NORTHERN TERRITORY GOVERNMENT

TOP END HEALTH SERVICE

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3 February 2020

Dr James Burrow
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Top End Health Service (TEHS)
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Dear Madam/Sir,

Re: Let us know what you think about proposed changes to our CPD registration standard

I am writing to express my concern as to the potential impact of the changes to CPD registration standards on health care delivery to remote and regional Australia.

I am a consultant physician and neurologist and have practiced in [redacted] and nearby regional centres for the last 30 years. During that time with there has always been difficulty staffing small hospitals with specialists. There are some practitioners, like myself, who have two specialties (General Internal Medicine & Neurology). This has enabled me to provide both general medicine and neurology care to Royal Darwin Hospital, Katherine Hospital and Gove Hospital. I now spend 40% of my time away from home providing both neurology and general medicine services to [redacted] and [redacted]. Over the years there has been increasing difficulty staffing the General Internal Medicine at Royal Darwin Hospital and there is no General Physician at Gove hospital and the only true General Physician at Katherine Hospital left recently. General Internal Medicine in each of these hospitals has been carried out to some degree by Specialists from other disciplines (eg cardiology, rheumatology, renal medicine and so forth).

My concerns, with the proposed CPD registration standard are several:

1. Maintaining registration in two specialties to comply with “CPD that is relevant to their scope of practice” will need double the time - which is already very scarce.
2. It will be difficult to do “at least 25 per cent on activities that review performance” and “at least 25 per cent on activities that measure outcomes” when working in remote areas: These are incredibly busy times generally covering for incumbent staff who are taking leave. Living in a hotel, working 7 days a week, being constantly on-call and travelling long distances does not allow enough time to rest let alone ‘review performance’ and ‘measure outcomes’.
3. Many specialists (eg cardiologists, rheumatologists, infectious diseases physicians) working in remote Australia, and who do not have dual training in general internal medicine, will be concerned (medico-legally) that they are providing services beyond their scope of practice and will opt to limit their practice especially if there is the added constraint of extra CPD in areas outside their specialty. This will be disaster for staffing small and remote hospitals.

May I give an example? If I as a neurologist, whilst working in Katherine hospital, am confronted with a patient with severe pneumonia and cardiac failure (as I was on a Sunday evening last year) and things go wrong and the patient dies I would be very concerned that the Medical Board might decide I was working outside my scope of practice, especially if I had not maintained CPD in infectious diseases or cardiology. However, I had to treat the patient. There is no other physician in Katherine, there is no Infectious Diseases physician, there is no microbiologist, there is no cardiologist. (PS the patient did not die).

I ask you to think very carefully about adding additional burdens to medical practitioners working in remote Australia. These people by necessity have a broader scope of practice and mandating impossible to achieve CPD requirements across this broad scope will only lead to more doctors leaving the bush thereby abandoning very needy Australians.

Yours sincerely,

[redacted]

James Burrow MBBS FRACP
Neurologist & General Physician
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