptional circumstances, they are, patient consent is required and the recording would need to be treated as part of the patient’s clinical record.

Amanda Bryan
Road less travelled

Conceiving a better world

Australian medical and commerce students work together to help Indian villagers

Three years ago, medical student Mr James Wei attended a 3-week primary health care course in Jamkhed, India. It turned out to be a life-changing experience.

The course was run by the Nossal Institute for Global Health, in collaboration with the Comprehensive Rural Health Project (www.crhpjamkhed.org) — a world-leading health and community development organisation established in India 40 years ago.

While there, Mr Wei met an Indian doctor, Dr Moses Kharat, who inspired him with his dream to improve the health of people living in his home district of Buldana, in Maharashtra state, western India.

Dr Kharat had spent most of his medical career working in various hospitals around India, but had long wanted to return to his home town to provide medical care to the mostly poor villagers. Having been raised as a Dalit, or member of the “untouchable” community in the Indian caste system, Dr Kharat knew the plight of the poor and marginalised, Mr Wei says.

After attending the course, Dr Kharat soon returned to Buldana, where he used his own funds to establish the Community Based Health Project (CBHP). The project focuses on training village health workers to teach families how to treat and prevent common health problems. The health workers are also trained to identify more serious health problems requiring referral. The project currently works with 10,000 people in six villages in Buldana.

While Dr Kharat was busy establishing this project, Mr Wei returned to the University of Melbourne where he set up an organisation called “Conceive” with other students. Conceive aims to raise much-needed funds for CBHP and also works to ensure that the project is in line with best-practice models of development.

Conceive also has an interesting collaboration with a group of commerce students from the University of Melbourne, Students in Free Enterprise, who focus on creating financially sustainable solutions for community organisations.

Together, the commerce and medical students have developed a “semi-business model” for Dr Kharat’s project, based on a volunteer immersion program. People pay to experience rural Indian life, with the funds reinvested into CBHP.

The first group of five volunteers travelled to Buldana in January this year, where they immersed themselves in activities such as cotton picking, visiting traditional healers and teaching at local schools. The volunteers paid $1850 for the 4-week itinerary, including food, accommodation and translators. The first group was comprised of University of Melbourne students, but the program is open to everyone.

“The idea is for them to get a sense of what it’s like to live as a rural Indian villager,” Mr Wei says.

The volunteers also helped a team of fifth-year medical students conduct a health audit, to develop a baseline for CBHP’s activities.

Conceive developed the itinerary for the volunteers, and Mr Wei arrived in Buldana 2 weeks before their arrival, to ensure that all the arrangements were in place. He worked with Dr Kharat to renovate accommodation, and met with many local people such as farmers and politicians so that everyone was prepared for the arrival of the young Australians.

His hard work paid off — the volunteer immersion program, in conjunction with a humanitarian grant from the University of Melbourne, raised $8000 in profit for CBHP.

Conceive aims to run two more volunteer immersion programs in 2012. Mr Wei says the long-term goal is that Dr Kharat will take over the volunteer program, so that CBHP can become self-sustainable.

In the meantime, Mr Wei has many other ideas for CBHP. He is hoping to develop an ongoing research partnership between CBHP and the University of Melbourne, such that every year at least one medical student travels to Buldana to conduct research.

He is also hoping to launch interventional projects to improve the health of people in Buldana. First on the agenda is a smokeless stove project, to replace the dangerous, smoke-generating stoves currently used in the district.

Mr Wei, who is now a final-year medical student, acknowledges that there have been numerous challenges in building his fledgling humanitarian organisation, and in working in such a culturally different environment.

However, he has relished the opportunity of working with CBHP from its inception.

“I wanted to work with someone from scratch. And that person was Moses. It was his integrity and vision and heart to serve the people with no pay [that impressed me].”

Mr Wei attended several global health conferences through the Nossal Institute before it all clicked and he realised he had to do more than just listen.

“I think in our generation we are quite aware that the world is not a just place. I just thought, ‘I’ve heard enough, I’ve seen enough, I want to get engaged with something myself’.”

More information: http://communitybasedhealthproject.org/vp.html

Sophie McNamara
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Contact John Guymer on 0408 579 357 or j.guymer@bigpond.com for further details.

The Kinghorn Cancer Centre (TKCC)
St Vincent's Hospital and the Garvan have joined to create the soon to be opened TKCC and now seek EOI’s for the renting of rooms in its purpose built Wellness Centre.
The Wellness Centre will provide advice on improving health as well as access to treatments to improve the quality of life.
Further details www.thekinghorncancercentre.org.au

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> NEWS AND RESEARCH
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Applications are invited from appropriately qualified academics with recognised clinical skills in the area of rheumatology/musculoskeletal medicine for appointment to a newly created Chair in Rheumatology/Musculoskeletal Medicine supported by The University of Western Australia, North Metropolitan Area Health Service and Arthritis and Osteoporosis WA. The appointee will be a Winthrop Professor in the University’s School of Medicine and Pharmacology and the position will be based in the Department of Endocrinology at Sir Charles Gairdner Hospital.

The School of Medicine and Pharmacology is responsible for the teaching of musculoskeletal medicine and its sub-specialities to undergraduate medical students at all teaching hospitals and most secondary hospitals in Perth.

The successful candidate will make a significant contribution to the development of the disciplines of rheumatology/musculoskeletal medicine (including both bone and joint disorders) in the University, North Metropolitan Area Health Service at Sir Charles Gairdner Hospital and the wider community by close involvement with the objectives of Arthritis and Osteoporosis WA. The Chair will provide academic leadership in undergraduate, postgraduate and vocational education, provide a minimum of 3 clinical sessions per week within the North Metropolitan Area Health Service and take an important role in the delivery of the Area’s rheumatology/musculoskeletal medicine service.

World-class research is currently being undertaken by a variety of groups within the School of Medicine and Pharmacology and the successful candidate will act as a focus for the discipline’s research activities. The appointee will have a strong record of published research and productivity, and possess the exemplary interpersonal skills and leadership capabilities to inspire staff and students to foster the continued development of research in rheumatology/musculoskeletal medicine in Western Australia.

For further information please contact: Associate Professor Brendan McQuillan, Head of Unit, School of Medicine and Pharmacology, Sir Charles Gairdner Hospital on (08) 9346 7908, email brennan.mcquillan@uwa.edu.au or Professor Richard Prince, School of Medicine and Pharmacology, Sir Charles Gairdner Hospital on (08) 9346 2577 or 0419 937 100, email richard.prince@uwa.edu.au.

The appointment will be fixed-term for five years, and includes rights of private practice (limited) or election to a private practice allowance. An attractive remuneration package is offered and includes both Winthrop Professorial (Level E) university and hospital salaries plus a clinical loading. Benefits include generous leave provisions, superannuation and relocation assistance (if applicable) for the appointee and dependants. A substantial start up package that includes a half-time administrative support position will be available to the successful candidate.

Closing date: Friday, 13 July 2012
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for excellence in medical research

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