Doctors who are decisive and quick-thinking may be well suited to a career in emergency medicine, says Professor George Braitberg, director of emergency medicine and a consultant toxicologist at Southern Health in Melbourne.

“It suits doctors who like to multitask and who enjoy dealing with a number of different hospital and external services”, says Professor Braitberg, who is also professor of emergency medicine at Monash University.

Doctors considering the field need strong interpersonal skills, as emergency physicians not only liaise with other doctors in the hospital, but also with paramedics, allied health workers, nurses and even police.

The specialty also involves considerable interaction with junior doctors and students, and offers specialists quarantined teaching time.

Professor Braitberg says this means emergency medicine suits doctors with an interest in education. He adds that many emergency physicians complete a second degree in education.

The specialty also lends itself to clinical research, given the huge numbers of patients that come through emergency departments. For instance, the three emergency departments at Southern Health see about 190,000 patients each year.

Many emergency physicians are also involved in management or administrative-type roles (see also Medical Mentor, page C5), perhaps because they liaise with so many aspects of the health system.

“We are systems analysts. We think about systems, and the context in which the patient is being treated. There’s a lot of interest in patient flow and how health systems interact”, says Professor Braitberg.

One key outcome of this interest in systems has been the introduction of the national emergency access target, which aims to ensure that 90% of patients progress through the emergency department within 4 hours.

Professor Braitberg loves the variety of work he is able to do as an emergency physician.

“l’m fortunate in my position as I can do it all. I see patients, plus I do research, teaching and administrative work. Emergency medicine lends itself to that sort of career; or you can develop the [particular] side of your work that you want to develop”, he says.

Clinically, emergency physicians are true generalists who see an incredible variety of presentations.

“I like being able to see undifferentiated patients — people don’t present with a diagnosis, they present with symptoms. Your role is to look at the symptoms and signs and develop a provisional diagnosis. It has an intellectual side.”

There are also a number of subspecialty options including toxicology, disaster medicine, hyperbaric medicine and trauma.

Professor Braitberg says one of the misconceptions about the specialty is that it’s just about triaging patients.

“The role of the emergency department is to undertake resuscitations, provide the first essential treatment, make a provisional diagnosis, and refer patients to the most appropriate person. We do the same things as other doctors, but in a different way.

I like being able to see undifferentiated patients — people don’t present with a diagnosis, they present with symptoms.”

continued on page C2
Emergency medicine can be full on, but once you walk away you hand over to someone else. “

Training as an emergency physician

After completing 2 years of basic training — which is normally Postgraduate Year 1 and Postgraduate Year 2 — emergency medicine registrars need to complete at least 1 year of provisional training. A primary exam must be completed at any stage during provisional or basic training. This is followed by at least 4 years of advanced training, which includes 30 months of emergency training and 18 months of non-emergency training. The fellowship exam needs to be completed in the final year of advanced training. The program offers registrars substantial flexibility (see also Registrar Q+A, right). For instance, all training can be done part-time, and registrars can choose whether they complete all their training in one state, or all over the country.

Sophie McNamara

Registrar Q+A

Dr Phillip Webster, first-year advanced trainee in emergency medicine, Gosford Hospital, and deputy chair of the Australasian College for Emergency Medicine trainee committee.

Why did you decide to specialise in emergency medicine? I found that whenever I was working in the emergency department as a prevocational doctor, I enjoyed my job the most. I was happy. I like the excitement of it, the fact that it’s something different every day. There’s such a wide variety, from sprains and fractures, to sepsis and major trauma. There’s never a dull moment.

What are you enjoying about the training? The emergency medicine training program has massive flexibility. One of the best things is that you spend 18 months training outside the emergency department, which means you can gain loads of extra skills. I’ve spent time doing anaesthetics and am soon to do some intensive care, plus I’m hoping to do some paediatric emergency medicine. Some people also arrange overseas training experiences, say for 6 months, and apply to the college to have it accredited to their training. As long as everything’s arranged well in advance, the college is quite accommodating.

What do you dislike/find challenging? You do have to do a lot of shiftwork, including weekends. Some people find that tough, but the advantage is you get time off during the week which is great if you have a family. You generally also work a 40-hour week, with no on-call, so your time off is really your time off. That suits me. We can go away for a few days in the middle of the week, or go to a restaurant on a weekday and not have to fight to get in. The emergency department can be stressful, and sometimes you feel exhausted after a shift. But it works if you make the most of your time off — I tend to get outdoors, go for a surf or a run. That helps.

What do you want to do once you’ve completed the training? I’ll probably stay in New South Wales as an emergency physician. I’m also keen to get more involved in education — promoting and improving emergency medicine and health care where I live.

Do you have any specific mentors in medicine, or emergency medicine specifically? I spent 6 years training in the United Kingdom, including a couple of years as a non-accredited emergency medicine trainee. I was inspired to study emergency medicine in Australia by an Australasian specialist I worked with in the UK. He was quite different from the other specialists and epitomised what I thought a good emergency physician should be. He was a supportive leader who combined expert knowledge and skills with honest compassion and a good sense of humour.
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Specialists in medical recruitment
Dr Sally McCarthy reflects on her career in emergency medicine

Dr Sally McCarthy is president of the Australasian College for Emergency Medicine and a senior staff specialist in the emergency department at Prince of Wales Hospital in Randwick, Sydney. A graduate of the University of Sydney medical school, Dr McCarthy is also medical director of the Emergency Care Institute New South Wales.

“During my residency at St Vincent’s Hospital, I enjoyed my terms in surgery, as well as in emergency medicine. At the time I was thinking I’d do surgical training. But during my resident year in 1985, my mother died of breast cancer. I took a year off and did a lot of soul-searching, and decided I really wanted to do emergency medicine. The specialty was still fairly new, so I saw that there was a lot of scope for contributing to its development.

I started off doing purely clinical work, as most doctors do. Because it was a new specialty, you could take on administrative roles at an earlier stage in your career in those days. I felt the need to try to improve things, and took on more management-type roles. After holding emergency director positions at other Sydney hospitals, I became director of the emergency department (ED) at Prince of Wales. I held this position for almost 8 years, until March 2011, when I stood down to take on the medical director role with the Emergency Care Institute.

The Emergency Care Institute is part of the Agency for Clinical Innovation and aims to improve care for patients across NSW EDs. It does that by improving communication across departments, advocating on behalf of EDs and fostering research and innovation. A key challenge that I’m trying to bring to people’s attention is the prevailing staffing structure in the ED. I'm very glad I did it.

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Emergency medicine probably pushes people into roles where they can change the system in some way.

because the ED feels the impact of dysfunctionality in the rest of the system. You’re interacting with the whole system, so you get a good view of what works well and what doesn’t. If you look at the current Australian system, our Commonwealth Chief Medical Officer [Professor Chris Baggoley] is an emergency physician, as are several Australian Medical Association state presidents or presidents-elect, and, increasingly, hospital chief executives.

In 2000, I completed a Master of Business Administration (MBA) degree from the Australian Graduate School of Management. I was prompted to do it because I was sick of being told what to do in the hospital by people who didn’t value the insight of doctors! There was a bit of a tendency to say, ‘oh doctors can’t do management’. I think that’s false! Having an MBA gives you some legitimacy, and it gives you different frameworks in which to look at things.

I wanted to get some perspective outside the health system, so I chose to do a general MBA rather than a health management degree. It reinforced that there are some aspects of health system management that need to change substantially. I was later an alumni mentor for the business school for 6 or 7 years. I mentored students, and I’ve had management trainees do attachments with me, from health and other backgrounds.

One of my career highlights has been doing retrieval work. I enjoyed the close working relationships between all of the critical care and emergency services people. I have also enjoyed working with a variety of research groups, including people outside medicine, such as linguists and psychologists. I’ve done lots of research on the effects of access block and overcrowding. Recently, I contributed to a qualitative study on the interaction emergency clinicians have in trying to get patients accepted into the rest of the hospital, which was reviewed as a coming-of-age for qualitative research in emergency medicine.

One of the downsides of working in the ED is that emergency physicians are pushed to get patients out, so it can put you in an adversarial position with other services. I hope the national access targets will change that. In the past, I think there was a perception that anybody could work in “casualty”, but it is increasingly recognised that specialist emergency care improves patient care and system outcomes.

Being president of the College has given me the fantastic opportunity and privilege to influence the system across Australasia. I’m very interested in all the things that go into making great emergency services, and workforce, training and education are fundamental to that. Another highlight has been introducing non-specialist certificate and diploma courses for non-specialist doctors working in emergency departments across Australasia. That was something I was very keen to do.

Emergency medicine is interesting, sociable and you get to make an impact at a crisis point in patients’ lives. You interact with lots of students, and it offers great opportunities to collaborate across the system. Clinically, it’s extremely varied — you’re always seeing new things. It’s a real privilege getting to know a lot about people in a short space of time, and to often have a significant impact on their lives. It can also be a lot of fun working with a large multidisciplinary team. I’m very glad I did it.”

Interview by Sophie McNamara
Road less travelled

A life in the theatre

Urologist Professor Mohamed Khadra wields both scalpel and pen with precision.

What do famous Australian playwright David Williamson and Mohamed Khadra, a professor of surgery at the University of Sydney, have in common? They are the joint-authors of a new Australian play about end-of-life decisions.

Their co-creation At any cost? was performed 60 times at the Ensemble Theatre last year and is about to be published in an anthology of plays.

The unlikely collaboration was born at a pivotal moment: Williamson called when Professor Khadra was in the middle of performing a nephrectomy.

The call wasn’t entirely out of the blue though. Professor Khadra had approached Williamson at the Brisbane Writers Festival six weeks earlier, suggesting they team up.

He presented the surprised playwright with two non-fiction books he’d penned and had published, Making the cut and The patient, to help his case.

“I’m not one to ignore the little voices in my heart, so I said ‘Mr Williamson, you don’t know me but we should write a play together’.”

At any cost? deals with the decisions that patients and their families make when the end of life looms. Professor Khadra was charged with writing the plot and the medical dialogue. Williamson applied his genius, says Professor Khadra, to creating a believable family with the various intricacies of conflicts, baggage and the history that becomes evident whenever major decisions are being contemplated.

As these issues were thrashed out on the stage, Professor Khadra could be found in a different sort of theatre — taking media calls between operations.

Despite his publishing success, Professor Khadra says surgery remains his first love. “Growing up, the only thing I wanted to do was become a doctor. I used to operate on my teddy bear and my first toy was a doctor’s kit.”

Professor Khadra was born in Ghana to Lebanese parents. He tells how his father, who fought in the Second World War, moved to Africa to make his fortune.

Although his dad didn’t achieve his ambition, he did get married and, in 1970, when Professor Khadra was 10, the young family moved to Sydney.

At the time, Australia was going through remarkable change, Professor Khadra says. By 1972, he was handing out leaflets in support of Gough Whitlam.

“I had an immediate interest in what was happening in terms of politics. I saw the introduction of Medicare and the abolition of fees for university — which meant I could get an education without being beholden to anyone else.”

But his career dreams were temporarily stymied after he missed out on medicine by one mark in his HSC. “It was hard-hitting at the time”, he says.

After studying dentistry for 3 years, however, he was able to transfer to medicine at the University of Newcastle. He completed his internship at Prince Alfred Hospital, and then trained as a urologist and became a senior lecturer.

However, his personal and professional life took a few twists and turns before he picked up the pen.

In 1996, just after the birth of his second son, he woke up with a lump in his neck. It was thyroid cancer and, during the months of treatment that followed, he discovered he wanted more from life.

“It struck me that the usual model of specialist training was to graduate, put up a brass plaque and then retire 40 years later. I wanted more.”

The 8-year venture had extracted a hefty financial cost on the family, so Professor Khadra returned to medicine. He took a post at Nepean Hospital in Sydney’s west, where he currently practises. He is also a professor of surgery at the University of Sydney.

In 2007, a patient (also an author) introduced him to a literary agent, and Professor Khadra’s writing career was born.

His most recent book, Terminal decline, was published in 2010. It dissected the national health system and points to a system in crisis. Professor Khadra says he has a couple more books in mind — including a story about his father’s life.

Next, he became pro-vice-chancellor at the University of Canberra, where he ran the health and science schools.

When Professor Khadra got a hankering to get back to clinical medicine, he started a new surgical school at the Australian National University.

It was here, he says, that something started to weigh on him: Australia’s medical education system was luring the best and brightest students away from developing countries.

Hoping to flip the model on its head, he and his wife established the Institute of Higher Education, which offered Australian degrees in developing countries at prices the students could afford.

The students would undertake to stay in their country and, in return, would get a good quality Australian education. In addition to medicine, the institute also offered courses in business, information technology and health informatics.

“It was huge. It spanned 22 countries and we had 1000 students but, at the end of the day, the model required more funding than we had, so McGrath Education Centres took us over.”

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Amanda Bryan
Doctors tend to be more fixated on taxation than other professionals. Sure, a lot of money can flow into the coffers but, because this often attracts the top marginal tax rate, a sizeable chunk flows right back out again.

This dynamic can sneak up on the unwary: spending decisions based on gross earnings can lead to financial over-commitment once the BAS (business activity statement) arrives.

But doctors have another disadvantage: those operating their own businesses are not entitled to the 30% company tax rate on any “personal services” income they generate.

Doctors must therefore think outside the box to take advantage of the tax-friendly options at their disposal, such as trust structures and self-managed super funds, say experts.

Here are some of the available options:

Superannuation
Superannuation is the most tax-effective vehicle available to doctors regardless of their employment arrangements, as all doctors are able to contribute money into superannuation pre-tax to reduce their tax liability.

This is known as salary sacrificing, whereby pre-tax income is used to make a contribution to a superannuation fund attracting a 15% tax rate as opposed to the doctor’s marginal tax rate of up to 46.5%. Tax experts, however, point to other tax-effective strategies relating to super.

Mr James Gerrard of PSK Financial Services says doctors who are over age 60 could consider commencing a transition to retirement (TTR) pension using the money in their super fund.

Under the TTR pension you can draw up to 10% of your super account each year while still working. For those over the age of 60, super withdrawals are tax-free, so doctors can withdraw from their super account while also salary sacrificing part of their employment income into super and paying only 15% tax on that amount.

Another potentially tax-effective move is to utilise your super as a deposit to obtain a loan which allows you to purchase property inside your super fund, Mr Gerrard says. The doctor can salary sacrifice into super (again, attracting a lower tax rate) and then use that money to repay the loan used to purchase the property.

“In simple terms, 85c in the dollar would be used to repay the loan in super, opposed to as little as 53.5c in the dollar if the property was purchased personally, if the doctor was on the 46.5% tax rate. Therefore, an investment loan can be paid off a lot quicker inside of super”, he says.

According to Mr John Fara of Fiducia Advisors, those who own their surgery can actually transfer the ownership of that property into their super fund. This can be arranged without paying stamp duty and with minimal capital gains tax.

Once it’s in super, it’s taxed concessional so any rent paid into the super fund is taxed at only 15c in the dollar.

“The beauty of that strategy is that when the doctor retires and converts the super fund to pension phase, the income generated from that property will be tax-free. Further, the capital gain he makes on the eventual sale of the property will be ignored”, Mr Fara says.

Business structures
Although the government has plans to reform the way trusts are taxed, these business structures have been around for years and remain a legitimate and tax-effective strategy, says Mr Paul Cooke, a Canberra-based financial planner with Centric Wealth.

“We think that provided they meet accounting guidelines, trusts are appropriate in some instances for doctors”, he says.

Service trusts provide doctors with a practice structure that allows for some appropriate income distribution to family members on lower marginal tax rates. A partner who takes care of a doctor’s diary and deals with some administration in the office, for instance, can be paid a moderate salary via this structure.

Avoidance versus minimisation
Legal question marks hang over some tax-minimisation strategies because although they are technically legal, they may be deemed to fall outside the spirit of the legislation and be classed as tax avoidance.

So how do you know on which side of the line a potential investment or business strategy sits?

Mr Jarrod Bramble of Cutcher & Neale accounting firm says Part IVA of the Income Tax Assessment Act has a three-point test to help taxpayers determine this: 1. Is there a scheme? 2. Was a tax benefit obtained? 3. Would it be concluded that there was a sole or dominant purpose of obtaining a tax benefit?

“If you’re only going into elaborate schemes to achieve a tax benefit, you’re going to fall foul of the anti-avoidance provision”, he says.

He gives the following two examples:

- If a GP who employed one other GP adopted a service trust structure in order to gain a tax benefit, that would be deemed tax avoidance. If the dominant reason that doctor adopted the structure was to attract other GPs to the practice, it would not.

or

- If a doctor moved an asset into the family trust to gain a tax benefit, that would be deemed tax avoidance. If the doctor moved the asset into the family trust to protect that asset in the case of being sued, it would not.

Ultimately, it is up to the taxpayer to ensure their tax strategies are legal.
This structure suits doctors with rooms and employees. The trust is also allowed a “make-up” profit of 10%, which can be distributed to family members. However, consider your motives when establishing this sort of structure, to ensure you don’t fall foul of the Australian Taxation Office (see box, below left).

Another type of trust that can provide tax efficiencies is an investment trust, Mr Cooke says. It can be set up so doctors don’t have to buy their assets in their own name, and can distribute income and capital to beneficiaries such as family members on a low or no income. This means less capital gains tax if the assets are sold before the doctor stops working.

“Super funds are the most tax-effective investment vehicle you can get, but the next best is an investment trust, and it’s a more flexible arrangement”, he says.

According to Mr Gerrard, an option for doctors who operate through a trust, and who have multiple income sources, is to have a beneficiary that is a company.

This company has the sole purpose of “holding” income generated from the doctor’s business (excluding personal services income earned specifically by the doctor). Because it’s a company, it would be taxed at 30% as opposed to up to 46.5% if received by the doctor personally, he says.

Other income sources could include service trust income or other income-generating services offered by the practice such as physiotherapy or specialist nurse services, according to Mr Fara.

“Practices are moving away from traditional models, and income from complementary services within the surgery should be tracked separately to make sure they’re treated correctly for tax purposes”, Mr Fara says.

**Tax-friendly investments**

Because of doctors’ large tax obligations, they are prone to seek out investments that offer short-term tax advantage at the expense of their long-term investment interests, tax experts say.

However, Mr Cooke says the GFC (global financial crisis) has curtailed this urge, and brought people back to focusing on good, long-term assets.

Although negative gearing makes sense in terms of tax effectiveness (and the higher your marginal tax rate, the more benefit you can reap from it), you do need capital growth to make it pay off.

“Since the GFC, we haven’t seen that capital growth so negative gearing into property and shares hasn’t really worked the way it has in the past and lots [of people] have lost confidence in it”, he says.

“It does also have an upfront cash-flow impact so you have to be more careful about selecting an asset before you move into negative gearing.”

Highland Financial’s Chris Wren says investors are nervous about the markets because of the uncertainties in Europe.

“Investors tend to move away from the share market and property market, generally speaking, in volatile times”, he notes.

He says in this climate, the investment focus should be on more conservative, income-generating assets, such as term deposits and fixed-interest options.

However, he notes that it’s best to check the tax implications with your accountant before implementing new investment strategies that require borrowing or gearing.

“Everyone is different and advice should be given on an individual basis, based on personal circumstances, but make sure you talk to those who understand this environment: those who use structures such as super and trusts themselves.”

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**Investment red flags**

Doctors are understandably attracted to investments that offer a tax advantage. Schemes spruiking such benefits, however, should be approached with caution. According to financial advisers, look out for the following warning signs:

- schemes that are promoted on the basis of tax minimisation
- investments with high upfront fees
- vague explanations of how it all works or overly complex transactions on something you know is simple
- when only one firm or tax practitioner appears to have the insight into the legislation (you may find yourself becoming the test case when the Australian Taxation Office (ATO) challenges it)
- schemes that involve borrowing large amounts of money; borrowing money magnifies both positive and negative investment returns
- schemes that involve exotic offshore accounts. The ATO has severe penalties for tax avoidance and targets overseas schemes
- schemes related to agribusiness (trees, nuts, etc)
- schemes offered by companies that don’t hold an Australian Financial Services Licence
- “capital-guaranteed” investments (check the fine print for hidden costs and high exit fees)
- companies promoting the purchase of property through your super. Become familiar with the terms “business real property” and “sole purpose test” before going down this path
- Check websites like https://www.moneysmart.gov.au/scams to get the current listing of scams and ways to identify them.

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Consultant Neonatologist

Applications are invited for 3 full-time NHS consultant Neonatologist posts based in the Neonatal Unit of the Simpson Centre for Reproductive Health, Royal Infirmary of Edinburgh. The vacancies are new posts that are being added to the existing team of 6.0 WTE consultants in order to strengthen the regional neonatal services provided in the Royal Infirmary of Edinburgh and St John’s Hospital Livingston. There are around 10,000 births per annum between the 2 hospitals.

Applicants are required to be on the GMC’s Specialist Register or within six months of their expected date of receipt of a Certificate of Completion of Training (CCT) at the time of interview. Applications are welcomed from those unable to work full time for personal reasons or those wishing to job share.

Informal enquiries about this post should be addressed to Ben Stenson, email: ben.stenson@luht.scot.nhs.uk Tel: 0131 242 2574 or Dr Edward Doyle, Associate Divisional Medical Director email: edoyle2@nhs.net Tel: 0131 536 0007.

The NHS Structured Application and job description can be obtained by emailing: medical.personnel@nhslothian.scot.nhs.uk The completed NHS structured application together with the names, email and postal addresses of three referees should be sent to the above email address by the closing date of 13 June 2012 by 12 noon, no applications will be considered after this time. Please quote reference CG 216. We are working towards equal opportunities.

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Consultant Paediatricians

Applications are invited for four substantive consultant paediatricians at St Johns Hospital Livingston and the Royal Hospital for Sick Children, Edinburgh.

The posts are based at the St Johns Hospital, Livingston with out of hours work there. There is time in the proposed job plans for day time sessions in a sub-specialty at the Royal Hospital for Sick Children in Edinburgh or in neonatology at the Simpson’s Centre for Reproductive Health.

Sub-specialties available include:
- Respiratory paediatrics
- Gastroenterology, hepatology and nutrition
- Community child health
- Neurology
- Neurodisability
- High dependency paediatrics
- Emergency medicine
- Diabetes
- Rheumatology

Applicants should be licensed to practice and on the specialist register for paediatrics or within six months of being eligible.

Informal enquiries should be made to Dr David Valentine, Consultant Paediatrician, email: david.valentine@nhslothian.scot.nhs.uk or to Dr Paul Eunson, Clinical Director of Paediatrics email: paul.eunson@luht.scot.nhs.uk Tel: 0131 536 0000 or to Dr Edward Doyle, Associate Divisional Medical Director email: edoyle2@nhs.net Tel: 0131 536 0007.

The NHS Medical Application form and job description can be obtained by emailing: medical.personnel@nhslothian.scot.nhs.uk The completed NHS structured application together with the names, email and postal addresses of three referees should be sent to the above email address by the closing date of 16 June 2012, no applications will be considered after this time. Please quote reference CG 215.

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Chair in Cardiology (REF: 3990)
ROYAL PERTH HOSPITAL
SCHOOL OF MEDICINE AND PHARMACOLOGY

Applications are invited for appointment to the position of Chair in Cardiology in the School of Medicine and Pharmacology at The University of Western Australia, and the Department of Cardiology at Royal Perth Hospital. The position provides a challenging opportunity for a suitably qualified person who has a record in leadership in an area of clinical cardiology and research.

Applicants must hold appropriate higher qualifications and be registered or eligible for registration in Western Australia. The appointee will take a full range of academic responsibilities for undergraduate and postgraduate teaching, supervision, research and clinical responsibilities in an area of cardiovascular medicine.

The appointment will be fixed-term for five years in the first instance with the possibility for further periods and includes limited rights of private practice or election to a private practice allowance. The appointee will be offered an attractive remuneration package that includes professorial and hospital salaries and a clinical loading. Benefits will also include eligibility for sabbatical leave and generous leave provisions, superannuation and relocation assistance (if applicable) for the appointee and dependants.

For information regarding the position contact Winthrop Professor Gerald Watts, Head of Royal Perth Hospital Unit, School of Medicine and Pharmacology, on 0415 698 140 or email gerald.watts@uwa.edu.au. Alternatively contact Dr James Rankin, Head, Department of Cardiology, Royal Perth Hospital on (08) 9224 2067 or email james.rankin@health.wa.gov.au.

Closing date: Friday, 20 July 2012

The Information for Candidates brochure which contains details to lodge your application may be found at https://www.his.admin.uwa.edu.au/Advertising/3990CandidateInformation.pdf or via a link at http://jobs.uwa.edu.au/ or by contacting Ms Toni Pilgrim, Human Resources, email toni.pilgrim@uwa.edu.au.
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