

**Australian Medical Association Joint Submission on the
Proposed Registration Arrangements for the
National Registration and Accreditation Scheme for the Health Professions
(the scheme)**

Executive summary

This joint submission is made by the Australian Medical Association (the AMA), the Australian Society of Otolaryngology Head & Neck Surgery, the Australian Society of Anaesthetists, the Urological Society of Australia and New Zealand, the Australian Society of Ophthalmologists, the National Association of Practising Psychiatrists, the Australian Association of Surgeons, the National Association of Specialist Obstetricians and Gynaecologists, the Council of Procedural Specialists, the Australian Society of Orthopaedic Surgeons, the Royal Australian College of General Practitioners, the Rural Doctors Association of Australia and the Australian Orthopaedic Association (the co-signatories).

The AMA and the co-signatories continue to support national registration arrangements and consistent standards for the medical profession across Australia. We support the scheme's objectives of ensuring that only suitably trained and qualified medical practitioners are able to practise. We welcome reduced red tape for medical practitioners who seek to work in more than one jurisdiction. We remain opposed to the overarching architecture of the Intergovernmental Agreement (the IGA) and the scheme.

We are very concerned that, in the context of a workforce reform agenda, the architecture of the scheme will permit the lowering of professional standards with consequences for patient safety and quality of care.

The consultation paper on the proposed registration arrangements only heightens our concerns that the current proposed scheme will be a vehicle for government to use other health providers to inappropriately undertake medical competencies in response to workforce challenges.

In our submission on the first bill we clearly outlined our concerns about the disenfranchisement of the medical colleges and their role in medical professional standards. We also highlighted strong concerns about the ability of individual health profession boards to expand the scopes of practice of their registrants without reference to or input from other professions. As this latest consultation paper is silent on these issues, we assume our concerns are yet to be addressed. For the sake of patient safety and quality healthcare outcomes, we will set them out again in the context of the proposed registration arrangements.

The AMA and the co-signatories have five major areas of concern with the registration arrangements proposed in the paper:

1. There is no recognition or guarantee of the continued role of medical colleges in determining specialist qualifications for, and conferring them on, medical practitioners (section 10);

2. The scope of practice for the other health professions will be able to be expanded without any obligation for one health profession board to consult with other boards, particularly the medical profession board (section 10);
3. The scheme seeks to introduce new onerous continuing competence/CPD requirements, which will effectively create a new scheme for the medical profession, and does not guarantee the ongoing role of the colleges in continuing competence and professional development for the medical profession (section 9);
4. Registration will provide a direct legislative link to Medicare and pharmaceutical benefits for patients of all registered health professions (section 10); and
5. The medical board will be able to register a person who does not meet the requirements for registration in certain circumstances (section 7).

The proposals confirm our belief that there is a real risk that the new scheme will erode the medical board's ability to protect patient safety. Health Ministers are afforded a role in the registration arrangements beyond the scope of the IGA. The underlying architecture of the scheme and the proposed registration arrangements provide a framework for the lowering of medical standards and the expansion of roles for other health professions. The proposed scheme will allow this to occur without parliamentary, public or professional scrutiny.

This submission is provided to inform government about aspects of the existing framework for medical qualifications, recognition, registration and continuing professional development. The proposed scheme must serve to enhance this framework, not dismantle it.

We remain deeply concerned with the proposed arrangements. Our submission does not imply our concurrence with the final outcome. Our final view on whether the IGA delivers an acceptable model will depend on whether the issues we have identified in our submissions to government on the scheme are addressed satisfactorily. It will also depend on how closely the final scheme reflects the existing arrangements and truly protects the public interest.

MAJOR CONCERNS

Section 10 Endorsement of registration

The AMA and co-signatories have significant concerns with this section of the consultation paper and the proposals contained therein which reveal the workforce reform agenda behind the IGA.

Further, the AMA believes these proposals are beyond the scope of the IGA and accordingly should not be included in the legislation to implement the scheme.

Specialist qualifications

The paper “expects” that recognition of specialties and specialists will be required under the scheme for the medical profession to:

- Confer the right to use a specific professional title; and
- Recognise other laws as an entitlement to provide certain services, using the examples of prescribing rights and Medicare and PBS funded services.

Our major concern with the proposals in section 10 is that the role of the medical colleges in conferring specialist qualifications on medical practitioners, which is currently part of jurisdictional arrangements, is (again) not recognised or incorporated into the implementation of the proposed scheme.

Proposal 10.1.1 completely negates the existing role of medical colleges in determining specialist qualifications. Given that jurisdictional arrangements will cease when the new scheme commences, the national legislation for the scheme must require the national medical board to recognise the role of the medical colleges in conferring specialist qualifications on medical practitioners.

With regard to proposal 10.1.3, the medical profession has already nominated the title of “medical practitioner” to be protected by the scheme (Table 2 of the IGA). There is little reason at this time to introduce specialist recognition for the medical profession under the scheme, particularly if it is not also being introduced for the other health professions.

In summary, we would not support any specialist recognition for the medical practitioner register under the scheme unless the legislation requires the medical profession board to adopt the specialist qualifications conferred by the medical colleges.

Secondary purpose of the register

The paper proposes that the public registers maintained by the national boards will be the source of authoritative information for Medicare (sic) and others to identify which practitioners have certified qualifications for reimbursement purposes. This is a clear secondary purpose for the register that is beyond the scope and objectives of the IGA. It has not been agreed to by COAG or Health Ministers and was not part of the consultation with the professions prior to the signing of the IGA.

Paragraph 3D(2)(c) of the *Health Insurance Act 1973* already requires medical practitioners to have obtained, as a result of successfully completing an appropriate course of study, a relevant qualification in relation to a medical college for Medicare benefits purposes. The Health Insurance Act also makes provision, and there are administrative arrangements in place in Medicare Australia, for the recognition of medical practitioners who have not obtained a relevant qualification from a medical college.

There is no reason to dismantle these arrangements, and introduce a new arrangement for Medicare benefits purposes linked to a national registration process, which is being established for a totally different purpose. We strongly oppose these proposals.

Ministerial Council powers

The IGA empowers the Ministerial Council to approve registration, practice, competency and accreditation standards (Clause 1.25(b) of Attachment A). Proposal 10.1.1 bestows powers on the Ministerial Council that go beyond the IGA, in particular to approve qualification requirements for specialist endorsement.

As stated in our submission on the first bill, we don't accept that it is appropriate for the Ministerial Council to approve the standards for accreditation of medical education and training courses. Further, we also don't accept it is appropriate for Ministers to have any role in approving the qualifications for specialist endorsement as proposed by 10.1.1 b iii and iv.

We submit that a medical profession board with sufficient medical representation and expertise (as proposed in our submission on the first bill) will be well qualified to liaise with and take advice from the medical colleges on specialist categories and recognition. The Ministerial Council will not be qualified to make these decisions.

Scope of practice and qualifications for other health professions

The AMA and the co-signatories remain extremely concerned that the architecture of the scheme is being constructed in such a way that will allow patient safety and quality to be seriously compromised without the scrutiny of parliaments, the public or the profession. We have already made these arguments in our submission on the first bill. In this consultation paper, the broader agenda for widening the scopes of practice for non-medical professions is further revealed.

Firstly, there is no requirement in any of the proposals in section 10 of the paper for one professional board to consult with other boards and engage other affected professions prior to any decision to expand a particular profession's scope of practice and/or qualifications. Each professional board will be able to make recommendations in respect of their own qualifications in a silo. They have absolute discretion about who and how and whether they consult at all.

There is also no requirement for the Ministerial Council to consult with other professions when approving qualifications for the health professions. Nor is there sufficient accountability for Ministerial decisions and policy directions, particularly when those decisions are inconsistent with advice provided by the professional board. Further, the current scrutiny that state and territory parliaments can apply to expansion of scopes of practice, including prescribing rights, will be removed.

Secondly, the paper proposes that the registers for other health profession boards will be used to recognise providers for the purposes of MBS and PBS funded services and other services that they would otherwise be prevented by law from delivering (proposal 10.3.1). This will clearly provide a mechanism for formal recognition of role substitution arrangements across the health workforce. This is absolutely unacceptable to the AMA and the co-signatories. Registration is a necessary, but not of itself sufficient, requirement for MBS and PBS purposes. The *Health Insurance Act 1973* and the *National Health Act 1953* should remain the legislative authority for determining access to Medicare and pharmaceutical benefits.

There are already Federal Government administrative processes for recognition of some allied health professions for Medicare purposes and, as for the medical profession, there is no reason to introduce new arrangements.

Prescribing endorsement

We firmly believe the medical prescriber model is in the best interests of patient safety and quality care. Only medical practitioners are trained to take account of the entire patient's conditions and the treatments the patient is receiving. Only medical practitioners are trained to understand the potential interactions, and reactions, of combinations of treatments for various conditions.

We do not support the wholesale endorsement of prescribing privileges to other health professionals by their boards or any automatic recognition for the purpose of Pharmaceutical Benefits Scheme (PBS) prescribing. It is essential to patient safety and the quality of patient care that any endorsement of prescribing rights for non-medical health professions only occurs where adequate medical supervision is part of a co-management protocol.

It is unacceptable that proposal 10.2.1 provides boards with unilateral power for prescribing endorsement and does not include any requirement to consult with or take advice from the medical profession before endorsement decisions are made.

These decisions should in fact be taken by the Federal Health Minister (given the potential PBS expenditure implications) on the advice of an expert medical committee that would evaluate the clinical evidence and the appropriateness of co-management and prescribing protocols.

Section 9 Renewal of registration and continuing competence

The AMA and the co-signatories believe government has underestimated the magnitude of its proposals in this section. We cannot support the government using the introduction of the scheme to concurrently and unilaterally introduce wholesale and complex new continuing competence requirements (proposal 9.2.1).

We would expect that a government policy proposal of this magnitude is supported by a comprehensive discussion paper, is backed by scientific evidence and is the subject of extensive consultation with the medical profession and the public. This would need to occur before any decision is made by government to introduce new requirements to demonstrate continuing competence to practice. As part of this, the cost to government and the medical profession of introducing any such requirements would need to be weighed against the tangible benefits to patient safety and quality outcomes, before any final decision is made.

Such an approach would be consistent with the government's approach to the introduction of any new regulatory requirement.

With respect to continuing profession development (CPD) requirements, it is unclear how this may or may not relate to requirements to also demonstrate continuing

competence to practice. It is also unclear how it may or may not relate to existing CPD arrangements for the medical profession.

As Attachment 6 of the paper highlights, there are various CPD requirements across the jurisdictions for medical practitioners currently managed by the medical colleges for the craft groups. The introduction of new national CPD requirements to apply across the whole of the profession will have the effect of introducing a new set of requirements for all medical practitioners to gain renewal of their registration after the commencement of the scheme.

We do not support creating a new CPD process that either supersedes or operates alongside existing medical colleges CPD processes. Nor do we support the introduction of additional requirements beyond the college processes that are linked to the introduction of the scheme.

The role of medical colleges in continuing professional development

As has already been highlighted in this submission, there is no mention of the current role of the medical colleges in respect of CPD programs. Nor is it clear whether or not the new medical profession board will have the ability to recognise any of the existing medical colleges processes and programs in new continuing competence and/or CPD requirements.

The medical profession and the medical colleges have a long history of demonstrating the importance of continuing competence through programs for their members (fellows). The medical colleges regularly collaborate on improvements to CPD programs, particularly on the cross-profession elements such as professional qualities, behavioural and ethical expectations. Individual colleges determine the particular continuing competency requirements for their respective specialities.

The medical college CPD programs should not be replaced by a new scheme. Any enhancement to existing programs for the medical profession cannot be developed outside of, or in parallel to, the medical colleges. The legislation must require the medical board to delegate responsibility for continuing competence or CPD requirements to the medical colleges. This would guarantee the role of the medical colleges, rather than giving the board the discretion to approve an external body as per proposal 2.2.2 paragraph b. The day-to-day administration and monitoring of CPD programs for the medical profession must remain with the medical colleges. Any administrative arrangements required by boards to record continuing competence and/or CPD participation must not create onerous requirements on registrants to duplicate information for the medical colleges and the board.

The legislation must formalise and maintain the existing role of the medical colleges. There is no reason not to. There are no other entities that are able to perform this role and there is no reason to overturn or usurp existing processes. The AMA and the co-signatories cannot support the scheme if the legislation does not recognise the role of the medical colleges.

Reform of continuing competence and/or CPD requirements

Any reform of medical practitioner continuing competency and/or CPD requirements would involve substantial resources, not only for the national agency and the medical

board, but also for the medical colleges. Further, transitional arrangements would be needed. We expect the medical profession to be involved in extensive consultation with the medical board and colleges in any reform of continuing competence and/or CPD.

While generic CPD requirements could apply across the profession, different clinical requirements will need to apply to different specialties. Individual doctors will need absolute certainty about what the transitional arrangements are, when the new requirements are in place, the requirements that apply to them and from what date they will be required to meet them in order to renew their registration.

Cost of new continuing competence and/or CPD requirements

The full cost of introducing new continuing competence and/or CPD requirements for the medical profession must be identified. Costs will be incurred by:

- individual practitioners – for participation and compliance as set out in proposal 9.3.1;
- the medical colleges – for development, program administration, compliance monitoring and audit; and
- the new medical board - for development, monitoring and audit.

We maintain that the Government will need to meet the additional cost of revising or changing existing CPD arrangements or introducing any new requirements to demonstrate competency to practice.

Proposal 9.2.2 introduces new roles for the medical board in respect of continuing competency and/or CPD requirements. This represents a significant workload for the medical board that will also require adequate resources. In the joint submission on the first bill, the AMA and the co-signatories have already outlined our concerns about how resources will be allocated to the medical board so that it is appropriately resourced to carry out its functions. This latest paper highlights yet another funding and resource pressure on the medical board.

Commencement of new continuing competency and/or CPD requirements

Given the statements made above, the timeframe of 1 July 2010 in proposal 9.2.1 for the health profession boards to establish requirements for their respective health professions to demonstrate continuing competence at the time of the annual renewal of registration is entirely unrealistic unless the medical board adopts in full the existing medical college CPD requirements for the medical profession.

It would not be logistically possible to properly develop any new requirements or enhancements to existing CPD programs in the timeframe proposed. Nor would it be possible for any requirements to be implemented in such a way that ensures individual medical practitioners will be able to renew their registration when it falls due after 1 July 2010.

Guidelines on standards of professional practice

Proposal 9.4.2 will give general powers to the boards to issue guidelines for professional practice standards. It must be clear in the legislation that such standards are for guidance only and do not presume to cover all circumstances.

The Australian Medical Council (AMC) is currently preparing a Code of Conduct for the medical profession for incorporation into the scheme.

It is important that the medical profession owns and endorses these standards. A Code of Conduct that is imposed on the medical profession will not be owned and therefore embraced by doctors. The current draft Code of Conduct is a long way from being embraced by the medical profession.

Section 7 Types of registration granted

Specific registration: permitting certain practitioners to practise who do not hold approved qualifications

In respect of proposal 7.1 (proposed categories listed under *specific* registration in Table 2 of the paper), the AMA and the co-signatories suggest the Government take advice from the medical boards in respect of the categories needed for people who are training to be, or are trained but not practising as, a medical practitioner.

However, we have specific concerns about two of the categories listed:

- b. Area of need; and
- h. Temporary registration in the public interest.

Section 7.2 of the consultation paper states that specific registration will permit practitioners who do not hold approved qualifications to work. We maintain that the board should not register unqualified people for an *area of need* or for *temporary registration in the public interest* if they do not meet the requirements and standards met by other registrants.

It is entirely inappropriate to address short-term workforce supply problems by registering people who do not meet the registration requirements. To do so, will lead to the systematic lowering of standards, which in respect of the medical profession will have serious consequences for patient safety and quality care. A person who does not meet the registration requirements for a health profession should not be registered. This is the primary purpose of the scheme – to ensure the regulated health professions are suitably trained and qualified to provide safe and quality care.

The AMA has consistently maintained that the solution to the medical workforce supply problems is to train more doctors. The solution is not in allowing unqualified people to do the work of doctors.

Specific registration: students

In respect of medical students, the AMA and the co-signatories support the view of the Australian Medical Students Association that there should be mandatory registration of medical students who are enrolled in an approved course of study or undertaking approved supervised clinical training that involves contact with patients/clients, in order to obtain approved qualifications.

Specific registration: occasionally practising medical practitioners

Consideration should be given to an appropriate registration category for medical practitioners who practice occasionally. This category could allow these doctors to prescribe and write repeat referrals and to provide assistance in emergency situations but restrict their ability to practice medicine in any other form. By specifying a discrete category of registration, it could then flow on to reduced administrative and legal requirements for these doctors who are not predominantly providing medical care other than in extenuating circumstances.

OTHER CONCERNS

The AMA and the co-signatories have a number of other concerns with some of the more specific proposals in the consultation paper regarding the proposed registration processes.

Section 8 Authorities conferred by registration

The use of the title ‘doctor’

Proposal 8.1.1 proposes not to legislate to protect the use of the title ‘doctor’ or ‘professor’ or to reserve their use by particular health professions. A national health profession registration and accreditation scheme has a responsibility to the public to ensure non-medical health professionals, or other people, do not hold themselves out as medical practitioners.

There will be instances where non-medical health professionals possess a doctorate. The relevant health profession board could decide to recognise certain doctorates as a “qualification” as set out in proposal 10.1.1.

It is important that the public is not deliberately misled by non-medical health professionals who hold a doctorate using the title ‘doctor’. In addition to the restrictions outlined in the consultation paper, the legislation must also require the use of the title ‘doctor’ by these health professionals to be accompanied by information that they are not medical practitioners.

Restrictions on practice

If the scope of practice for each of the health professions is clearly articulated by the boards through a process of listing and approval by the Ministerial Council, we assume the effect of the legislation will be to prohibit any health professional not registered by the relevant board from providing the services that are the purview of another health profession board unless it is also included in their specific scope of practice.

The proposals to outline specific restrictions in respect of dentistry, optometry and spinal manipulation (proposals 8.3.1, 8.4.1, 8.4.2 and 8.5.1) in the legislation are therefore unnecessary and anti-competitive. Restrictions would also have the effect of precluding medical practitioners from providing some medical services that they currently provide. Oral and maxillofacial surgeons perform operations and fit appliances as described in proposal 8.3.1. Ophthalmologists prescribe optical

appliances and prostheses. Spinal manipulation is performed by medical practitioners.

The dentistry and optometry practice definitions should be treated in the same way as other professions i.e. by defining what is in scope for each of the health professions by virtue of the registration, practice and competency requirements.

If the government proceeds with the restrictions on dentistry and optometry practice and spinal manipulation, the legislation should exempt medical practitioners from the restrictions, consistent with jurisdictional legislation, to avoid any unintended consequences and reflect current medical practice.

Section 6. Registration decisions

Health assessments

Proposal 6.1.1 proposes that the board, at its discretion, be permitted to require the applicant to undergo a health assessment to assess the applicant's capacity to practise. The board should only be able to require an applicant to undergo a health assessment where there is an identifiable cause or reason.

Composition of board committees

Proposal 6.2.1 could have the effect of a committee of the national board, which would be established to make local decisions on registration, being chaired by someone who is not a medical practitioner. All state and territory medical boards are currently chaired by and have a majority of medical practitioners on them. Under the new arrangements it is essential for the medical board and its committees to also be chaired by and have a two-thirds majority of medical practitioners on them. Many of the day-to-day decisions will require the expertise of medical practitioners to assess and provide technical advice on an applicant's medical qualifications and experience. Indeed, in respect of these committees, which will be dealing with individual registration decisions, we would question the value of anyone other than a medical practitioner undertaking these roles.

Medical representation

It is important that the national medical board and its committees have the support of the medical profession. This will occur if the medical profession is confident that the board and its committees have the appropriate expertise and medical representation to carry out their functions. This can be achieved if medical practitioners are able to be involved in the nomination process for the medical representatives for the medical board and its committees.

Committee proceedings

Under the current proposal to allow local board committees to regulate their own proceedings (paragraph b of proposal 6.2.1), there is a risk of inconsistency across the country in the assessment and processing of applications for registration. Some committees may be less rigorous than others. There needs to be a national process to ensure this doesn't occur.

Delegation powers

We recognise the need for the board to delegate some of its registration powers and functions to its committees. We also recognise the need to delegate administrative actions to administrative staff, for workload purposes.

However, the effect of proposal 6.2.2 as it is written would be that administrative staff could be delegated to make decisions to register individuals. This is inappropriate. Decisions to register medical practitioners must be made by people who are well qualified to assess the applicant's medical qualifications and experience.

Professional indemnity insurance

The AMA and the co-signatories agree with proposal 6.3.1. All patients of health professionals should have the protection of being assured that the registered health professional treating them holds professional indemnity insurance for the healthcare that they provide.

Proposals 6.3.1 and 6.4.1 (item i) require consultation with the professional indemnity insurers to reach a practical solution. Some insurers require proof of registration before agreeing to indemnify a professional, yet these proposals require proof of indemnity coverage at the time of registration.

The insurers will also need to be consulted on the power for the board to issue guidelines on acceptable indemnity arrangements as per proposal 6.3.2.

Further, no arrangements should be introduced in respect of non-medical health professions that result in medical practitioners being required, either explicitly or implicitly, to cross subsidise their indemnity premiums.

Criminal history and criminal history checks

Proposal 6.4.1 (paragraph d) proposes that a board may decide to not register an individual because he or she has been convicted of an offence. There is no clarification of what type of offence would warrant non-registration. Further, we note that any requirement to provide criminal history information will only ever reflect a registrant's background at a particular point in time.

The AMA and the co-signatories do not believe all medical practitioners should be required to provide criminal history checks to support their registration and renewal applications. Such a measure would have significant resource implications for registrants, the police and the boards.

The current arrangements that exist in many medical boards, whereby registrants self-declare their criminal history and boards then have the discretion to ask for further information, including police checks, is suitable.

Further, it is expected that employers would undertake checks of this kind when considering employing a health professional, as is currently the case. Therefore, the AMA and the co-signatories support option 4 in proposal 4.3.1 for applicants to self-declare their criminal history.

Sections 4 and 9: Information and reporting obligations for applications and renewals

Sections 4 and 9 of the paper variously propose that certain information be required to be provided by registrants with applications and registration renewals. The AMA and the co-signatories are generally concerned that some of these requirements are unrealistic, and unreasonable.

In respect of proposal 4.2.1, most of the information requirements are couched in general terms. In their current form, and without further clarification, they would be difficult for registrants to comply with.

Under proposal 4.1.1 it is contemplated that applications for new registrations could be made electronically. However, it is likely that boards will require applicants to furnish original and/or certified copies of documents that won't be able to be lodged electronically.

Information about complaints

In respect of proposal 4.2.1 the AMA understands that not all complaints previously made about a health professional would be useful to a board for registration purposes.

Proposal 4.2.1 implies that every complaint ever made about an individual must be notified. This would include complaints in progress, unresolved, not upheld, and made to health care complaints commissioners and in the workplace. This is unrealistic and unreasonable.

Complaints handling mechanisms specifically assist consumers to mediate and resolve issues they have with health care providers. These processes are informal. The fact that a complaint has been made against a medical practitioner does not necessarily have a bearing on their competence to practise.

Workforce data

Proposals 4.2.1 and 9.3.1 would require registrants to supply data, as part of the application and renewal processes, for workforce analysis. The AMA and the co-signatories recognise there is a paucity of workforce data. This has made it difficult, particularly in respect of the rural workforce, undertake proper workforce planning. Any data collection should not be onerous or impose red tape on registrants. The medical profession should be consulted to ensure the best possible data is collected for workforce analysis and planning purposes.

It would be inappropriate for the board to not register an individual simply on the basis that he or she had not provided information beyond that which is material to the board's decision to register an individual or renew an individual's registration.

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