AUSTRALIAN MEDICAL PROFESSIONALS SOCIETY

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SUBMISSION TO THE

QUEENSLAND PARLIAMENT

HEALTH AND ENVIRONMENT COMMITTEE

Transforming Health Practitioner Regulation in Australia: The Case for Return to State-Based Medical Boards, Elected Professional Representatives, and Self-Regulation

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Submitted by:

Kara Thomas

President, Nurses Professional Association of Australia ((NPAA) on behalf of NPAA

Dr Duncan Syme

President, Australian Medical Professionals Society (AMPS) on behalf of AMPS

Contact: hotline@amps.asn.au | (07) 3497 5048

14-18, 17 Bowen Bridge Road, Bowen Hills QLD 4006

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Executive Summary

The Australian Medical Professionals Society (AMPS) and the Nurses Professional Association of Australia (NPAA) represent more than 22,000 health practitioners across Australia. We welcome this opportunity to submit to the Queensland Parliament's Health and Environment Committee on the reform of health practitioner regulation. We note that Queensland, as the host jurisdiction of the *Health Practitioner Regulation National Law*, carries a unique responsibility to lead structural reform.

This submission does not focus narrowly on the provisions of any single Bill. It is a broader call for the comprehensive transformation of the regulatory architecture governing health practitioners in Australia, a system that has demonstrably failed practitioners, patients, and the public over a sustained period.

Over more than a decade, parliamentary committees have conducted six separate inquiries into AHPRA (2011, 2014, 2016, 2017, 2022, 2025). Each has identified the same systemic failures: vexatious complaints inadequately managed, investigations taking years to resolve, inadequate procedural fairness protections, conflicts of interest in investigative and decision-making processes, suppression of clinical dissent, and a lack of meaningful accountability. The 2025 Dawson Review, an independent government-commissioned assessment, once again catalogued these failures and recommended urgent reform. **The pattern is clear: AHPRA has not reformed itself, and external mandate has not compelled it to do so.**

AMPS and NPAA therefore submit that incremental legislative amendment is insufficient. What is required is structural reform: a return to accountable, democratically constituted state-based medical boards, the introduction of self-regulatory frameworks modelled on the Queensland legal profession, legislative amendments to the National Law that protect the foundational principles of informed consent, clinical freedom, and practitioner due process, and the establishment of genuine parliamentary accountability for a regulator that currently answers to no single minister and no parliament.

Summary of Recommendations

AMPS/NPAA — Key Recommendations
Recommendation 1: Return to state-based medical boards, constituted by elected representatives of the profession and accountable to state parliaments, replacing AHPRA's centralised governance model.
Recommendation 2: Adopt a self-regulatory framework for health practitioners modelled on the Queensland legal profession, combining elected professional governance with an independent statutory health ombudsman for serious complaints.
Recommendation 3: Amend the National Law to limit notifications accepted by AHPRA, HCCC and the OHO to clinical issues directly relating to patient safety, excluding practitioner opinion, commentary, and academic expression.
Recommendation 4: Introduce mandatory statutory timeframes for all investigations (assessment: 60 days; investigation: six months standard, twelve months complex), with

automatic external review on expiry and compensation rights where no misconduct is found.
Recommendation 5: Amend the National Law to restore the protection of the public as the sole paramount principle, removing “public confidence in the safety of services” as a co-equal ground for regulatory action. Amend the National Law to enshrine protections for informed consent, medical exemptions, and clinical freedom of speech.
Recommendation 6: Create penalties for vexatious complainants, including costs orders and a formal offence for false or misleading notifications. Require a mandatory good-faith statutory declaration from all complainants.
Recommendation 7: Eliminate anonymous complaints, except in cases involving abuse, harassment, or personal safety risk.
Recommendation 8: Require mandatory disclosure and balanced weighing of exculpatory evidence in all investigations and clinical advisor briefings, with written reasons required where contrary evidence is rejected.
Recommendation 9: Establish a levy-funded practitioner support fund providing access to legal assistance and mental health support for practitioners under investigation.
Recommendation 10: Enshrine independent whistleblower protections for practitioners who raise AHPRA, OHO or HCCC governance concerns.
Recommendation 11: Exempt treating practitioners nationally from mandatory reporting obligations, consistent with the Western Australian model, while retaining existing obligations for non-treating practitioners and employers.
Recommendation 12: Require AHPRA’s annual reports to be tabled in every state and territory parliament and referred to a relevant standing committee, with AHPRA obliged to respond in writing to committee findings within 90 days.
Recommendation 13: Mandate that all Immediate Action and disciplinary decisions involve clinical peer review by at least two independent, same-discipline practitioners with no conflict of interest, each providing a separate opinion; where opinions conflict, the practitioner must be informed and given an opportunity to respond before any decision is made.
Recommendation 14: Create a statutory right of review of all notification decisions, including cautions.
Recommendation 15: Require mandatory statutory disclosure of conflicts of interest by all decision-makers and clinical advisors; establish independent oversight of expert advisor selection; and provide practitioners a right to be informed of and to challenge any undisclosed relationship between a decision-maker and a complainant.
Recommendation 16: Introduce income protection for practitioners suspended under Immediate Action provisions where no misconduct is ultimately established.
Recommendation 17: Mandatory Disclosure of International Affiliations. Amend the National Law to require AHPRA to disclose all formal international affiliations,

designations, and collaborative obligations, including its designation as a WHO Collaborating Centre for Health Workforce Regulation, to the Health Ministers' Meeting annually, with that disclosure tabled in each state and territory parliament.

1. Introduction

AMPS and NPAA are national organisations representing the professional interests of medical practitioners and nurses and midwives across Australia. AMPS and NPAA together have over 22,000 members. Both organisations have been active participants in regulatory reform advocacy, appearing before Senate committees, submitting to national reviews, and engaging directly with AHPRA, national boards, the National Health Practitioner Ombudsman (NHPO), and federal and state ministers.

Queensland holds a position of unique significance in this debate: it is the host jurisdiction of the *Health Practitioner Regulation National Law* (the National Law), meaning amendments that Queensland enacts carry weight across the national scheme. It also operates a co-regulatory model through the Office of the Health Ombudsman (OHO), and sits alongside New South Wales, which operates through the Health Care Complaints Commission (HCCC), as one of the jurisdictions offering a window into alternative approaches to the management of health practitioner complaints.

This submission is presented with urgency. Practitioners across Australia are being suspended, silenced, and destroyed professionally, not for harming patients, but for expressing professional opinions, questioning government health directives, and exercising their ethical duty to obtain informed consent. Throughout, AHPRA has operated without meaningful parliamentary scrutiny: no single minister is accountable for its performance, and no parliament has ever debated its annual report.

The 2024 AMPS survey of 1,081 health practitioners found that 52.2% had received a notification from AHPRA; 78.5% felt they had been unfairly treated; and the average practitioner rating of their AHPRA experience was 1.7 out of 10, with 51.6% rating it zero. Our members consistently report that the regulator appears to have limited capacity to identify and investigate true clinical incompetence or malpractice and that in practice, regulatory activity is directed disproportionately at practitioner opinion and guideline compliance rather than clinical patient harm.

These are not the statistics of a regulator in good standing. They are the statistics of a system in crisis. The 2025 Dawson Review, the most recent independent government-commissioned assessment, once again catalogued the same failures and called for urgent reform. That this was necessary fifteen years after AHPRA's establishment is itself the indictment.

2. Background: A Decade of Ignored Recommendations

Since AHPRA's establishment in 2010, parliamentary scrutiny has been unrelenting and largely futile. The following table summarises the principal inquiries into AHPRA's conduct and the key recommendations that have not been implemented.

Inquiry	Key Unimplemented Recommendations	Status
Senate 2011	Review AHPRA's complaints handling; improve timeliness of investigations; strengthen accountability mechanisms	Not implemented; same failures documented in every subsequent inquiry
Victorian Parliament 2014	Improve communication with practitioners; address vexatious complaints; strengthen governance	Not implemented
Senate 2016	Review complaints processing to reduce vexatious notifications; improved communication with practitioners; training for investigators to achieve consistent standards	Partially actioned; vexatious complaint deterrents remain inadequate
Senate 2017	Develop framework for vexatious complaints; recourse for practitioners subjected to vexatious claims; clinical peer advice at earliest opportunity; caution made appellable; monthly updates to parties	Not implemented; caution still non-appellable
Senate 2022	Limit notifications to clinical patient safety issues; statutory timeframes for investigations; exempt treating practitioners from mandatory reporting (align with WA model); independent oversight; broaden appeals rights	Not implemented
Dawson Review 2025	Statutory right of review of notification decisions; improve timeliness and investigation quality; implement NHPO recommendations on vexatious complaints; tribunal reform	Response pending; pattern suggests non-compliance

The consistent failure to implement these recommendations is not incidental. As Dr Julie Sladden documented in *The Spectator Australia* (June 2025):

"AHPRA has no real accountability. It answers to no single health minister. It is not subject to the National Anti-Corruption Commission. It is not required to adhere to performance KPIs enforced by the government. Even the National Health Practitioner Ombudsman,the only oversight body, is funded by AHPRA itself and lacks the power to enforce change."

This assessment is unambiguous: AHPRA is an appointed body that has been given a free hand, with no meaningful political accountability and no genuine parliamentary scrutiny. This is not a system designed to protect the public. It is a system designed to protect itself.

3. Systemic Failures of the AHPRA Model

3.1 Suppression of Clinical Freedom and Professional Debate

One of the gravest failures of the current regulatory model is its use as an instrument of ideological control. AHPRA and the national boards have systematically targeted practitioners who exercised independent clinical judgement, shared evidence-based information, or questioned government health directives. These practitioners were not suspended for harming patients, they were suspended for having professional opinions that conflicted with government public health advice and therefore 'undermined public confidence'. Our members have described AHPRA as a politician's dream, an unaccountable body that can silence dissenting practitioners without ministerial consequence.

Documented cases include:

- Dr Jereth Kok — suspended since 2019 (more than five years) for expressing professional views; no evidence of patient harm.
- Dr Valerie Peers — suspended for more than three years despite 57 years of unblemished clinical practice. No evidence of patient harm.
- Dr William Bay — suspended for raising ethical concerns about regulatory overreach; no patient complaints. No evidence of patient harm.
- Dr Mark Hobart — suspended 2021 for professional decisions during COVID-19; no patient harm established.
- Dr Denes Borsos — suspended for upholding ethical principles during the pandemic. No evidence of patient harm.
- Dr Mei Lei — suspended for more than three years for advocating evidence-based practices. No patient harm identified.
- Dr Paul Oosterhuis — an anaesthetist of 32 years' experience, suspended for Facebook posts questioning pandemic public health decisions. No evidence of patient harm.
- Dr Julian Fidge.

Most recently, in February 2026, AHPRA imposed conditions on the registration of **Dr Andrew Amos**, a Queensland academic psychiatrist and peer-reviewed author, banning him from speaking or posting on social media about gender medicine. Dr Amos had not engaged in clinical work for years; his publications were academic. No patient harm was alleged. AMPS and NPAA wrote jointly to the Queensland Health Minister, AHPRA CEO, and federal senators expressing alarm at this decision.

As AMPS wrote in that correspondence:

> *"Regardless of our various political and professional views, we strongly oppose AHPRA restricting health professionals from contributing to public debate on health and political issues. No health professional should have their livelihood threatened for voicing their opinion."*

The 2022 Senate Committee recommended that **"notifications accepted by AHPRA be limited to clinical issues relating to patient safety"**. AHPRA has ignored this recommendation entirely. The result is a regulatory body that functions as, one Doctor put it is, *"a politician's dream: an unaccountable AHPRA that can shut up rogue doctors."*

The AMA President Dr Danielle McMullen said publicly in April 2025:

> *"Immediate action is one of the strongest sanctions available to Ahpra allowing it to immediately suspend a practitioner or impose conditions after allegations have been made, but before any wrongdoing is proven. Such an action implies guilt before innocence can be proven, and can inflict irreparable damage to a practitioner's reputation, derailing their career and their relationships with patients, colleagues, and employers."*
>
> *"Extreme AHPRA power used too readily and with too little oversight."*

3.2 Misuse of Emergency Suspension Powers

Section 156 of the National Law confers emergency suspension powers intended for situations of immediate and serious public risk. These powers have been **systematically misused** as punitive tools against practitioners who pose no clinical risk to patients.

The specific legislative provision enabling this misuse is Section 156(1)(e) of the National Law, which empowers immediate action where *"the National Board reasonably believes the action is otherwise in the public interest."* This provision is framed so broadly that it can be invoked for virtually any purpose, with no requirement to demonstrate an immediate and specific risk to patient safety. Section 156(1)(e) should be amended so that it can only justify immediate action in extreme cases not covered by Sections 156(1)(a)–(d), functioning as a genuine last resort, not a default.

The consequences for practitioners are severe and often irreversible: loss of income, destruction of professional reputation, psychological trauma, family breakdown, and in some cases, death. There are no statutory timeframes for emergency action investigations. Practitioners have remained suspended for years with no resolution, no income, and no avenue for meaningful redress.

AMPS's March 2025 submission to the National Health Practitioner Ombudsman documented specific systemic deficiencies in the Immediate Action process, including the absence of: mandatory written reasons; adequate time to respond; access to legal representation and case materials; clinical peer review; and any effective appeal mechanism. The Ombudsman's own reports have identified the same deficiencies, **repeatedly and without resolution**.

In *du Toit v Health Ombudsman* [2023] QCAT 373, the Tribunal set aside an Immediate Action decision on the basis of insufficient evidential foundation, a finding that confirms the systemic problem of decisions being made on inadequate evidence. The Dawson Review itself acknowledged:

> *"The regulatory scheme requires an investigation to be undertaken 'as quickly as practicable' ... [but] does not expressly provide any protections for a practitioner if an investigation is taking what seems to be an excessively long time."*

3.3 Vexatious Complaints and the Failure to Protect Practitioners

Vexatious complaints, those made for purposes of harassment, professional rivalry, institutional retaliation, or ideological disagreement, have been consistently identified as a

serious problem in the regulatory scheme since the first parliamentary inquiries into AHPRA's operation.

The 2016 Senate Community Affairs References Committee found that "vexatious complaints are not always readily apparent, but is not convinced that AHPRA's processes are adequate for the purpose of identifying complaints made vexatiously," and that "there are no consequences for individuals who make vexatious complaints." It recommended that "complaints processing within AHPRA be reviewed to ensure more accurate reporting of notifications and to reduce the impact of vexatious complaints on health practitioners." The 2017 Senate Committee recommended AHPRA develop and publish a framework for identifying and dealing with vexatious complaints, and that the COAG Health Council consider making recourse and compensation available to practitioners subjected to vexatious claims. Neither recommendation was implemented. The 2022 Senate Committee was "deeply concerned and moved by the stories it has heard regarding the devastating impact of a notification on some health practitioners," and noted that the stress is "unduly exacerbated by a range of issues with the process." The 2025 Dawson Review directed AHPRA to implement National Health Practitioner Ombudsman recommendations for improving management of vexatious complaints, the fourth iteration of this direction in fourteen years.

AusDoc has documented how weaponised complaints to AHPRA are rarely punished, and that AHPRA must filter 'frivolous' complaints even if not formally vexatious a position supported by the RACGP. Public cases demonstrate the pattern: SA Salaried Medical Officers Association President Dr David Pope described his AHPRA referral as a "politically motivated attempt to silence him" after speaking publicly about hospital conditions. RACGP President Dr Nicole Higgins was investigated over public comments on 60-day prescribing. These are not isolated cases, they reflect a system structurally incapable of distinguishing public interest advocacy from regulatory risk.

As Dr Michael Gliksman wrote in *Medical Republic* (April 2025): "The modern use [of star chamber] refers to any legal or administrative process that considers evidence without rules, gives weight to opinions it prefers, and presumes guilt… the committee is concerned that there are not currently sufficient deterrents against practitioners lodging a complaint for vexatious reasons."

AMPS and NPAA submit that this is unconscionable. A regulatory system weaponisable as a tool of personal or institutional revenge, one that imposes no sanction on those who misuse it, accepts anonymous complaints, and provides no compensation to practitioners whose livelihoods are destroyed by complaints ultimately found to have no basis, does not serve the public interest. It serves bad actors at the expense of good practitioners. The National Law must be amended to require a signed statutory declaration of good faith from all notifiers, permit civil recourse for practitioners subjected to vexatious complaints, and impose enforceable consequences on notifiers found to have made false or malicious referrals.

3.4 Timeliness Failures — Unresolved Since AHPRA's Inception

The failure to resolve AHPRA investigations within a reasonable timeframe is not a recent discovery. It has been documented in formal reviews since the earliest years of the National Scheme and has never been resolved by legislation.

In 2012, Richard Chesterman AO RFD QC was appointed by the Crime and Misconduct Commission to review whistleblower allegations of medical malpractice in Queensland. His recommendations led directly to the appointment of the Forrester Review Panel, whose specific mandate included determining whether the Queensland Board of the Medical Board of Australia had made "timely and appropriate responses to complaints." The fact that timeliness had to be examined at all — in the scheme's second year of operation — established a pattern that would persist for more than a decade.

The 2016 Senate Community Affairs References Committee recorded that while AHPRA's stated aim was to complete each investigation within six months, confidential submitters reported investigations ranging from two to four years. The Committee found that "the slow timeframes concern both those who have made complaints and those who have had complaints made against them," noting the damage to both patient safety and practitioner welfare. It recommended AHPRA develop more consistent investigative standards and approaches as a matter of priority.

The 2017 Senate Committee returned to the same problem. Recommendation 13 called on the Australian Government to consider whether AHPRA had the resources to achieve timeliness, and Recommendation 14 required monthly progress updates to all parties neither of which became law.

By the 2022 Senate Community Affairs References Committee, the findings were almost identical to those of a decade earlier. The Committee confirmed that "there are no statutory timeframes for the conduct of investigations" and that timeliness remained "a common issue raised during the inquiry that was also raised in the committee's previous inquiries." The National Health Practitioner Ombudsman told the Committee that more work was needed to identify the root cause of delays, particularly for notifications proceeding to investigation. The Committee's Recommendation 11 again called for analysis of protracted timeframes — the fourth such recommendation in a decade.

The 2025 Dawson Review captured the legal vacuum that has allowed this to persist:

> "The regulatory regime does not expressly provide any protections for a practitioner if an investigation is taking what seems to be an excessively long time, or for any consequences in the event that the obligation is not being complied with."

The Dawson Review's Action 4.3 directed the AHPRA Board to "immediately improve timeliness and quality of investigation processes and decision making." That this direction was necessary in 2025, thirteen years after the Chesterman review first put timeliness on the record, is itself the indictment.

As Dr Michael Gliksman wrote in *Medical Republic* (April 2025): "Since the time to completion of an investigation can sometimes be measured in years, AHPRA's behaviour ensures the investigation is the punishment, regardless of the alleged transgression or the eventual outcome."

AMPS and NPAA submit that voluntary improvement targets are no longer acceptable. As Queensland holds the host jurisdiction for the National Law, the Queensland Parliament has

both the authority and the obligation to act where Health Ministers have repeatedly failed to do so. The National Law must be amended to establish enforceable statutory timeframes for every stage of the notifications process, with enforceable consequences for non-compliance.

3.5 Procedural Fairness Deficiencies

Multiple inquiries have identified a systemic absence of procedural fairness in AHPRA's investigation and notification processes. The 2022 Senate Community Affairs References Committee found that AHPRA does not always provide sufficient details to enable health practitioners to represent themselves fairly, that communication throughout the process is "inadequate and sometimes inconsistent," and that practitioners are not afforded sufficient time to obtain and submit independent expert opinions in response to a notification. The Committee documented that many practitioners reported "a presumption of guilt in the way they are notified of a complaint, a guilty until proven innocent approach."

A fundamental structural problem underlies these failures: the Health Practitioner Regulation National Law contains no provision for the presumption of innocence, no requirement for natural justice or procedural fairness, and no duty of care owed to the practitioner under investigation. AHPRA investigators are not required to be medically trained or qualified, a concern documented in the 2016 Senate inquiry, yet they are empowered to make consequential findings about clinical conduct. The 2017 Senate Committee found it necessary to recommend that AHPRA "develop a transparent independent method of determining when external advice is obtained and who provides that advice" a recommendation which has not been implemented. In documented cases, AHPRA has obtained expert opinions from practitioners outside the relevant specialty, then acted on that advice in preference to opinions from specialists in the field, without explanation. The Australian General Practice Alliance submitted to the National Health Practitioner Ombudsman that AHPRA currently operates as "inquisitor, prosecutor and judge and jury seeking to sanction and punish and end careers" rather than as a neutral body seeking truth, and called for a proper charge-sheet with evidence, due process, and the presumption of innocence before immediate action is taken.

3.6 Conflicts of Interest

The 2017 Senate Community Affairs References Committee recommended as Recommendation 5, that AHPRA "immediately strengthen its conflicts of interest policy for members of boards and that the Chair of the board should make active inquiries of the other decision makers about actual or potential conflicts of interest prior to consideration of a notification." As a companion measure, Recommendation 6 called on AHPRA to "develop a transparent independent method of determining when external advice is obtained and who provides that advice." A contemporaneous analysis of the report by Panetta McGrath Lawyers confirmed these were among the Committee's core structural concerns.

Neither recommendation has been implemented in any enforceable form. The 2022 Senate Community Affairs References Committee found, five years later, that "inquiry participants, including a number of confidential submitters, raised concerns about conflicts of interest affecting the notifications process," noting ongoing gaps in conflicts of interest frameworks for advisors and decision-makers.

Practitioners and professional bodies continue to raise this concern. As Dr Michael Gliksman documented in *Medical Republic* (April 2025), AHPRA operates as a body that "gives weight to opinions it prefers", consistent with a process in which the selection of expert advisors is neither transparent nor independently verified. AMPS member survey respondents have reported discovering mid-process that committee chairs held personal grievances against them, and that investigators proceeded without disclosing relationships with complainants. These are not aberrations, they are the predictable result of a system with no enforceable conflicts of interest framework and no independent mechanism to compel disclosure.

Clinical Associate Professor Aniello Iannuzzi, Chair of the Australian Doctors Federation, identified a disturbing feedback loop that insulates AHPRA from genuine scrutiny. In a June 2025 Healthed survey of more than 2,000 GPs, he noted: "As soon as AHPRA's mentioned, such is the deep-seated fear, that doctors will not reply or reply more favourably than they feel because they are so petrified that they're going to be targeted. So I think there's a bias there." Even the data collected about AHPRA's conduct is distorted by the very power that conduct is meant to reflect.

Dr Mukesh Haikerwal, former AMA President, put the structural problem plainly in June 2025: "AHPRA get everything that they ask for when they go to governments for increased power and they never ask to modify or improve the situation for the registrants who they depend on for their funding." This captures the conflict at the heart of the current model: a regulator whose institutional interests lie in expanding its own authority, funded by the very practitioners it regulates, with no elected professional representation to check that expansion.

AMPS and NPAA submit that conflicts of interest in AHPRA proceedings must be addressed through mandatory statutory disclosure obligations, independent oversight of expert advisor selection, and a right of the practitioner to be informed of and to challenge any undisclosed relationship between decision-makers and complainants.

3.7 Absence of Parliamentary Accountability

AHPRA reports to Health Ministers through the Health Ministers' Meeting. No single minister bears responsibility for its performance, responsibility and authority are deliberately diffused across eight jurisdictions. No state or territory parliament debates AHPRA's annual reports. There is no mechanism for parliamentary interrogation of AHPRA's conduct, no ability for committees to compel the production of documents or examine individual cases, and no political consequence for sustained failure.

This structural design insulates AHPRA from genuine democratic scrutiny. As Kerry Breen AO, a retired physician and longstanding critic of the national scheme, wrote in *Pearls and Irritations* (November 2022), AHPRA "has become a huge and well-resourced bureaucracy which now has the capacity to 'pull the wool over the eyes' of distant and poorly-briefed health ministers whose accountability for the regulator is remote."

The National Health Practitioner Ombudsman, the only oversight body, is itself funded by AHPRA, and lacks the power to enforce change. AHPRA is not subject to the National Anti-Corruption Commission. It is not required to adhere to government-enforced performance KPIs.

The consequence is a regulator that accumulates power without consequence. Despite being the subject of Senate inquiries in 2011, 2016, 2017, and 2022, and despite consistent findings of systemic failure, no substantive legislative reform has followed. AHPRA continues to expand its powers while the practitioners who fund it through registration fees have no elected representatives on its governing body and no parliamentary mechanism through which to demand change.

This is not accountability. It is the appearance of oversight in the absence of its substance.

4. The Case for Return to State-Based Medical Boards

4.1 The Case for State-Based Elected Boards with Clinical Peer Assessment

The proposal put forward in this submission is not a return to the pre-2010 patchwork but a model that addresses the documented failures of the centralised approach: state-based boards, elected by the profession they regulate, supported by thorough clinical advice from appropriately trained peers, and with jurisdiction restricted to clinical issues.

Elected by the profession. The current Medical Board of Australia is appointed, not elected. Practitioners have no democratic voice in who regulates them, no mechanism for removing board members who fail them, and no representative accountability between the board and the profession. The Queensland legal profession offers an instructive model: the Queensland Law Society operates under the *Legal Profession Act 2007* with a council elected by its members, giving practitioners direct accountability over their regulator. There is no principled reason why the medical profession, which bears greater public responsibility and greater personal risk from regulatory overreach, should be governed by an appointed body accountable to no one it regulates. As the June 2025 'Misdeeds of AHPRA' conference concluded, "The medical board must be elected by the doctors it regulates. This will restore professional confidence and ensure representation, not subjugation."

Clinically expert investigation. A fundamental structural failure of the AHPRA model is that investigations are conducted by staff without clinical qualifications, and decisions are made by board members who depend entirely on those investigators' work. Leaked internal AHPRA documents reported by the RACGP in January 2023 revealed investigators making initial clinical risk determinations were spending less than one hour working on each case per week, under 'ever-changing standards for how to assess complaints.' State-based boards, with appropriately qualified investigative staff employed by and responsible to the board, eliminate this structural divorce between investigation and accountability. Assessments of clinical competence must be conducted by trained clinical peers, specialists or generalists with direct, current experience in the relevant field, not by medical administrators applying a checklist.

Jurisdiction restricted to clinical issues. The current regime allows notifications on a vast range of non-clinical grounds, employment disputes, social media posts, billing disagreements, and conduct that raises no question of patient safety whatsoever. This has converted AHPRA into a general-purpose grievance mechanism available to disgruntled colleagues, employers, patients and anonymous complainants. The consequences are borne entirely by practitioners, while patients receive no benefit. Successive Senate inquiries have recommended reform on this point. The 2022 Senate Community Affairs References Committee made it explicit in Recommendation 9: "Notifications accepted by AHPRA should be limited to clinical issues relating to patient safety." That recommendation has not been implemented. It should be the foundation of the reformed model. Over 71% of all medical notifications already result in no further action a figure that reflects not a profession prone to misconduct but a system that processes vast quantities of unmeritorious complaints at enormous cost to practitioners' wellbeing, professional confidence, and clinical time.

A state-based model with elected professional boards, clinical peer assessment, and jurisdiction confined to patient safety issues is not a weakening of regulation. It is more rigorous regulation, targeted, expert, proportionate, and accountable.

4.2 Elected Representatives, Not Political Appointments

The current national boards are constituted by government appointments, practitioners and community members selected by Health Ministers, not by the profession. This creates an inherent structural conflict: board members owe their position to government, not to practitioners, and are susceptible to pressure, explicit or implied, to advance government regulatory priorities to maintain confidence.

This is not a theoretical concern. The period 2021–2024 saw AHPRA and national boards take widespread regulatory action against practitioners who questioned COVID-19 vaccine mandates and public health directives, including issuing revised guidelines that effectively required practitioners to endorse government messaging, to maintain confidence in government public health messaging, irrespective of clinical evidence. This was government health policy enforced through the threat of registration loss, an extraordinary use of regulatory power that would not have been possible had boards been answerable to the profession.

AMPS and NPAA submit that boards constituted by elected representatives of the profession are structurally more resistant to this kind of political capture. Elected boards are accountable to their members, transparent in their decision-making, and subject to the check of professional confidence. Political appointees are accountable to ministers who appointed them, and to no one else.

4.3 Constitutional and Legislative Pathway

The National Law is a Queensland Act. Queensland has the authority to amend it, and those amendments are replicated across other jurisdictions. Queensland also hosts the OHO, one of Australia's most developed co-regulatory structures for health complaints.

Queensland is therefore not merely a participant in this reform debate. It is the **primary legislative actor**. If Queensland moves to amend the National Law to enable the re-establishment of state-based boards with elected professional representation and to require each other jurisdiction to adopt compatible amendments it can drive national reform from within the existing constitutional architecture.

5. Self-Regulation: The Queensland Legal Profession Model

The Queensland legal profession offers a well-established, functioning model of professional self-regulation that provides both public protection and professional accountability, without a centralised government-appointed regulator in the AHPRA mould.

The legal profession in Queensland is regulated through a tripartite structure:

- The Queensland Law Society — an elected professional association that sets standards, provides education, and addresses complaints against solicitors.
- The Bar Association of Queensland — governing barristers, with elected leadership and peer-based disciplinary processes.
- The Legal Services Commission (LSC) — an independent statutory body that handles complaints, with the power to investigate, discipline, and refer serious matters to the Legal Practice Tribunal.

This model works because it combines **elected professional self-governance** with **independent statutory oversight**. It is transparent, responsive to the profession, and directly accountable. Practitioners are judged by their professional peers, not by government appointees or bureaucrats without clinical expertise.

AMPS and NPAA submit that an equivalent model for health practitioners would deliver superior outcomes for both practitioners and the public. Such a model would include:

- Elected professional associations for medicine and nursing, constituted by practitioners and accountable to members.
- Discipline handled primarily through peer-based processes, within the profession, by the profession.
- An independent statutory health ombudsman (analogous to the LSC) for serious complaints, co-regulatory matters, and appeal, with clear statutory timeframes and a legislated right of review.
- State-based administration, with national consistency maintained through agreed standards rather than centralised AHPRA bureaucracy.

The Queensland legal profession model has the additional advantage of institutional longevity and social legitimacy. The public trusts that legal self-regulation, with independent oversight, works. There is no equivalent public trust in AHPRA, the regulator that 82.6% of surveyed practitioners described as failing to act fairly and transparently (AMPS Survey, as reported in *The Courier Mail*).

6. Proposed National Law Amendments

The following amendments to the *Health Practitioner Regulation National Law* are submitted for the Committee's consideration. Several are drawn from proposed amendments developed by AMPS legal advisors in consultation with clinical and practitioner stakeholders. We urge the Committee to treat these as a starting framework, recognising that detailed drafting will require parliamentary counsel input.

6.1 Protection of Informed Consent and Clinical Freedom of Speech

The 2022 amendments to the *Health Practitioner Regulation National Law* introduced "public confidence in the safety of services provided by registered health practitioners" as a co-equal paramount principle alongside the protection of the public. That change severed the connection between regulatory action and patient harm. A practitioner can now be investigated, suspended, and deregistered not for harming a patient, but for expressing a view that is deemed to undermine confidence in official health messaging — even where that view is factually accurate, evidence-based, and clinically sound.

The consequences are not hypothetical. In March 2021, AHPRA and the National Boards issued a joint position statement warning practitioners that publicly contradicting official COVID-19 health advice could result in regulatory action. Practitioners who raised legitimate, evidence-based concerns about vaccine risk profiles or treatment options were investigated and suspended, not for patient harm, but for "undermining public confidence" in government messaging. In July 2025, the Victorian Civil and Administrative Tribunal found Melbourne GP Dr Jereth Kok unfit to practise VCAT explicitly acknowledged his clinical work was competent and there were no patient complaints solely on the basis of personal views expressed online. He was suspended for six years. AHPRA confirmed that 60 health practitioners were reported over social media posts about Gaza political speech with no clinical content whatsoever.

The mechanism that enables this overreach is the combination of the "public confidence" paramount principle with anonymous complaints. Professor Kerryn Phelps, former federal AMA President, described being the subject of an anonymous complaint to the Health Care Complaints Commission about one of her COVID information videos. The complaint had no basis and was closed, but she noted it "certainly alerts you to the attempts by some people to anonymously use Ahpra and the HCCC as potential threats or weapons against doctors expressing views publicly." An anonymous complainant suffers no consequence for a vexatious report. The practitioner faces years of investigation, with no right to face their accuser, and no compensation if cleared.

Under the pre-2022 framework, protection of the public from genuine clinical harm was the anchor of regulatory action, a standard capable of objective assessment. "Public confidence" is incapable of principled limitation: it is subjective, politically defined, and can be invoked against any statement that challenges prevailing orthodoxy. No equivalent principle exists in the regulation of the legal profession, where solicitors and barristers may publicly argue for unpopular causes, criticise judicial decisions, and challenge prosecutorial conduct and face regulatory action only for clearly defined professional misconduct.

The proposed amendment would:

- Give legislative force to the Senate Community Affairs References Committee's 2022 Recommendation 9 that "notifications accepted by AHPRA should be limited to clinical issues relating to patient safety";
- Remove "public confidence" as a standalone ground for regulatory action, restoring protection of the public as the sole paramount principle;
- Expressly protect the provision of information required for informed consent — a foundational principle of medical ethics under the *Montgomery* standard and confirmed in Australian law through *Rogers v Whitaker* (1992) 175 CLR 479;
- Prohibit anonymous complaints about published speech or opinion, requiring that complaints allege specific clinical conduct carrying a measurable risk to an identified patient or class of patients; and
- Ensure that a practitioner's published professional views — however contested — are treated as a matter of professional discourse, not a patient safety matter.

This amendment does not shield practitioners from genuine misconduct. It restores the boundary between clinical regulation and political enforcement, a boundary that the 2022 National Law amendments erased, and whose absence is now causing direct, documented harm to practitioners and to the patients who depend on their willingness to speak.

6.2 Mandatory Timeframes

The National Law should be amended to:

- Impose mandatory timeframes for completion of assessment (60 days) and investigation (six months for standard matters; 12 months for complex matters).
- Require automatic referral to an independent external review body if an investigation exceeds the prescribed timeframe without resolution.
- Provide for compensation, as of right, where an investigation exceeds the mandatory timeframe and no finding of misconduct is ultimately made.

The absence of enforceable timeframes is one of the most consistently documented failures of the current regulatory model.

The 2022 Senate Community Affairs References Committee inquiry found that timeliness of the notifications process was "a common issue raised during the inquiry" and noted it had also been raised in the Committee's *previous* inquiries. Despite this, no mandatory timeframes have been legislated. The Committee's Recommendation 11 called on AHPRA to analyse protracted timeframes and improve them. Years on, the problem persists.

A 2025 Healthed survey of more than 2,000 GPs captured the lived reality in practitioners' own words:

> "AHPRA's power to impose immediate action has outpaced the procedural safeguards necessary to ensure fairness. Investigations can drag on for years with minimal communication, while practitioners are effectively punished in the interim even when no final finding is made. There are no enforceable timelines, no external review mechanisms, and no consequences for AHPRA's own delays. This asymmetry erodes practitioner trust and undermines the integrity of the regulatory process."

AVANT, one of Australia's largest medical defence organisations, made the same point in its submission to the National Health Practitioner Ombudsman's 2025 investigation into AHPRA's use of immediate action: "Currently, there are no consequences for AHPRA and National Boards when investigations are not expedited after immediate action has been taken. Without a legislated timeline… there is no accountability."

Australia's failure to legislate timeframes is not merely a domestic policy gap, it is an international anomaly. To the best of our knowledge, Australia is the only country with comparable regulatory arrangements that imposes no limit on the duration of immediate actions. The United Kingdom, Singapore, and Malaysia all legislate strict timelines for the resolution of emergency suspension proceedings. That Australia, with one of the most highly regulated medical professions in the world, provides less procedural protection to suspended practitioners than these comparable jurisdictions is not a defensible position.

A practitioner under investigation, particularly one subject to immediate suspension, is not merely inconvenienced. They lose income, patients, professional standing, and in documented cases, their lives. The government-commissioned *Expert Advisory Group to explore practitioner distress while involved with the regulator*, examining the period from January 2018 to December 2021, identified 16 deaths and four instances of attempted suicide or self-harm among practitioners subject to regulatory notifications. Fifteen recommendations were made in response. That a government-commissioned study of this gravity was necessary is itself an assessment of the human cost of the current regulatory model. The absence of timeframes means a practitioner can be suspended indefinitely, without charge, without hearing, and without any external body empowered to intervene.

The National Scheme also fails to adopt a rehabilitative approach to impaired practitioners. Courts and tribunals routinely publish the names of practitioners under investigation for health impairment before any finding of wrongdoing, removing their opportunity to recover before public identification. Return-to-work needs are not considered when determining the severity of sanctions. A regulatory model that treats an impaired practitioner's career as forfeit rather than recoverable with appropriate support loses capable practitioners unnecessarily and creates powerful deterrents to seeking help early, which is precisely the opposite of the patient safety outcome regulation is meant to achieve.

The compensation provision is not punitive, it is structural. As the 'Misdeeds of AHPRA' conference concluded in May 2025, compensation for wrongful or prolonged suspensions "not only incentivises better regulation, it protects the profession from long-term harm." A regulator that bears no financial consequence for delay has no institutional incentive to resolve matters promptly. Mandatory compensation creates that incentive without requiring additional oversight bodies or bureaucratic machinery.

Beyond compensation for delay, the National Law should be amended to mandate that AHPRA has a statutory duty of care to every registrant subject to a notification a duty to minimise mental health impacts and financial harm throughout the process. This is not a novel concept: it is the standard to which every other body exercising coercive power over individuals is held. A practitioner who is wrongfully suspended and suffers documented harm must have a right of legal redress, not merely a support fund.

The AMA's submission to the 2022 Senate inquiry stated that "ideally the AMA would support no investigation taking longer than 2 years other than in exceptional circumstances." NPAA and AMPS submit that two years remains far too long for a process that strips a practitioner of their livelihood from day one. The timeframes proposed above reflect what genuine procedural fairness requires.

6.3 Vexatious Complaints — Penalties and Good Faith Declaration

The National Law should be amended to:

- Require all complainants to sign a statutory declaration that the complaint is made in good faith and on the basis of genuine concern for patient safety.
- Create an offence for making a notification known to be false or misleading, with a graduated penalty structure.
- Empower the regulator to order a complainant to pay a practitioner's compensation where a complaint is found to have been made vexatiously.

The current system is structurally designed to favour complainants over practitioners, with no mechanism to deter abuse.

A complainant faces no consequence for making a false, malicious, or vexatious notification. They may remain anonymous throughout. The practitioner, by contrast, is immediately named (sometimes publicly), faces years of investigation, and may be suspended before any finding is made. This asymmetry is not a regulatory accident, it is a structural feature of the National Law that has been identified and criticised across multiple Senate inquiries without legislative remedy.

The 2022 Senate Community Affairs References Committee found that "high numbers of 'meritless' or 'frivolous' claims made to AHPRA are not being identified and closed early in the process."

The anonymity of the complainant is a particular concern. Dr Andrew Miller, former President of AMA Western Australia, put it plainly in *InSight+* (August 2022): "Ahpra is, in my view, open to being used as a tool of anonymous bullies." Dr Andrew Watkins, a Melbourne paediatrician, was more specific: "If they are political complaints against a doctor for public comments, they will be from interested parties and the complaint, process and any sanction cannot be fully assessed by the community and those complaining must be forced to do so publicly, so their actions can be judged." Professor Kerryn Phelps, a former federal AMA President, described being the subject of an anonymous complaint about a COVID information video, noting it "certainly alerts you to the attempts by some people to anonymously use Ahpra and the HCCC as potential threats or weapons against doctors expressing views publicly."

AMPS members have reported the same pattern directly. In our member survey, practitioners described complaints lodged by disgruntled colleagues, former employers, and individuals opposed to a doctor's published views, with no clinical basis whatsoever. One member described a complaint filed on the same day a workplace dispute escalated. Another received a notification from a person who had never been their patient.

A Healthed survey of more than 2,000 GPs found widespread agreement, with practitioners describing the current system as one where "our legal system is supposed to be based on innocent until proven guilty, but AHPRA adopts the reverse" and calling out "obviously spiteful and baseless complaints" being pursued with the full weight of regulatory machinery.

The analogy to the law of malicious prosecution is instructive. The tort of malicious prosecution exists precisely because the machinery of legal process can itself be weaponised, and because those who weaponise it should bear personal consequence. The same principle applies here. A statutory declaration requirement imposes no burden on a genuine complainant with an honest concern for patient safety. It imposes an insurmountable barrier only on those who intend to use the system as a weapon, which is precisely the point.

The graduated penalty structure and costs order power proposed above are consistent with analogous provisions in civil litigation. Courts routinely award costs against parties who bring proceedings vexatiously or without reasonable basis. There is no principled reason why health regulation, which can destroy a career and a life, should provide less protection against abuse than civil court proceedings.

6.4 Elimination of Anonymous Complaints

Anonymous complaints should be abolished, with a narrow exception for complaints involving abuse, sexual harassment, or personal safety concerns where the complainant has reasonable grounds to fear reprisal. All other complaints must be made with identification and a stated interest in the outcome. The practitioner subject of a complaint should have the right to know who has complained and on what basis.

The right to face one's accuser is foundational to every system of justice Australia recognises. It is not available to practitioners under the current National Law. A practitioner may be suspended and face years of investigation without ever being told who made the complaint, what their relationship to the practitioner is, or what motivated the referral. The 2022 Senate inquiry found practitioners reported "feeling a presumption of guilt in the way they are notified of a complaint" a presumption structurally reinforced when the accuser cannot be identified or their credibility assessed.

Anonymous complaints combined with the "public confidence" paramount principle create a uniquely dangerous pairing: any person, for any reason, may report a practitioner for a published opinion triggering a formal investigation without ever being named, questioned, or held to account for the referral.

The narrow exception proposed is genuine and principled. Where a patient or junior colleague has documented grounds to fear personal reprisal, in cases of alleged sexual misconduct, physical intimidation, or abuse of a power relationship, anonymity serves a legitimate protective purpose consistent with analogous provisions across Australian workplace and coronial law. That exception can be retained. What cannot be justified is a system that extends the same protection to a colleague settling a professional dispute, an employer pursuing a disgruntled separation, or an ideological opponent seeking to silence a practitioner's public voice.

Identification is not a high bar. It is the minimum condition of a fair process.

6.5 Mandatory Disclosure of Exculpatory Evidence

The National Law should be amended to impose an express statutory obligation on investigators and decision-makers to:

- Identify and disclose all material evidence favourable to the practitioner, including to independent clinical advisors.
- Document in writing why significant contrary evidence was rejected or given limited weight.
- Provide practitioners with access to all materials provided to clinical advisors before a final adverse decision is made.

The current process is structurally opaque and the information asymmetry is severe.

Practitioners are required to respond to complaints, often under tight deadlines, without access to the full picture of what investigators hold. The 2022 Senate inquiry found that "AHPRA's communication with notifiers and health practitioners during the notifications process is inadequate," with issues including "difficulty contacting AHPRA, inconsistent information, and delays in communication throughout the process." The AMA's submission to the NHPO's 2025 investigation documented practitioners given two weeks to find a lawyer and prepare to testify, only for AHPRA to then go silent for ten months.

The specific problem this recommendation addresses is the clinical advisor process. AHPRA engages clinical advisors to assess the merits of a complaint, but practitioners have no right of access to the brief those advisors receive, no ability to correct factual errors in the materials put to them, and no entitlement to see their reasoning. An adverse clinical opinion, reached on an incomplete or one-sided evidentiary record, can determine the outcome of proceedings against a practitioner who had no opportunity to address it. As the AMA noted in the same submission, practitioners face suspension and career destruction with "no real course of redress", in part because they cannot see what the decision-maker saw.

The obligation to document why contrary evidence was rejected is equally important. Without a written record, there is no basis for review, no accountability for selective reading of the evidence, and no means by which a practitioner can identify errors of fact or reasoning that drove an adverse finding. Documentation is not an administrative burden, it is the minimum condition of a decision that can withstand scrutiny.

6.6 Broadening of Appeal Rights

As recommended by the 2017 and 2022 Senate committees, a caution should be an appellable decision. The National Law should be amended to create a statutory right of review of all notification decisions, not merely the most serious. Given the substantial reputational and professional consequences of a caution, the absence of an appeal pathway is indefensible.

This recommendation has been waiting for legislative action for nearly a decade.

The 2017 Senate Standing Committee on Community Affairs made it explicitly — Recommendation 11: "The COAG Health Council consider making a caution an appellable decision." It also recommended, at Recommendation 12, that notifiers be permitted to appeal

board decisions to the relevant tribunal. Neither recommendation has been implemented. The 2022 Senate inquiry, examining many of the same systemic problems, found they persisted. The failure to act on either recommendation across nine years is itself evidence of the structural accountability gap that this submission identifies.

The current position is that practitioners may only appeal a narrow category of appellable decisions, primarily the imposition or variation of conditions on registration. A caution, an undertaking, and many other formal regulatory outcomes sit entirely outside this framework. There is no right of appeal. There is no independent review. The decision stands on the record permanently.

This matters because a caution is not, in practical terms, a minor administrative outcome. It is recorded on the practitioner's regulatory history, disclosed in credentialing processes by hospitals and health services, and may affect professional indemnity insurance. For a practitioner applying for a hospital appointment, an academic position, or privileges at a private facility, a caution on their record carries weight regardless of whether it was warranted. The absence of any appeal mechanism means a practitioner who received a caution based on a misunderstanding of the clinical facts, an inadequate investigation, or undisclosed exculpatory evidence has no pathway to have that finding reviewed or set aside.

6.7 Mandatory Clinical Peer Review

All immediate action decisions and disciplinary outcomes should require input from at least **two** registered clinicians practising in the same discipline as the subject practitioner, each with no conflict of interest and relevant recent clinical experience, and each providing an independent opinion. Where the matter involves clinical judgement, no adverse finding should be issued without both qualified peer opinions having considered all material evidence, both inculpatory and exculpatory. Where the two opinions conflict, the practitioner must be informed and given the opportunity to respond before any decision is made.

The 2017 Senate Standing Committee recommended at Recommendation 4 that "AHPRA and the national boards institute mechanisms to ensure appropriate clinical peer advice is obtained at the earliest possible opportunity in the management of a notification," and at Recommendation 6 that AHPRA develop "a transparent independent method of determining when external advice is obtained and who provides that advice." Nearly a decade on, neither has been legislated.

The structural problem was identified plainly by Kerry Breen AO in *Pearls and Irritations* (November 2022): AHPRA's investigative staff "appear to lack knowledge and experience of medical matters," and "the MBA and its state and territory boards have no responsibility for quality of the work of the staff that investigate those complaints." Clinical findings are being made by people with no accountability for the clinical quality of the process producing them.

The reliability of AHPRA's clinical assessments has been called into question both by internal evidence and empirical outcomes. Leaked internal AHPRA documents reported by the RACGP in January 2023 revealed investigators making initial clinical risk determinations were spending less than one hour working on each case per week, under "ever-changing standards for how to assess complaints." Dr Edwin Kruys, a member of the RACGP Expert Committee, warned this "should set off alarm bells" and that "the quality of the work

delivered by investigators would be called into question" under such conditions. The outcomes data confirms the concern: the AMA's 2025 submission to the NHPO documented that in nearly half of all cases where immediate action was taken, no final regulatory action was ultimately required, a finding the AMA described as calling into question "the specificity, sensitivity, and reliability of immediate action in protecting the public." Clinical assessments of sufficient quality to suspend a practitioner should not rest on a process this unreliable and this unaccountable.

AHPRA engages part-time clinical advisors, but there is no legislative requirement that they practise in the same specialty as the subject, that their advice be disclosed to the practitioner, or that more than one opinion be obtained. A single advisor's view, potentially erroneous, potentially based on incomplete materials, can determine the outcome of proceedings against a practitioner with no ability to challenge it. The AMA's submission to the NHPO's 2025 investigation documented cases of immediate action taken "when it was unclear what the risk to the public was," suggesting clinical assessment of risk was absent or inadequate at the point of suspension.

Courts require expert witnesses in medical negligence proceedings to be specialists in the relevant field, currently practising, and subject to challenge. A requirement for two independent same-discipline opinions, the standard applied in any serious clinical second-opinion process, is not a high bar. It is the minimum condition for a finding about clinical conduct to be credible.

6.8 Parliamentary Accountability

AHPRA is accountable not to parliament but to the Health Ministers' Meeting, a body of executive ministers with no obligation to scrutinise or publicly debate AHPRA's performance. No single minister bears responsibility for the scheme.

The National Health Practitioner Ombudsman provides nominal oversight but cannot make binding findings, enforce apologies, or compel practice changes. Complaints about AHPRA cannot be lodged with the NHPO without first being raised with AHPRA itself, a circular process that deters practitioners who fear reprisal. As the AMA's 2025 submission to the NHPO noted, "a practitioner who is mistreated by Ahpra during the management of a notification has virtually no way to hold AHPRA accountable."

AHPRA has been the subject of parliamentary inquiries in 2011, 2014, 2016, 2017, 2022 and 2025. None produced legislative reform of its accountability structure. Inquiries can recommend; ministers can file and forget.

By contrast, major national regulators including the Australian Securities and Investments Commission and the Australian Competition and Consumer Commission are required to table their annual reports in both Houses of parliament, where standing committees have power to call witnesses and make public findings.

AMPS and NPAA submit that AHPRA's annual reports should be required by law to be tabled in every state and territory parliament and referred to a relevant standing committee for examination. That committee should have statutory power to call AHPRA officers, examine case-level data under appropriate privacy protections, and make findings, with AHPRA

obliged to respond in writing within 90 days. A regulatory body with the power to end a practitioner's career must be subject to democratic scrutiny, not merely executive convenience.

6.8.1 Disclosure of International Affiliations

AHPRA holds a formal designation as a World Health Organization (WHO) Collaborating Centre for Health Workforce Regulation, a role it has maintained since April 2019 (AHPRA, 2019). In that capacity, AHPRA is tasked with promoting regulatory approaches across WHO member states and providing technical support to strengthen health workforce regulatory systems internationally. As AHPRA's own CEO stated at the launch: *"Australia's National Registration and Accreditation Scheme for health professions is recognised as a leading model for regulating the health workforce."*

This designation creates obligations and relationships appears to sit entirely outside the National Law framework and are invisible to Australian parliaments. Health ministers and state and territory legislatures have no mechanism to scrutinise how AHPRA's international obligations influence its domestic regulatory priorities. During the COVID-19 pandemic, AHPRA took a series of significant regulatory actions affecting practitioner conduct and scope of practice. Whether those actions were shaped by AHPRA's WHO obligations has never been examined by any parliamentary body, and under the current framework, they cannot be. Peer-reviewed analysis of WHO-affiliated bodies has raised serious questions about whether their recommendations reflect evidence or institutional authority (Bell et al., 2025), making independent parliamentary scrutiny of AHPRA's international affiliations all the more necessary.

Australia's health workforce is supposed to be regulated in the public interest of Australians. That regulatory body must be accountable first and foremost to Australian parliaments, not to international bodies. The National Law should be amended to require AHPRA to disclose all formal international affiliations, designations, and collaborative obligations to the Health Ministers' Meeting annually, with that disclosure tabled in each state and territory parliament.

6.9 Exemption of Treating Practitioners from Mandatory Reporting (Alignment with WA Model)

The mandatory reporting obligations placed on treating practitioners should be removed, consistent with the Western Australian model. The Medical Board of Australia's own Guidelines for Mandatory Notifications confirm that in Western Australia, treating practitioners are fully exempt from the requirement to make mandatory notifications about a practitioner-patient. Outside WA, treating practitioners retain the obligation at a "substantial risk of harm" threshold introduced by 2020 amendments to the National Law. Those amendments were a partial concession to long-standing concerns, but they did not resolve the fundamental problem.

A treating practitioner who must notify about a practitioner-patient faces an irresolvable conflict between therapeutic duty and regulatory obligation. The predictable result is that practitioners avoid seeking help. That outcome is a greater risk to patients and to practitioners themselves than treatment under clinical confidentiality.

AMPS and NPAA submit that the treating practitioner exemption should apply nationally. Non-treating practitioners and employers would retain their existing mandatory reporting obligations in full. Public safety is better served by ensuring impaired practitioners can seek treatment early — and by concentrating mandatory reporting on those who observe risk from outside the therapeutic relationship, where no conflict of duty arises.

7. Summary of Recommendations

Structural Reform

1. Return to state-based medical boards, constituted by elected representatives of the profession and accountable to state parliaments, replacing AHPRA's centralised governance model.
2. Adopt a self-regulatory framework for health practitioners modelled on the Queensland legal profession, combining elected professional governance with an independent statutory health ombudsman for serious complaints.
3. Require AHPRA's annual reports to be tabled in every state and territory parliament and referred to a relevant standing committee, with standing committees empowered to examine performance data and compel AHPRA's appearance, and AHPRA obliged to respond in writing to committee findings within 90 days.

Scope of Regulation

4. Amend the National Law to restore the protection of the public as the sole paramount principle, removing "public confidence in the safety of services" as a co-equal ground for regulatory action.
5. Amend the National Law to limit notifications accepted by AHPRA, HCCC and the OHO to clinical issues directly relating to patient safety, excluding practitioner opinion, commentary, and academic expression.
6. Amend the National Law to protect informed consent, medical exemptions, and clinical freedom of speech as inviolable professional rights not subject to regulatory sanction.

Procedural Fairness

7. Introduce mandatory statutory timeframes for all investigations (assessment: 60 days; investigation: six months for standard, twelve months for complex), with automatic external review on expiry and compensation rights where no misconduct is found.
8. Require mandatory disclosure and balanced weighing of exculpatory evidence in all investigations and clinical advisor briefings, with written reasons required where contrary evidence is rejected.
9. Mandate that all Immediate Action and disciplinary decisions involve clinical peer review by at least two independent, same-discipline practitioners with no conflict of interest, each providing a separate opinion; where opinions conflict, the practitioner must be informed and given an opportunity to respond before any decision is made.
10. Create a statutory right of review of all notification decisions, including cautions. Enshrine independent whistleblower protections for practitioners who raise clinical, safety, or governance concerns.
11. Require mandatory statutory disclosure of conflicts of interest by all decision-makers and clinical advisors; establish independent oversight of expert advisor selection; and provide practitioners a right to be informed of and to challenge any undisclosed relationship between a decision-maker and a complainant.

Vexatious Complaints and Anonymous Notifications

12. Require a mandatory good-faith statutory declaration from all complainants.
13. Create penalties for vexatious complainants, including costs orders and a formal offence for false or misleading notifications.
14. Eliminate anonymous complaints except in defined circumstances of abuse, harassment, or personal safety.

Practitioner Support

15. Establish a levy-funded practitioner support fund providing access to legal assistance and mental health support for practitioners under investigation.
16. Introduce income protection for practitioners suspended under Immediate Action provisions where no misconduct is ultimately established.
17. Amend the National Law to impose a statutory duty of care on AHPRA and National Boards to the registrant, including a duty to minimise the mental health impacts and financial effects on any practitioner subject to a notification, and to provide practitioners with a right of legal redress where that duty is breached.
18. Enshrine independent whistleblower protections for practitioners who raise clinical, safety, or governance concerns.

Mandatory Reporting

19. Exempt treating practitioners nationally from mandatory reporting obligations, consistent with the Western Australian model. Non-treating practitioners and employers retain their existing mandatory reporting obligations in full.

8. Conclusion

The evidence presented in this submission is not new. Parliamentary committees have documented these failures since 2011. Independent reviews have reached the same conclusions. Practitioners have testified to the same harms. AHPRA has acknowledged shortcomings and promised improvement. And nothing has fundamentally changed.

The cost of that inaction is not abstract. AMPS's 2024 survey of 1,081 practitioners found that 52.2% had received a notification from AHPRA; 78.5% felt they had been unfairly treated; and the average practitioner rating of their AHPRA experience was 1.7 out of 10, with 51.6% rating it zero. A regulator so feared by the profession it governs does not only harm practitioners, it harms patients. The AMA has described the consequences in direct terms:

> *"The AMA hears from members on a consistent basis about their fear of Ahpra and the regulatory scheme and the impact it has on their lives. Even if a notification is baseless, minor or vexatious, it evokes doubt within the practitioner about their practice, causing fear of damage to their reputation and career. They also fear a notification, even if no further action is taken, may be used in the future against them."*

The mechanism that generates that fear is well understood. As AMA spokesman Dr Antonio Di Dio has stated publicly:

> *"If you want to ruin a doctor's life, all you really have to do is make a complaint against them and walk away. There will be no consequences against you. Certainly 90 per cent of the time the doctor will be found to have done nothing wrong, but you will have ensured that doctor has a year of utter misery."*

AMPS and NPAA therefore call on the Queensland Parliament's Health and Environment Committee to act with conviction. Queensland holds the National Law. Queensland has the power to initiate the structural change that no amount of AHPRA's self-reform has achieved. The case for state-based boards with elected representatives, self-regulation on the legal profession model, legislative protections for clinical freedom and informed consent, and genuine parliamentary accountability for a regulator that currently answers to no single minister and no parliament, is overwhelming. It is time to act on it.

AMPS and NPAA are willing to provide further written submissions, appear before the Committee, and work with members and their offices to develop legislative drafting for any of the proposed amendments in this submission.

Yours sincerely,

Kara Thomas
President, Nurses Professional Association of Australia ((NPAA)
Dr Duncan Syme
President, Australian Medical Professionals Society (AMPS)

9. References

- **Parliamentary and Government Reports:**

- Senate Finance and Public Administration References Committee (2011). *Inquiry into the Administration of Health Practitioner Registration by AHPRA*. Commonwealth of Australia.

- Parliament of Victoria, Legal and Social Issues Legislation Committee (2014). *Inquiry into AHPRA*. Parliament of Victoria.

- Forrester Review Panel (2013). *Review of Queensland Health's management of serious medical complaints*. Queensland Parliament.

- Senate Community Affairs References Committee (2016). *Administration of Registration and Notifications by AHPRA*. Commonwealth of Australia.

- Senate Community Affairs References Committee (2017). *Complaints Mechanism Administered under the Health Practitioner Regulation National Law*. Commonwealth of Australia.

- Senate Community Affairs References Committee (2022). *Administration of Registration and Notifications by AHPRA and Related Entities under the Health Practitioner Regulation National Law*. Commonwealth of Australia.

- Dawson, S. (2025). *Transforming Health Professionals' Regulation in Australia: Independent Review Final Report*. Australian Government Department of Health and Aged Care.

- **Legal Decisions:**

- *Rogers v Whitaker* (1992) 175 CLR 479 (High Court of Australia).

- *du Toit v Health Ombudsman* [2023] QCAT 373.

- *Pridgeon v Medical Council of NSW* [2023] NSWCA (Supreme Court of Appeal).

- VCAT (July 2025). *Medical Board of Australia v Kok* [re Dr Jereth Kok]. Victorian Civil and Administrative Tribunal.

- **Professional Organisation Submissions:**

- Australian Medical Association (2025). Submission to the National Health Practitioner Ombudsman: Investigation into delay and procedural safeguards for practitioners subject to immediate action. https://www.ama.com.au/sites/default/files/2025-04/AMA_submission_to_the_Ombu

dsmans_investigation_into_delay_and_procedural_safeguards_for_health_practitioners_subject_to_immediate_action.pdf

- AVANT Mutual Group (2025). Submission to the National Health Practitioner Ombudsman: Investigation into delay and procedural safeguards for practitioners subject to immediate action. https://assets.avant.org.au/cdf6134c-01d7-0292-26f5-2f5cf1db96f8/0334bc93-8f2e-40ff-9436-399ed3dcc4ff/

- Australian General Practice Alliance (2025). Submission to the National Health Practitioner Ombudsman.

- **AMPS/NPAA Submissions and Correspondence:**

- AMPS & NPAA (2022). Submission to the Health and Environment Committee: Inquiry into the *Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022*.

- AMPS (September 2024). Urgent Concerns Regarding AHPRA's Conduct, Regulatory Framework, and Scientific Integrity in Healthcare. Letter to Mr Martin Fletcher, CEO AHPRA.

- AMPS (January 2025). Exposing the Misuse of Emergency Suspension Powers: A Call for Justice in Australian Healthcare. Submission to the NHPO and Independent Dawson Review.

- AMPS & NPAA (March 2025). Submission to the National Health Practitioner Ombudsman: Inquiry into Delay and Procedural Fairness for Practitioners Subject to Immediate Action.

- AMPS (June 2025). Restoring Integrity in Medical Regulation: A Call to End Politically Motivated Investigations and Uphold Ethical Medical Practice. Letter to Mr Justin Untersteiner, CEO AHPRA.

- AMPS & NPAA (January 2026). Request for Immediate Review and Resolution of COVID-19-Related Disciplinary Actions. Letter to Mr Justin Untersteiner, CEO AHPRA.

- AMPS & NPAA (March 2026). AHPRA Action Against Dr Andrew Amos and the Suppression of Professional Debate in Medicine. Letter to the Hon Tim Nicholls MP, Minister for Health.

- **Academic and Professional Sources:**

- Harpur, P., Bedford, D., & Bismark, M. (2022). Reform recommendations for AHPRA immediate action provisions. *Medical Law International*.

- Bradfield, O., Spittal, M., & Bismark, M. (2020). Proportionality and clarity in Australian medical regulation. *AJGP*.
- Australian Society of Anaesthetists (2024). *Workforce Modelling Report*.
- AMPS Human Cost of AHPRA Survey (2024). Responses from 1,081 health practitioners.
- Bradfield, O. (2023). *Regulation in Need of Therapy? Relationships Between Doctors' Health, Medical Regulation, and Medical Negligence Claims in Australia: A Legal, Quantitative, and Qualitative Analysis* [doctoral dissertation, University of Melbourne]. http://hdl.handle.net/11343/336873
- Expert Advisory Group to Explore Practitioner Distress While Involved with the Regulator (2022). *Report and Recommendations*. Australian Health Practitioner Regulation Agency.
- Bell D, Brown GW, Tacheva B, von Agris J. Should Eminence Outweigh Evidence? The Global Preparedness Monitoring Board's Report on Pandemic Preparedness. *Global Policy*. 2025;16(2):410–418. https://doi.org/10.1111/1758-5899.70016

- **Media and Professional Commentary:**
- Breen, K. (November 2022). A matter of conscience: What to do about the national medical regulator. *Pearls and Irritations*. https://johnmenadue.com/a-matter-of-conscience-what-to-do-about-the-national-medical-regulator
- Gliksman, M. (April 2025). Overreach and misdeeds by AHPRA and the MBA — forum. *The Medical Republic*. https://www.medicalrepublic.com.au/overreach-and-misdeeds-by-ahpra-and-the-mba-forum/116859
- Healthed (June 2025). Does AHPRA need to be reined in or struck off? Survey of more than 2,000 GPs. https://www.healthed.com.au/clinical_articles/does-ahpra-need-to-be-reined-in-or-struck-off/
- Sladden, J. (June 2025). AHPRA: Unfit for purpose? *The Spectator Australia*. https://www.spectator.com.au/2025/06/ahpra-unfit-for-purpose/
- Swannell, C. (August 2022). Fallout continues from Ahpra "over-reach." *InSight+*. https://insightplus.mja.com.au/2022/29/fallout-continues-from-ahpra-over-reach
- *The Medical Republic* (2023). It's easy and free to ruin a doctor's life. https://www.medicalrepublic.com.au/its-easy-and-free-to-ruin-a-doctors-life/16457

- *The Spectator Australia* (August 2025). Controlled by confidence: The unchecked power of AHPRA and the state. https://www.spectator.com.au/2025/08/controlled-by-confidence-the-unchecked-power-of-ahpra-and-the-state/