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Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022

AMA submission to the Queensland Health and Environment Committee consideration of the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022

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The AMA welcomes the opportunity to make a submission to the Queensland Parliament on amendments to the National Law.

The operation of the National Registration and Accreditation Scheme (the scheme) for Health Professionals is of paramount importance to all medical professionals. The AMA supports a system which is transparent and accountable. It is vitally important that the profession retains the confidence of the public, and we understand that a transparent, easy-to-access complaints and disciplinary system is essential to achieve this goal.

The AMA agrees that the protection of the public is a critical role of the scheme. We believe that this is already achieved under the current arrangements and that many of the amendments in this Bill will unnecessarily negatively impact on medical professionals. We believe that the scheme needs always to uphold the principles of natural justice for all stakeholders as much as it needs to do anything else. It is essential that the wellbeing and state of mind of the practitioner be at the forefront of any investigations so as to reduce the negative impact on the mental health of the medical professionals we rely on so much to do the work that needs to be done.

It is vital that the system shows a commitment to impartiality, due process and must be evidence based. It is also vital that the wellbeing and state of mind of the practitioner be at the forefront of Australian Health Practitioner Regulation Agency (Ahpra)'s and the Medical Board of Australia (the Medical Board)'s considerations – particularly in investigations that can be long running and have negative health outcomes for the practitioners themselves.

Medical professionals often state that they perceive a lack of balance in the system. The process can be extremely stressful and onerous, involves a large time commitment from time-poor medical professionals, and it can have significant reputational and professional consequences, regardless of whether the practitioner in question is at fault.

The AMA has consistently advocated, in the previous reviews for a scheme that supports:

- registration arrangements that enable medical professionals, who are qualified and safe, to work anywhere in Australia;
- independent accreditation of medical education and training that meets international guidelines;
- medical practice registration standards set by the Medical Board, with clear jurisdiction over all health care provided by medical practitioners; and
- a notification process for the Medical Board to receive, consider and determine concerns about the health, performance or conduct of individual medical practitioners where there is a risk of harm to the public, and which is efficient and affords due process to the medical professional under review.

The AMA is satisfied that the scheme has met the expectations of the medical profession in respect of the first three points. We continue to work collaboratively with the Medical Board and Ahpra to improve the notification and compliance functions of the scheme.

The AMA supports the regular reviewing of all regulatory schemes and legislation, however we continue to be disappointed at the lack of rigour and evidence applied to the assessment of the effectiveness and efficiency of the scheme. In particular the lack of evidence or appropriate business cases to support major changes to the National Law that are liable to have significant impacts on the lives and livelihoods of medical professionals without necessarily improving standards of care for patients.

The AMA believes that there needs to be an appropriate balance maintained between increasing regulatory scrutiny and power to protect against situations that occur extremely rarely. We do not believe that all the proposed changes deliver this balance. In this context the AMA provides our best opinion on the proposed amendments raised in this consultation paper.

AMA Opposed Amendments

Part 2 - Paramount Principle (Clauses 33 - 35)

The AMA agrees that the protection of the public is a critical role of the scheme and believes that current arrangements already deliver on this goal. The amendment is unnecessary and will not help the operation of the scheme as:

- it is not clear what the new main principle means in practice; and
- the introduction of a "main guiding principle" further complicates the interpretation of an already complex scheme.

The concept of public confidence is not always clear cut and often depends on perspectives. The plethora of online information available on health and wellbeing, including misinformation, is an important consideration in any contemporary discussion of health literacy let alone public perception.[1]

We are seeing more people rely on information sources that do not always provide evidence-based information. Many people have difficulty determining which sources of information are reliable, or they easily absorb misinformation delivered directly to them through advertising and/or social media. The internet has the potential to significantly magnify health misinformation campaigns, such as those associated with the anti-vaccine movement or the use of hydroxychloroquine as a treatment of COVID-19. Such examples show us that public perception of what constitutes a safe health service cannot always be relied upon.

The guiding principles (including the main guiding principle) are only referred to in section 4, which says that:

> *An entity that has functions under this Law is to exercise its functions having regard to the objectives and guiding principles of the national registration and accreditation scheme set out in sections 3 and 3A.*

This potentially adds a "gloss" to every provision that:

- gives Aphra or a National Board a discretion; or
- requires Aphra or a National Board to balance competing principles.

For example, as noted below, new section 220A(4) provides that the obligation to notify employers and other third parties does not apply if it is not in the public interest to give the notice. While the example refers to the practitioner's right to privacy, in interpreting this provision the National Board would need to give paramountcy to:

(a) protection of the public;
(b) public confidence in the safety of services provided by registered health practitioners and students.

[1] https://www.ama.com.au/articles/health-literacy-2021

This would appear to trump the other guiding principles, including the requirements that:

(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;
(b) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

In other words, if there is a conflict between protecting the public (or being seen to protect the public) and imposing restrictions on practitioners, protecting the public will win – even if the risk is trivial or the public perception is unfounded.

The new main principles appear to suggest that:

- Health services can be provided in a way that is risk free; and
- The procedure that is lower risk is always preferable.

The AMA does not support this view. For example, a doctor must be able to respect the patient's choice to:

- try and have a natural delivery even though the medical professional accepts that a caesarean is a lower risk option; or
- participate in a clinical trial for a new treatment which is untested.

Part 14 – Previous scheduled medicine offences (Clause 81)

These amendments require health practitioners and students to report offences related to regulated medicines and poisons to the relevant National Board. The AMA does not support this amendment. The AMA notes that:

- Section 5 defines "scheduled medicine" as a substance listed on the Poisons Standard. This includes drugs like aspirin (Schedule 2). Previous discussion papers have focused on Schedule 8, which includes drugs of dependence.
- Practitioners are currently required to self-report if they are charged with an offence punishable by at least 12 months' imprisonment (even if they are not actually prosecuted or are found not guilty) or convicted of an offence punishable by imprisonment (even if they receive a fine or community service).
- The proposal would require practitioners to self-report if they are charged with any scheduled medicine offence (even if they are not actually prosecuted or are found not guilty). Unlike the existing definition of "relevant event" there is no difference in the standard for reporting a charge versus reporting a conviction.

An offence is a "scheduled medicine offence" where:

(i) [a State or Territory law] regulates the authority of registered health practitioners or students to administer, obtain, possess, prescribe, sell, supply or use scheduled medicines; and
(ii) the offence relates to registered health practitioners or students administering, obtaining, possessing, prescribing, selling, supplying or using scheduled medicines.

The AMA is concerned that this may capture minor offences, noting that more serious "scheduled medicine offences" (such as trafficking) would normally attract imprisonment (so are already captured). The AMA recommends that:

- The obligation to notify offences that do not attract imprisonment only apply where a practitioner is convicted (rather than merely charged).
- The definition be limited to offences with a minimum specified fine (given the concern is that the offences may be subject to a fine rather than imprisonment).
- It be clarified that the offence relates to a health practitioner or student doing something in the course of providing a health service. By contrast, it would not cover a practitioner engaging in behaviour in their capacity as a private citizen (such as possession of excessive marijuana plants), unless that behaviour was also punishable by imprisonment.

We note that the Bill has been amended to:

- limit the term "scheduled medicine offence" to offences against a law of a participating jurisdiction (ie, all jurisdictions except WA); and
- allow each jurisdiction to declare in their own implementation of the National Law that particular offences in their jurisdiction (that would otherwise be captured) are not a scheduled medicine offence for the purposes of the National Law.

The AMA does not support this approach as it means that:

- Unless a jurisdiction expressly specifies otherwise, "scheduled medicine offence" means any offence related to "administering, obtaining, possessing, prescribing, selling, supplying or using scheduled medicine" even if it is relatively minor (eg, a $500 fine).
- Students and practitioners will need to report any instance where they have been charged with a "scheduled medicine offence" even if they were found not guilty or the DPP decided not to pursue prosecution.
- There is the potential for wide variation across jurisdictions as to what must be reported.
- Given the complexity of scheduled medicine legislation in each jurisdiction, it is likely that minor offences will be inadvertently captured.

Part 15 - Previous Practice Information (Clauses 82 – 84)

The Explanatory Notes outline the intention of these amendments:

> *The Bill extends these information sharing powers by allowing National Boards to request information about former practice arrangements, including entities that previously had an employment or other practice arrangement with the practitioner, and other registered health practitioners with whom they previously shared premises and the costs of premises. A National Board will be able to notify these persons if action is being taken against a registered practitioner. The power to notify affected persons is discretionary and available only if the Board reasonably believes the practitioner's conduct posed a risk of harm at the time of the prior employment, practice arrangement, or sharing of premises. This amendment will capture those circumstances in which practitioners have caused harm to patients through successive workplaces. It will improve information sharing between employers and regulators and allow for identification of previously unknown risks to the public.*

To achieve this Sections 220A and 206(3) expand the circumstances where the Board is required, or authorised, to issue notifications to "entities" with which the practitioner has, or has had, a "practice arrangement". While the primary focus is on employers, the definition is still much broader than this. New section 5 now defines a "practice arrangement" as:

> *(a) includes—*
> *(I) a contract of employment, contract for services or another arrangement or agreement between the practitioner or person and the entity in relation to the provision of services; or*
>
> *(ii) an agreement for the practitioner or person to provide services for or on behalf of the entity, whether in an honorary capacity, as a volunteer or otherwise, and whether or not the practitioner or person receives payment for the services; but*
>
> *(b) does not include a contract or agreement not directly related to the provision of a health service.*

The term "entity" includes a person. Arguably this includes current and former patients (given that a doctor is contracted to provide services to patients). This could be rectified by adding "(other than individuals)" or "(other than patients)" after the references to "entity" in these provisions.

It is also unclear whether a medical specialist who is self-employed but has a right of practice in a private hospital is intended to fall within paragraph (a) or (b) of the definition of "practice information" in section 132(4). Paragraph (a) relates to practitioners who are or were self-employed. Section 132(4)(b) now relevantly reads:

> *if the practitioner has, or had, a practice arrangement with one or more entities*
>
> *Example of practice arrangement—*
> *A physiotherapist practises, or practised, physiotherapy as a volunteer at a sporting club or charity under an arrangement with that entity.*

As noted above, paragraph (a)(I) of the new definition of "practice arrangement" includes any "other arrangement or agreement" with another entity. This could include a private practice arrangement with a hospital.

This distinction is important because if an arrangement falls within section 132(4)(b) it falls within sections 206(3) and 220A(3) and notification is mandatory. By contrast, notification of practice arrangements that fall within section 132(4)(a) is discretionary (sections 206(2) and 220A(2)). Most specialists will have arrangements with multiple private hospitals.

One option to avoid requiring notification would be to remove "or another arrangement or agreement" from the definition of "practice information". Alternatively, sections 206(2) and 220A(3) could be amended so that it does not require notification for practitioners who fall within 206(2) and 220A(2).

Part 16 - Advertising Offences (Clause 85)

The AMA does not support this amendment. The existing provisions prohibit testimonials. Testimonials are easily faked or taken out of context. They are also likely to be relied upon by patients, even if their condition is not comparable.

Currently Aphra and the National Boards can easily:

- check whether any allegation that a practitioner is using testimonials (usually on their website) is accurate; and
- take action (eg, by sending a letter to the practitioner advising that the conduct is illegal, and that further action will be taken if it is not rectified within 30 days).

If testimonials are legalised, then regulators will only be able to act if they are able to demonstrate that the testimonials are actually false or misleading. Aphra and the National Boards are unlikely to be able to do this given their resources.

The AMA agrees with Ahpra that "Advertising can influence a consumer's decision-making about their health care needs. It is important that consumers have access to information that is accurate, not misleading, and is supported by acceptable evidence".[2]

The removal of the ban on testimonials coupled with the lack of resources available to Ahpra and the National Boards is likely to see a significant increase in use of testimonials across the internet – many of which will be inaccurate or fake. The AMA believes that this will undermine a consumer's ability to make an accurate and evidence-based decision regarding their medical treatment. We contend that this is likely to lead to worse health outcomes for a proportion of these patients.

Part 23 – Public statements (Clauses 100 – 102)

The AMA does not support this amendment. No evidence has been provided demonstrating that a significant problem exists warranting this level of regulation.

The AMA does not support the Medical Board or Ahpra being able to issue a public warning before a tribunal has completed its actions. To do so would imply guilt and is likely to ruin a practitioner's reputation. A public warning is a severe and non-retractable step and should be undertaken only after a health practitioner has been shown to have breached a code of conduct or convicted of a relevant offence. Under the current circumstances the Medical Board is able to issue a media statement at the conclusion of the tribunal process, which the AMA believes is entirely appropriate especially in the absence of evidence that this system is not working.

The AMA supports the inclusion of a show cause process for a public statement and the ability to appeal a decision to issue a public statement. The provisions for revision (section 159S) or revocation (section 159T) of a public statement do not adequately address the issue that once a

[2] https://www.ahpra.gov.au/publications/advertising-hub.aspx

statement is made the practitioner's reputation is damaged permanently. The reality is that media organisations that publish the initial statement have no obligation to publish the correction or revocation. The AMA believes that this will lead to significant reputational damage and personal suffering being inflicted on medical professionals who are subject to this process.

The AMA notes also that, while section 159R includes a show cause notice and decisions are appealable:

- any submissions must be made "within the reasonable time stated in the notice" (section 159R(1)(d)); and
- the regulatory body is only required to give one business days' notice of their decision to proceed with publication (section 159R(4)(b)).

While some improvements have been made on the previous draft, in our view, practitioners should be given at least 7 days in which to lodge a submission and at least three business days' notice of intention to publish (to give them time to lodge an appeal).

Part 27 - Disclosure of information about registered practitioners to protect the public (Clause 110)

New section 220A applies where a National Board has received a notification (or is conducting an investigation) and it reasonably believes that:

- because of the registered health practitioner's health, conduct or performance, the practitioner poses a serious risk to persons; and
- it is necessary to give notice under this section to protect public health or safety.

Where section 220A applies, section 220A(3) requires the National Board to notify each entity referred to in paragraph (b) of the definition of practice information in section 132(4) that has a current "practice arrangement" with the health practitioner of the risk.

In other words, if a serious (but potentially vexatious) complaint was made that a surgeon has a tremor and the Medical Board considered that it was necessary to notify one third party (eg, the public hospital where the surgeon works), section 220A would be triggered and the Medical Board would be required to notify any other third party that falls within paragraph (b). These could include arrangements which do not carry this risk. For example, the surgeon may be recorded as the first aid officer for their daughter's netball team. Similarly, there may be situations where a practitioner has an infectious disease which requires notification but has no impact on their ability to conduct telehealth consultations or attend meetings via teleconference or videoconference.

We appreciate that:

- section 220A(4)(c) provides that section 220A(2) and (3) do not apply if "the National Board decides that “it is not in the public interest to give the notice”; and
- the examples provided include where “the public interest is outweighed by the registered health practitioner’s right to privacy.”

However, it is not clear how this will be applied in practice given that section 220A(3) is mandatory and new section 3A(1) provides that safety (and the perception of safety) is paramount.

We also have the following additional comments:

- Section 220A does not include any show cause process or even any obligation to tell the practitioner that the Board has notified their employer or other third parties (or intends to do so). This obviously puts the practitioner in a difficult position, particularly where the complaint proves to be vexatious. Employers (and third parties) may wrongly assume that the practitioner has been found guilty and dismiss them.
- Section 220A(3)(b) requires the disclosure of “any relevant information”. This is potentially very broad. Given that the matter is at a very early stage, the only information that should be disclosed is information necessary to manage the risk.

AMA Proposed Improvements

Part 7 - Approval of registration standards (Clause 54)

This amendment will allow the Ministerial Council to delegate to "any entity it considers appropriate to exercise the power". The definition of "entity" is very broad, meaning it is not clear who is responsible for approving registration standards:

- New section 12(4) allows the Ministerial Council to disclose to "any entity it considers appropriate to exercise the power".
- Section 5 defines an "entity" as including a person and an unincorporated body.

This provides little transparency to practitioners on who is responsible for approving registration standards

The AMA recommends that:

- Section 12(4) be worded along the lines of section 37 (which provides for delegation of functions by the National Board).
- There be clear information for practitioners on Aphra's website on what functions have been delegated (and how and why this occurs).

The AMA proposes the following wording:

> *(4) The Ministerial Council may delegate any of its functions, other than this power of delegation, to—*
> *(a) a committee of the Ministerial Council; or*
> *(b) the National Agency; or*
> *(c) a member of the staff of the National Agency; or*
> *(d) a person engaged as a contractor by the National Agency.*
>
> *(5) The National Agency may subdelegate any function delegated to the National Agency by the Ministerial Council to a member of the staff of the National Agency.*

Part 17 - Directing and inciting offences (Clause 86)

There is an overlap between the definition of "unprofessional conduct" and conduct that is regulated by PSR under the Health Insurance Act (HIA). In particular, overservicing (paragraph (d)) which involves Medicare is regulated by both the National Law and the HIA.

Any allegations of inciting unprofessional conduct or professional misconduct that involve Medicare claiming should be referred to PSR. Any penalties imposed under section 136 should take into account the outcomes of the PSR process (as they will commonly include obligations to pay back Medicare).

The AMA recommends adding a new section 136(3):
(3) The maximum penalty under this provision will be reduced to the extent that:
(a) the unprofessional conduct constitutes inappropriate practice under the *Health Insurance Act 1973* (Cth); and
(b) the person has repaid money to the Commonwealth under that Act in relation to that unprofessional conduct.

Part 26 – Discretion not to refer matters to responsible tribunal (Clauses 107 – 109)

The AMA supports the proposal for the National Law to be amended to empower a National Board to decide not to refer a matter to tribunal for hearing. The AMA believes that this is a common-sense approach where there are no ongoing risks to the public. However, the AMA calls on Ahpra to develop the guidelines that would support this discretionary power in consultation with practitioners.

The AMA also suggests a minor rewording to section 193A(2)(f). Currently it provides that the Board "must" have regard to "any other matter the Board considers relevant to the decision". We suggest that the Board "must" have regard to the matters in paragraphs (a) to (e) and "may" have regard to any other matter that the Board considers is relevant to the decision.

Part 28 - Disclosure of information about unregistered persons to protect the public (Clause 111)

The AMA is supportive of this amendment in principle. The AMA believes that for the most part unregistered people are likely to be a risk to public safety and employers would expect them to have appropriate medical qualifications. The AMA does not support any person 'holding out' to be a medical professional and therefore does not oppose their employer being informed of the risk involved.

However, the AMA notes that, unlike section 220A(3) (which uses "must"), section 220B(2) says that Aphra or the National Board "may" notify employers and volunteer organisations. It is unclear why this lower standard applies given that:

- Section 220B only applies where "the unregistered person poses a serious risk to persons; and it is necessary to give notice … to protect public health or safety"; and
- Unregistered persons will not have any professional indemnity insurance (so pose a higher risk to their employers and volunteer organisations).

AMA Supported Amendments

Part 3 - Cultural safety for Aboriginal and Torres Strait Islander Peoples (Clauses 36 - 37)

The AMA supports these amendments.

Part 4 - Disestablishment of Australian Health Workforce Advisory Council (Clauses 38 - 41)

The AMA supports these amendments.

Part 5 - Agency Management Committee (Clauses 42 – 51)

The AMA has no comment to make about the naming of the Agency Management Committee.

Part 6 - Functions of National Agency (Clause 52)

The AMA supports these amendments.

Part 7- Ministerial Council (Clause 53)

The AMA supports these amendments.

Part 8 - Commencement of registration (Clauses 55 - 59)

The AMA supports this amendment. We note that:

- The proposed provisions align with the existing wording of section 56 (period of general registration).
- The selection of 90 days is consistent with sections 85 and 106, which provide that the Board is deemed to have failed to make a decision about an application if it fails to make it within 90 days.

Part 9 - Undertakings (Amendment of s52, 57, 62, 65, 112; insertion of a new s83A, s103A, Clauses 60 – 66)

The AMA supports increased flexibility in the application of the National Law in order to reduce the administrative, financial and mental health burden that can be experienced by medical professional in their dealings with the Medical Board and Ahpra. Accordingly, the AMA supports the ability of a National Board to accept an undertaking voluntarily proffered by a health practitioner, instead of the more onerous process of applying a condition.

The AMA notes that:

- Section 112(2)(ba) now provides that the National Board can refuse to re-register because the applicant failed to comply with an undertaking given by the applicant to the Board that was in effect during the applicant's previous period of registration.
- Decisions under section 112 to refuse registration are appealable decisions (section 199).

Part 11 - Withdrawal of registration (Clauses 69 – 74)

Given the serious risks that improperly qualified practitioners pose to the health of the community, the AMA supports the amendment to allow the withdrawal of a practitioner's registration (where it has been established that their application relied on false or misleading documentation) without having to refer the matter to tribunal.

The AMA highlighted in our previous submission that this is a serious step for any practitioner, and we are glad to see that Health Ministers have heeded our advice and included a show cause process. The AMA believes this provides a balance between streamlining proceedings and ensuring that individuals have some avenue for 'appeal'.

Part 10 - Conditions (Clauses 67 – 68)

The AMA supports these amendments.

Part 12 – Renewal of Endorsement as midwife practitioner (Clauses 75 – 77)

The AMA supports these amendments.

Part 13 - Renewal of registration after suspension period (Clauses 78 – 80).

The AMA supports this amendment. The AMA is pleased to see that Health Ministers have adopted our suggestion that the new section 112B(2) be amended to replace "period" with the defined term "suspension period" so that it reads:

> *If the registered health practitioner intends to renew the practitioner's registration in the profession, the practitioner must apply to the National Board established for the practitioner's health profession within one month after the suspension period ends.*

Part – 18 Disciplinary action in relation to health practitioners while unregistered (Clause 87 -90)

The AMA supports these amendments. Individuals who hold themselves out to be a practitioner without proper registration should not avoid disciplinary action under Part 8 (Health, performance and conduct) by letting their registration lapse.

Part 19 - Mandatory notification by employers (Clause 91)

The AMA has no issue with the example added to section 142 as it reiterates the definition of "notifiable conduct" in section 140. However, the AMA considers that more guidance is required as to what is notifiable. For example:

- Medical practitioners trialling new treatments (with patient consent) may be departing from "accepted professional standards" and there is always some risk to their patients.
- A patient may choose to undertake a risky surgery (which may result in the patient's death) because it may resolve what would otherwise be terminal cancer.

Part 20 - Requirement to provide records for preliminary assessment (Clause 92)

We note that section 149A(3) has been amended to clarify that it does not limit the concept of a reasonable excuse. This is consistent with our previous submission.

New section 149A(1) requires a person to comply with a notice to produce "within a stated reasonable time". There should be a minimum time frame for production. The AMA suggests one month.

Part 21 - Interim prohibition orders (Clauses 93 – 98)

The AMA supports amendments which give regulators additional powers to take action against persons who are unregistered. However, we are concerned that the:

- New section 159D(1) allows notices to be given verbally. Any notices should be in writing.
- New Division 7A only allows interim prohibition orders to be given against persons who are not registered health practitioners. Interim prohibition orders should also be able to be given to persons who are registered health practitioners but who are operating outside their registered health profession (e.g., a registered chiropractor who is providing medical services or holding themselves out as a medical professional).

Part 22 - Prohibition orders (Clause 99)

The AMA supports these amendments.

Part 23 – Show cause processes (Clauses 105 – 106)

The AMA notes that section 179 has been amended to allow a Board to "take other action under this Part" (rather than the initially proposed action). The AMA supports this amendment.

Part 29 - Use of an alternative name (Clauses 112 – 115)

The AMA supports these amendments.

Part 30 - Exclusion of information from registers (Clause 116)

The AMA supports these amendments.

Part 31 - Minor Amendments (Clauses 117 – 129)

The AMA supports these amendments.

Conclusion

In their briefing on 23 May 2022, the Queensland Department of Health stated that these amendments bring a balance to the National Scheme in favour of consumers. They then argued that this would not have a significant impact on health professionals due to the small number of practitioners that receive a complaint.

The AMA disagrees with this statement when it comes to medical professionals. Ahpra's 2020/2021 annual report[3] states that 7,379 registered medical professionals had a notification lodged against them – constituting 5.7% of our profession in a single year. Even assuming this percentage stays constant, over the course of a 25-year career almost 185,000 complaints will be made against doctors. There were 129,066 medical professionals in Australia in 2020/21. Statistically this suggests that a high proportion of doctors are likely to receive at least one complaint in their career.

The impact of this on the livelihoods, mental health and indeed longevity of practice for doctors cannot be downplayed. The constant state of fear doctors practice under – waiting for their turn to be the next one under the Ahpra microscope weighs heavily across our profession. This level of fear and uncertainty is heighted by amendments such as these. Amendments that have not demonstrated a need for increased scrutiny and punitive actions, even in the absence of any finding against a health practitioner as is the case for public statements. The amendments outline in considerable detail the actions that must be taken when such a decision is revoked – but by then it will be too late. The reputation and the life of that doctor will be materially damaged and doubtless a statement by the regulator that they were wrong is unlikely to change that significantly.

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[3] https://www.ahpra.gov.au/Publications/Annual-reports.aspx