AMPS Australian Medical Professionals' Society

1 June 2022

Submission to the Health and Environment Committee

Inquiry into the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022 (the Bill)

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Introduction

The Australian Medical Professionals Society (AMPS) and the Nurses' Professional Association of Australia (NPAA) welcome the opportunity to provide feedback to the Health and Environment Committee inquiry review of the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022 (the Bill). AMPS would like to note that a two week consultation period for the most wide ranging reforms in the scheme's history is grossly inadequate.[1]

AMPS and NPAA represent more than 10,000 health practitioners across Australia, we are an industrial association whose principal purpose is to protect and promote the interests of our members and their patients, and to support the best possible health outcomes for all Australians.

Our members have raised serious concerns about further refocusing the objectives and guiding principles of the Health Regulation National Law to make "public safety and confidence" a primary consideration, and the ability to issue public statements about persons whose conduct poses a serious risk to public health and safety. While we understand the intent of the proposed changes, we believe the broad and discretionary nature of claims to "Public safety and confidence" are already being used as a mechanism to enforce compliance with government directives. Directives that lack evidence based science, and indeed lack consensus support from health practitioners not being asked, but who are being directed to implement. Public health orders supported by secret health advice built on secret science. Policy decisions should be based on evidence, experience, and complete transparency.

Furthermore, the idea that non-compliance with government decrees poses an immediate risk to patient safety is dangerous to evidence based patient care. We do not feel the explanatory notes provide any clarity regarding the risk-based approach to be used to interpret "Public health, safety and confidence.[2]" Therefore, we have no confidence that provisions for Public health and safety will, in application, improve public protection from clinical misconduct nor increase confidence in the public health system.

Further, AMPS cannot support the extension in law to publicly name and shame practitioners who "pose a risk to public safety," without defining how risk is to be interpreted. For example a conviction of a relevant offence or an investigational finding of patient harm. Otherwise this is yet another discretionary legislative amendment that our members feel could be used to publicly shame non compliant practitioners, without the presumption of innocence, causing severe financial and permanent reputational damage, while regulators are provided with liability protection for any harms or damage caused. These proposed powers also serve to conveniently silence voices of expertise that wish to correct health authorities, which may and has counter-productively prevented necessary information and communication from entering the public sphere.

[1] 2022_05_11_WEEKLY (parliament.qld.gov.au)
[2] https://documents.parliament.qld.gov.au/tp/2022/5722T633-74BD.pdf

Our membership has highlighted serious concerns about claims to “public safety and confidence” leading to conflict with our codes of conduct which make our patients our primary concern. Our codes of conduct are predicated on The Hippocratic Oath, the Declaration of Geneva, the International Code of Ethics and outline our dedication to serving humanity, to do no harm, making our patients our first consideration. Discretionary laws prioritising “public health and safety” raise serious concerns that our codes of conduct prioritising our patients will be further overridden by enforced compliance to domestic public health messaging, essentially by decrees in the name of “public safety and confidence.”[3][4][5][6][7]

We will address a number of the amendments in our submission which we believe require review to ensure the public is protected from both practitioner professional misconduct, and government dictates enforcing practitioners to act against their conscience and scientific evidence. These dictates enforce compliance with domestic public health laws that breach Human Rights and best practice. Public health and safety can only be assured in an environment of open, informed, and transparent policy discussion. Community confidence is created when people know their Health Practitioner is free to speak without threat or intimidation, in accordance with their implied civil and political rights to advocate for their patients.[8]

Proposed Amendments to the Health Ombudsman Act 2013

Chapter 2 Amendment 10 to s 59 (Show cause process) - Section 59 (1A) (b)

Current: (b) *inviting the practitioner to make a submission to the health ombudsman, within a stated period of at least **7 days,** about the proposed action*.

Proposed: (b) *inviting the practitioner to make a submission to the health ombudsman, within a stated period of at least **5 business** days starting after the notice is given, about the proposed action*.

Insufficient opportunity for practitioners to respond to notifications has been repeatedly highlighted in senate committee hearings as an issue that inhibits a practitioner's ability to access procedural fairness. When immediate actions are taken, 7 days has already proved insufficient for practitioners to get legal advice and make other arrangements for their

[3] Decl-of-Geneva-v2006-1.pdf (wma.net)
[4] WMA International Code of Medical Ethics – WMA – The World Medical Association
[5] Nursing and Midwifery Board of Australia - Guidelines (nursingmidwiferyboard.gov.au)
[6] Medical-Board---Code---Good-medical-practice-a-code-of-conduct-for-doctors-in-Australia---1-October-2020 (3).PDF
[7] Australian Health Practitioner Regulation Agency - Shared Code of conduct (ahpra.gov.au)
[8] Doctors for Refugees: Constitutional Challenge to Border Force Laws Filed in the High Court - TimeBase

patients. Despite the repeated calls to increase time frames these amendments further restrict their ability to access procedural fairness[9].

Recommendation:

AMPS recommends an increase in response time be provided to practitioners who receive a show cause. AMPS recommends 21 days.

In addition, AMPS calls for a review of **Section 59** (4) to be renumbered to section 59(5), which reads as follows

> *However, if the health ombudsman is satisfied it is necessary to do so to ensure the health and safety of an individual or the public, the health ombudsman may take immediate registration action without complying with subsections amended (2) to (4)* .

We have serious concerns that regulatory action taken during this pandemic has demonstrated an *ultra vires* use of these provisions overriding due process and natural justice at the expense of patient advocacy. There must be defined criteria to support immediate action that bypasses due process. Undefined clauses like the "*health and safety of the public*" have been used by regulatory agencies to threaten and immediately suspend health practitioners who contradict public health orders and government public health messaging.[10]

It is now clear that "public health and safety" provisions of the Act have been exploited by regulators to mean any statement that is at odds with government public health orders or government messaging, regardless of the science placed forward in support.

These powers have been used to control health practitioners, creating a conflict with their ethical duties and code of conduct obligations. Immediate registration action should only be taken when there is objective evidence of patient harm. Immediate action taken otherwise by a government or agency can and has begun to take on the character of decrees against ad hoc and extra-legislatively imposed thought crimes, against instances of ethical or evidence based challenges to public health orders or government messaging, in the absence of patient harm. Where such decrees lack a proper basis in law and arise out of extra-legislative pronouncements like the Position Statement decreed without consultation by AHPRA on 9 March 2021, Health Practitioners become subjects of Rule by Fiat, for which ill-defined provisions like Section 59(5) enable a wide discretion for enforcement actions supporting such decrees, that completely override notions of natural justice and the presumption of innocence, let alone any proper consideration of evidence placed forward by highly qualified health practitioners possessing views in opposition. As such Section 59(5) must undergo amendment to safeguard against compounding instances of government messaging becoming some 'new normal', where patient advocacy and universally accepted codes of conduct flowing from Hippocrates' oath To Do No Harm, are extinguished.

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[9] Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law (aph.gov.au)
[10] https://support.mips.com.au/home/12-commandments-to-avoid-ahpra-notifications

The case of Dr Paul Oosterhuis demonstrates this concerning issue:

> *'Before the medical board, Dr Oosterhuis presented evidence to support the accuracy of his social media posts. The medical board, however, declined to engage in any discussion regarding the evidence, or the veracity and legitimacy of Dr Oosterhuis' statements. At issue was one thing and one thing only: whether Dr Oosterhuis had contradicted the Government. He had, and he was suspended.'*[11].

Dr Oosterhuis' case evidences AHPRA and the National boards no longer consider highly expert professional judgement and scientific evidence as sufficient defence worthy of being entertained when called to account for possessing opposing views. This is not an environment of scientific debate and the exchange of ideas, but wholesale indications of authoritarian rule incapable of entering into scientific discourse.

This dangerous shift in stance by AHPRA and the National Medical Board was recently recognised by the Medical Indemnity Professionals Society, when the MIPS outlined the caution to be taken by health practitioners in their 12 commandments to avoid AHPRA notifications:

Be very careful when using social media (even on your personal pages), when authoring papers or when appearing in interviews. Health practitioners are obliged to ensure their views are consistent with public health messaging. This is particularly relevant in current times. Views expressed which may be consistent with evidence-based material may not necessarily be consistent with public health messaging[12].' It appears adherence to public health messaging is the new '*accepted professional standard* of best practice, about which none of the health practitioner community was consulted, nor indeed has it been seen to endorse.

Another case which raises further concerns is that of Dr Hobart, an experienced GP who had his premises searched and confidential patient documents confiscated. A spokeswoman for AHPRA told *the Sydney Morning Herald* that: *'*

> *If a notification is made to us that a practitioner is providing exemptions in circumstances other than those described in the [official] advice, we will investigate … an investigation could lead to restrictions on a practitioner's registration. This could affect their ability to continue to provide exemptions, to manage patients in relation to COVID-19, or where there is significant continuing risk or it is in the public interest, could result in a suspension of registration."*

Additionally, a recent *Epoch Times* article discussing Doctors' concerns about the AHPRA gag order, included a revealing quote from AHPRA in response to practitioners advocating views which may differ from the public health messaging:,

> *Experience tells us that most practitioners, when concerns are raised directly with them, modify their behaviour to become **compliant**," an AHPRA spokesperson said*

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[11] https://mercatornet.com/yes-australian-health-regulators-are-threatening-doctors-with-deregistration-over-covid-19/76052/

[12] https://support.mips.com.au/home/12-commandments-to-avoid-ahpra-notifications

at the time. "In a small number of cases, national boards are likely to take action to ensure the actions of the practitioner do not place the public at risk of harm."[13]

The above cases and comments are only some of the many AMPS is aware of, where practitioners are immediately suspended or disciplined as 'a risk to public health', for not facilitating public health orders decreed without consultation or supporting evidence, or for simply questioning or challenging public health messaging advanced in contradiction of the available science. It defies comprehension that AHPRA, entrusted to ensure public safety, has stated it is not within their mandate to evaluate the scientific validity of statements or exemptions, but only to assess if the statements or exemptions go against the Public Health Orders[14].

If Public Health Orders have no demonstrable, transparent, objective, empirical data and are not open to public scrutiny or review, then our Regulatory laws are being used to enforce politics and outcomes favourable to pharmaceutical interests, not ensure public health and safety. If evidence-based medicine is controlled by public health bureaucrats using publicly unavailable and undisclosed so-called 'health advice', to thereafter enforce same by regulators and boards, then "evidence-based medicine" is an illusion and our code of ethics have no effect.[15]

As a consequence we find Informed Consent has been hijacked and denied from the Australian community, (as the continue AHPRA and government position towards Covid-19 'vaccines' has amply demonstrated), when and where health practitioners are gagged and told to unreservedly adopt government messaging, thereby excluding every health practitioner from sharing their expert opinion and views with their patients, who come to them for their skills and independence and ability to professionally evaluate all the available evidence.

When you deny patients Informed Consent you remove 'Health' from the phrase 'Health System', and find Australians subject to a Government System with whom no patient can be said to have a direct and immediate relationship, like that historically understood and formerly protected between a Doctor and Patient.

Instead we have witnessed AHPRA, as our national regulator of health professionals, having inserted itself between Doctors and Patients, to gag the Doctor, and itself speak to the Patient as **a single-minded enforcer of government policy rather than a regulator of safe, effective and trustworthy professional practice**. This makes Politicians and bureaucrats the primary concern of health practitioners across the country, not their patients.[16] [17]

Additionally, regulatory overreach has been an issue even prior to the pandemic. The recent Supreme Court decision in *Pridgeon v. Medical Council of New South Wales* highlights the issue and how it results in a denial of health services to the community. That judgement

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[13] Hundreds of Doctors 'Very Terrified' of Speaking Out of Turn on COVID-19 Policy: Lawyer (theepochtimes.com)
[14] https://www.gerardrennick.com.au/doctors-ahpra-letter/
[15] The illusion of evidence based medicine | The BMJ
[16] COVID UPDATE: What is the truth? - Surgical Neurology International
[17] https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx

found that Dr Pridgeon had been unlawfully denied the presumption of innocence by Health Authorities, and it took three and a half years to obtain justice and return of his registration, and with it the ability to practise and earn a living again. How can it be said '*the health and safety of the public*' was protected in this instance?

This issue has been previously highlighted in committee reviews. Avant Mutual Group outlined in their submission to the Health Regulation National Law and Other Legislation Amendment Bill 2017 that taking immediate action "in the public interest" is starting to be used as a matter of routine rather than as an exception.[18]

The Statement of compatibility reads:

> '*The amendments seek to protect the public and ensure public confidence in the safety of services provided by registered health practitioners and students. In human rights terms, the objective is to:*
>
> • *fulfil the state's obligation under section 16 of the Human Rights Act to protect the right to life;*
>
> • *protect the right to security of the person in section 29(1) of the Human Rights Act (insofar as that is a standalone right); and,*
>
> • *protect the right of every person to access health services without discrimination under section 37(1) of the Human Rights Act.*
>
> *At the international level, the United Nations Committee on Economic, Social and Cultural Rights has acknowledged that the right to health services includes a right to an adequate standard of health services.This right may be engaged by a failure to regulate health practitioners adequately*[19]."

These statements however, fail to acknowledge that practitioners that have been suspended under immediate action provisions as a '*threat to public health',* have been advocating for what they believed were adequate health services, such as the benefits of early treatments, the harms of lockdowns, the uselessness of masks and informing people of the risks of gene-based vaccines.

They take seriously their obligations under Informed Consent provisions, to ensure the rights of their patients to be free from medical or scientific experimentation or treatments without the person's full, free and informed consent.[20] They advocate using their lawful right to freedom of expression and political communication, using emerging peer-reviewed scientific evidence and objective data to protect the security of persons and adequate standards of care of their patients.[21] They advocate for Patients who are being denied their right to life and security of person under government dictates, which refuse organ transplantation to patients that do not want to risk a provisionally approved gene-based vaccine. Denying life

[18] 011.pdf (parliament.qld.gov.au)
[19] Statement of Compatibility (parliament.qld.gov.au)
[20] See section 17(c) of the Human Rights Act 2019 (legislation.qld.gov.au)
[21] Letter-to-ATAGI-TGA-FedHealth-8MarchFINALsignatures2.pdf (covidmedicalnetwork.com)

saving surgery is a true example of breaching human rights and being a threat to public health[22].

Recommendation:

AMPS has shown ongoing acts by regulators properly to be seen as *ultra vires* at law. AMPS members recommend Health Professionals be urgently returned their right to advocate for the best interests of their patients and community, using peer-reviewed scientific evidence without being intimidated and threatened with immediate regulatory action by AHPRA and national boards. If AHPRA and the boards have concerns about a practitioner's conduct resulting from questioning the public health messaging, where no patient complaint or harm can be clearly demonstrated, they should convene a panel to review the scientific evidence. No immediate registration action should be taken without open and transparent scientific discussion.

In light of the foregoing AMPS recommend proposed amendment section 59(5) instead read:

> *However, if the health ombudsman is satisfied it is necessary to do so to ensure the health and safety of an individual or the public,* ***based upon information demonstrating a real and imminent threat of physical harm, or evidencing actual physical harm, to a patient or patients or the public,*** *the health ombudsman may take immediate registration action without complying with subsections amended (2) to (4)*

It follows AMPS recommend proposed amendment section 159E(1)(b) to the National Law instead read:

> *reasonably believes it is necessary to take urgent action to issue the interim prohibition order to protect public health or safety,* ***based upon information demonstrating a real and imminent threat of physical harm, or evidencing actual physical harm, to a patient or patients or the public***

Chapter 2 Amendment 20 inserting new Part 8AA Public statements

Proposed new section 90AA **Making of public statement,** reads in part:

(1) The health ombudsman may make a public statement about a person if—

(b) the health ombudsman reasonably believes that—

(i) because of the person's conduct, performance or health, the person poses a serious risk to persons; and

[22] Queensland Health confirms organ transplant recipients need to be vaccinated for COVID | 7NEWS

(ii) it is necessary to issue a public statement to protect public health or safety.

In respect of proposed section 90AA(1)(b) shown above,our membership has expressed serious concerns these amendments provide a singular public officer too much power and discretion to arbitrarily and publicly name, shame and blame Health Professionals for questioning or challenging public policy directives. This denies health practitioners the presumption of innocence, natural justice, and fair due process in light of the minimal response time afforded to a person the subject of the sections. Such powers should only be afforded and exercised in circumstances where evidence demonstrates objective patient harm. Scientific disputes need to be resolved in an open forum where peer reviewed scientific evidence and objective data can be debated and analysed. Liability protection for making potentially defamatory statements in "good faith", is another broad and discretionary power that can be used by the government to encourage behaviour change and compliance that could further curtail civil liberties, and the ability of Health Professionals to afford their patients and clients the information required for true and proper Informed Consent.

The Statement of Compatibility outlines:

> *'Disclosure of any of this information could have a significant adverse impact on a person's private life and reputation. The exercise of one of these powers could hamper a practitioner's ability to continue to work with others in their profession, or even effectively bring their career to an end. In assessing the extent of the harm, it must be remembered that the information relates to the practitioner's own actions and that any loss of reputation may be the foreseeable consequence of those actions.*[23]"

This above Statement sets forth the concerns of AMPS members, namely these sections and powers as currently proposed, being used to threaten Health Professionals with public shaming and career destruction, being a power capable of being used as a tool of oppression to further silence any dissent as demonstrated particularly throughout 2021 into 2022, of any expert views held by Health Professionals perceived as contrary to government health messaging.

These amendments confer legislative powers that further enable a public servant to unethically coerce Health Professionals into compliance with Government narratives. We fail to see how public health and safety is served by codifying compliance with Government public health messaging that may, as has been demonstrated during this pandemic, be unsupported by any publicly available evidence.

These proposed amendments are also silent as concerns a Health Practitioner's right to rely on evidence based research and objective data, together with the type of objective assessment the Ombudsman should undertake when receiving such evidence. It is well acknowledged Health Professionals abide by an international code of ethics which clearly state they owe their patients complete loyalty and all scientific resources available, when

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[23] Statement of Compatibility (parliament.qld.gov.au)

advocating for patients and the public.[24] These ethical undertakings must be respected and restored to Health Practitioners, and seen as concomitant with their rights of political communication and freedom of expression, to advocate for the wellbeing and best interests of their patients and the larger community.[25]

Recommendation:

AMPS does not support the proposed amendments to 90AA . These powers should be restricted to demonstrated patient harm. As currently proposed these powers could permanently damage the reputation and career of an innocent Health Professional . Furthermore, these powers could be used to enforce compliance through threats of public shaming.

In light of the foregoing AMPS recommend proposed new section 90AA(1) instead read:

> *(b) the health ombudsman may make a public statement about a person if —*
>
> *(i) the health ombudsman reasonably believes* ***there is sufficient information demonstrating a real and imminent threat of physical harm, or evidencing actual physical harm, to a patient or patients or the public,*** *it is necessary to issue an urgent public statement to protect public health or safety.*

Chapter 2 Amendment 29 to section 279 (Notice to employers about particular serious matters)

The amendments to section 279 propose new subsections (3)(a),(c), and (4A) that read:

> *(3) The health ombudsman may also give notice of the action mentioned in subsection (1) to—*
>
> *(a) a person who the health ombudsman believes has previously been an employer of the health practitioner; or*
> *(b) other health practitioners with whom the health practitioner shares premises, if the practitioner—*
>
> *(i)is self-employed; and*
>
> *(ii)shares the cost of the premises with the other health practitioners; or*

[24] WMA International Code of Medical Ethics – WMA – The World Medical Association
[25] Human Rights Bill 2019 (legislation.qld.gov.au)

(c) other health practitioners with whom the health practitioner has previously shared premises, if, at the time the premises were shared, the practitioner—

(i)was self-employed; and

(ii)shared the cost of the premises with the other health practitioners.

(4A) Also, the health ombudsman may give notice under subsection (3)(a) or (c) only if the health ombudsman believes that at the time the health practitioner was employed or shared the premises, the practitioner's health, conduct or performance posed—

(a)a risk of harm to a person or a class of persons; or

(b)a risk to public health or safety.

The current subsection 279(3) in force reads:

The health ombudsman may also give notice of the immediate action, the investigation or the issue or variation of the prohibition order, to other health practitioners with whom the health practitioner shares premises if—

(a) the health practitioner is self-employed; and

(b) the health practitioner shares the cost of the premises with the other practitioners.

Proposed new subsections (3)(a),(c), and (4A) serve no practical purpose for preventing any immediate or future threat, in the context of '*a risk to public health or safety*'.

The subsections seek to empower the informing of ***past*** employers and/or ***past*** colleagues of a present issue under investigation. And this is the critical issue - the proposed subsections empower the ombudsman to essentially '*inform on*' a Health Professional who is the subject of a present investigation or action, yet to be finalised, which investigation or action may be the subject of possible appeal.

In both instances - present investigation or action - possible appeal - the Health Professional the subject of inquiry stands every reasonable chance of an investigation or action ultimately finding the Health Practitioner has no case to answer, as equally there remains every reasonable chance a subsequent appeal will find in the favour of the Health Professional, thereby vacating all previous and punitive findings and orders made against the Health Professional.

Therefore subsections (3)(a),(c), and (4A) dangerously seek to preempt inquiry outcomes and appeal outcomes, by essentially allowing the ombudsman to deem the Health Professional the subject of an investigation or action as *Guilty,* (or at the very least convey a strong implication of guilt), prior to conclusive investigation findings, and before any potential appeal has been lodged.

While further, these powers seek to grant the ombudsman the right to essentially inform ***past*** colleagues and ***past*** employers of present actions being undertaken by the ombudsman, none of which is final, where informing past colleagues and past employers serves no other purpose than to potentially defame the Health Professional the subject of a present investigation or action, who has yet to receive conclusive findings, being findings that very possibly become the subject of an appeal, which appeal may very possibly clear the Health Professional. In other words, the subsections entitle the ombudsman to partake in defamation, before final quasi-judicial processes or appellate Tribunal decisions have been returned.

Thus subsections (3)(a),(c), and (4A) can only be viewed as yet another tool capable of being used to intimidate Health Professionals the subject of an investigation or action being undertaken by the ombudsman.The opportunity to use these subsections in a threatening manner for coercing a Health Professional to submit to Orders or Conditions or provide Undertakings to the ombudsman the Health Professional might not otherwise agree to, but for the sake of avoiding having their reputation and career potentially destroyed by an ombudsman exercising the powers proposed to be granted under these subsections, is clear and obvious.

These subsections serve no practical positive social good. These subsections do not prevent a risk to public health, as they concern ***past*** employers and ***past*** colleagues. These subsections are another example of legislative overreach for providing the ombudsman with further tools by which to intimidate Health Professionals.

Recommendation:

AMPS does not support proposed subsections (3)(a) and submits subsection (3)(a) must be deleted.

AMPS does not support proposed subsections (3)(c) and submits subsection (3)(c) must be deleted.

AMPS does not support proposed subsections (4A) and submits subsection (4A) must be deleted.

AMPS does support the current version of section 279 in force under the Health Ombudsman Act 2013.

Chapter 2 Amendment 30 to section 280 (Notice to employers about particular QCAT decisions)

The amendments to section 280 essentially propose new subsections (3)(a),(c), and (4) that read:

> *(3) The health ombudsman may also give notice of the decision to—*
>
> *(a) a person who the health ombudsman believes has previously been an employer of the registered health practitioner; or*
>
> *(b) other health practitioners with whom the registered health practitioner shares premises, if the practitioner—*
>
> *(i) is self-employed; and*
>
> *(ii) shares the cost of the premises with the other health practitioners; or*
>
> *(c) other health practitioners with whom the registered health practitioner has previously shared premises, if, at the time the premises were shared, the practitioner—*
>
> *(i) was self-employed; and*
>
> *(ii) shared the cost of the premises with the other health practitioners.*
>
> *(4) However, the health ombudsman may give notice to a person under subsection (3)(a) or (c) only if the health ombudsman believes that at the time the registered health practitioner was employed or shared the premises, the practitioner's health, conduct or performance posed—*
>
> *(a)a risk of harm to a person or a class of persons; or*
>
> *(b)a risk to public health or safety.*

The current section 280 in force reads:

> *(1) This section applies if, in a proceeding to which the health ombudsman is a party, QCAT decides a matter concerning a registered health practitioner.*
>
> *(2) The health ombudsman must give notice of the decision to each person who the health ombudsman believes is an employer of the practitioner.*
>
> *(3) The health ombudsman may also give notice of the decision to other health practitioners with whom the health practitioner shares premises if—*

(a) the health practitioner is self-employed; and

(b) the health practitioner shares the cost of the premises with the other practitioners.

Proposed new subsections (3)(a)&(c), and (4) serve no practical purpose for preventing any immediate or future threat, in the context of '*a risk to public health or safety*'.

The subsections seek to empower the informing of ***past*** employers and/or ***past*** colleagues of a present decision by QCAT. And this is the critical issue - the proposed subsections empower the ombudsman to essentially '*inform on*' a Health Professional who is the subject of a QCAT decision, which decision may be the subject of possible appeal by the Health Professional.

In each instance of a QCAT decision a Health Professional stands every reasonable chance a subsequent appeal will find in the favour of the Health Professional, thereby vacating all previous and punitive findings and orders made against the Health Professional.

Therefore subsections (3)(a)&(c), and (4) dangerously seek to preempt appeal outcomes, by essentially allowing the ombudsman to deem the Health Professional the subject of a QCAT decision as conclusively *Guilty,* (or at the very least convey a strong implication of guilt), prior to the Health Professional having had the opportunity to lodge an appeal, where any such appeal may very well determine the opposite of a QCAT decision.

While further, these powers seek to grant the ombudsman the right to essentially inform ***past*** colleagues and ***past*** employers of QCAT decision prior to any potential appeal, where informing ***past*** colleagues and ***past*** employers serves no other purpose than to potentially defame the Health Professional the subject of a QCAT decision that may very possibly become the subject of an appeal, which appeal may very possibly clear the Health Professional. In other words, the subsections entitle the ombudsman to partake in defamation, before allowing for a possible appellate decision being returned.

Thus subsections (3)(a)&(c), and (4) can only be viewed as yet another tool capable of being used to intimidate a Health Professional the subject of a QCAT decision. The opportunity to use these subsections in a threatening manner for coercing a Health Professional to submit to Orders or Conditions or provide Undertakings to QCAT the Health Professional might not otherwise agree to, but for the sake of avoiding having their reputation and career potentially destroyed by an ombudsman exercising the powers proposed to be granted under these subsections, is clear and obvious.

These subsections serve no practical positive social good. These subsections do not prevent a risk to public health, as they concern ***past*** employers and ***past*** colleagues. These subsections are another example of legislative overreach for providing the ombudsman with further tools by which to intimidate Health Professionals.

Recommendation:

AMPS does not support proposed subsections (3)(a)&(c), and (4) and submits subsections (3)(a)&(c), and (4)must be deleted.

AMPS does support the current version of section 280 in force under the Health Ombudsman Act 2013.

Proposed Amendments to the National Law

Chapter 3 Part 2 Amendments 33 and 34 to section 3

It is proposed to delete current subsection 3 of section 3 of the National Law which reads:

> *The guiding principles of the national registration and accreditation scheme are as follows—*
>
> > *(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;*
> >
> > *(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;*
> >
> > *(c) 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 place of the proposed deletion of subsection 3 above is a proposed new section 3A which reads:

> ***Guiding principles***
>
> *(1) The main guiding principle of the national registration and accreditation scheme is that the following are paramount—*
>
> > *(a) protection of the public;*
> >
> > *(b) public confidence in the safety of services provided by registered health practitioners and students.*
>
> *(2) The other guiding principles of the national registration and accreditation scheme are as follows—*

(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;

(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;

(c) 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.

Proposed new section 3A is not necessary nor warranted.

Section 3A serves only to stigmatise Health Professionals, where it effectively suggests in 3A(1)(a) that the public needs to be protected from Health Professionals by National Boards and AHPRA. This is immediately followed by the improper and suggested inference contained in 3A(1)(b), that public confidence has been affected in health services due to unsafe health services, having been provided by Health Professionals, requiring again National Boards and AHPRA to make health services safe, for restoring and/or maintaining public confidence.

The theatre here is astounding, false by the inferences and implications that arise, and completely unwarranted, particularly where Australian public confidence has been betrayed by National Boards and especially AHPRA, when AHPRA undertook the roll to gag, sanction, or seek to have deregistered those Health Professionals, who expressed their expert views and opinions in disagreement with government messaging towards what are now being called to account, namely, the so called Covid-19 'vaccines' that have and continue to cause unprecedented deaths and injuries across the Australian community, being gross Adverse Events causally associated with these 'vaccines'[26].

To this day the AHPRA gag order by its Position Statement of 9 March 2021, continues to threaten to sanction or deregister Health Professionals from even discussing with their patients for the purpose of providing the information required for Informed Consent, these historically unequalled levels of Adverse Events, both in this country and internationally, being a discussion Health Professionals are also threatened by AHPRA not to raise publicly and openly, despite being a matter of grave and serious National public concern, properly to be deemed an Emergency and failure in government messaging, and a gross failure by each National Board that remains mute and by implication in support of this government messaging[27][28].

Yet by the proposed amendments to section 3A, the unneeded new wording would instead seek to cast innuendo and negative aspersions on Health Professional, suggesting falsely the public needs protection from Health Professionals, through the actions of supervision and sanctions by National Boards and AHPRA.

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[26] https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-26-05-2022
[27] https://openvaers.com/covid-data
[28] https://www.adrreports.eu/en/disclaimer.html

In light of the current and ongoing National crisis in respect of Covid-19 ‘vaccines’ and the unqualified position taken by AHPRA and National Boards in support of same, without any provision for Health Professionals to call AHPRA and these National Boards to account for maintaining government messaging at all costs, despite the deaths and injuries that continue to mount daily from Covid-19 ‘vaccines’, AMPS regards this ongoing situation an absurd and tragic comedy when asked to submit on proposed amendments of this nature, which seek to suggest an alternate reality affecting the confidence of Australians in a public health system that denies them Informed Consent, let alone the ability to engage in educated and informed dialogue with Health Professionals at a community level, with Health Professionals who are bearing witness to an unfolding National tragedy caused by government misinformation and oppressive bullying and gagging tactics, being used by AHPRA and National Boards to repress Health Professionals from performing their duties towards their patients.

In the result, the actual reality on the ground for Australians and Health Professionals over the past nearly 2&½ years has been:

> AHPRA and National Boards, and particularly the National Medical Board, have increasingly failed and continue to fail in their duties to protect the public; and
>
> AHPRA and National Boards, and particularly the National Medical Board, have continued to erode and destroy public confidence in the Australian health system; and
>
> AHPRA and National Boards, and particularly the National Medical Board, have by their actions on the one hand, and by their silence on the other, undermined and continue to undermine the safety of services provided to Australians, particularly in respect of Informed Consent, and the ongoing National catastrophe surrounding the continued government messaging in respect of Covid-19 ‘vaccines’ as ‘*Safe and Effective*’; and
>
> AHPRA and National Boards, and particularly the National Medical Board, have by their actions on the one hand, and by their silence on the other, ensured health services have not been provided safely to Australians, particularly where cheap, safe, and effective early treatments for Covid-19 have been denied to Australians, and particularly in light of the historically unprecedented numbers of deaths and injuries causally associated with Covid-19 ‘vaccines’.

Recommendation:

AMPS does not support the proposed amendments to section 3.

AMPS does not support the proposed new section 3A.

AMPS does support the current version of section 3 in force under the National Law.

Chapter 3 Amendment 84 to section 206 (National Board to give notice to registered health practitioner's employer and other entities)

Amendment 84 seeks to introduce new subsections (2), (3), and (4) to section 206.

Relevantly subsections (2)(b) and 3(b) read:

> (2) If the practice information given to the National Board, or of which the Board becomes aware, is information referred to in paragraph (a) of the definition of ***practice information*** in section 132(4) and includes the names of other registered health practitioners, the Board, as soon as practicable after an event specified in subsection (1)(a) occurs, may give written notice of the decision to—
>
> > *(b) the named registered health practitioners with whom the practitioner previously shared premises and the cost of the premises if the Board reasonably believes the practitioner's health, conduct or performance while the practitioner shared the premises with the registered health practitioners posed—*
> >
> > *(i) a risk of harm to a person or a class of persons; or*
> > *(ii) a risk to public health or safety.*
>
> *(3) If the practice information given to the Board, or of which the Board becomes aware, is information referred to in paragraph (b) of the definition of practice information in section 132(4), the Board, as soon as practicable after an event specified in subsection (1)(a) occurs—*
>
> > *(b) if the practitioner had a previous practice arrangement with an entity named in the information—may give written notice of the decision to the entity if the Board reasonably believes the practitioner's health, conduct or performance while the practitioner had a practice arrangement with the entity posed—*
> >
> > *(i)a risk of harm to a person or a class of persons; or*
> > *(ii)a risk to public health or safety.*

Proposed new subsections (2)(b) and (3)(b) serve no practical purpose for preventing any immediate or future threat, in the context of '*a risk to public health or safety*'.

The subsections seek to empower the informing of ***past*** employers and/or ***past*** colleagues of a present investigation. And this is the critical issue - the proposed subsections empower

a Board to essentially '*inform on*' a Health Professional who is the subject of a present investigation or action, yet to be finalised, which investigation or action may be the subject of possible appeal.

In both instances - present investigation or action - possible appeal - the Health Professional the subject of inquiry stands every reasonable chance of an investigation or action ultimately finding the Health Practitioner has no case to answer, as equally there remains every reasonable chance a subsequent appeal will find in the favour of the Health Professional, thereby vacating all previous and punitive findings and orders made against the Health Professional.

Therefore subsections (2)(b) and (3)(b) dangerously seek to preempt inquiry outcomes and appeal outcomes, by essentially allowing the a Board to deem the Health Professional the subject of an investigation or action as *Guilty,* (or at the very least convey a strong implication of guilt), prior to conclusive investigation findings, and before any potential appeal has been lodged.

While further, these powers seek to grant a Board the right to essentially inform ***past*** colleagues and ***past*** employers of present actions being undertaken by a Board or other body, none of which is final, where informing ***past*** colleagues and ***past*** employers serves no other purpose than to potentially defame the Health Professional the subject of a present investigation or action, who has yet to receive conclusive findings, being findings that very possibly become the subject of an appeal, which appeal may very possibly clear the Health Professional. In other words, the subsections entitle a Board to partake in defamation, before final quasi-judicial processes or appellate Tribunal decisions have been returned.

Thus subsections (2)(b) and (3)(b) can only be viewed as yet another tool capable of being used to intimidate a Health Professional the subject of an investigation or action being undertaken by a Board or other body. The opportunity to use these subsections in a threatening manner for coercing a Health Professional to submit to Orders or Conditions or provide Undertakings to a Board or other investigating body the Health Professional might not otherwise agree to, but for the sake of avoiding having their reputation and career potentially destroyed by a Board exercising the powers proposed to be granted under these subsections, is clear and obvious.

These subsections serve no practical positive social good. These subsections do not prevent a risk to public health, as they concern ***past*** employers and ***past*** colleagues. These subsections are another example of legislative overreach for providing a Board with further tools by which to intimidate Health Professionals.

Recommendation:

AMPS does not support proposed subsections (2)(b) and (3)(b) and submits subsections (2)(b) and (3)(b) must be deleted.

AMPS does support the current version of section 206 in force under the National Law.

Chapter 3 Part 21 Amendments 93 to 98

Chapter 3 Part 21 Amendments 93-98 seek to introduce a new Division 7A under Part 8 of the National Law.

Division 7A concerns itself with prohibition orders against an 'unregistered person'.

Earlier in Chapter 3 Part 4 Amendment 38, new Definitions are proposed for the National Law, however an 'unregistered person' is introduced or defined.

Amendment 93 for new Division 7A proposes new Definitions for Part 7A, but again 'unregistered person' is not mentioned. However Amendment 93 appears to suggest an ‘unregistered person’ is a person ***who was registered as a health practitioner***, where it states:

> ***regulatory body****, in relation to a person, means any of the following—*
>
> *(a) the National Agency;*
>
> *(b) for a person who is or was a registered health practitioner—a National Board for a health profession in which the person is or was registered.*

Amendment 94 introducing new section 159B under Division 7A proposes new Definitions but again 'unregistered person' is not mentioned. However the following definition under proposed new section 159B appears to provide the true intent and purpose for proposed new Division 7A:

> `***interim prohibition order****, in relation to an individual named in the order, means an order in relation to any or all of the following—*
>
> *(a) prohibiting the individual from doing either or both of the following—*
>
> *(i) providing a specified health service or all health services;*
>
> *(ii) taking or using a specified title or any title protected under Subdivision 1 of Division 10 of Part 7*

Division 7A empowers AHPRA or a National Board to issue prohibition orders against a Health Professional who has chosen to no longer remain registered with a National Board, from using their specified title when they were registered, or practising or providing the same health services they provided when they were registered with a National Board.

The reading of these amendments suggests AHPRA and the National boards will have an unchallengeable legislative monopoly over all regulatory services of the more than 800,000 Australian Health Professionals. Since AHPRA sets the standards and policies that all registered health practitioners MUST meet, the idea that they can never be challenged, even in the presence of obvious regulatory failure to protect the health and safety of the public is of great concern to our members.[29] This division appears to guarantee no future competitor to AHPRA and the National Boards can ever be established to challenge this monopoly.

In other words, proposed new Division 7A operates as a penal Division for Health Professionals no longer registered with a National Board from any longer providing health services; and Division 7A operates as a formidable deterrent to all Health Professionals contemplating opting-out of the National Law system, where to do so will bring upon any such Health Professionals the wrath of prohibition orders, public shaming, and possible fines and imprisonment from AHPRA or their former National Board.

Recommendation: AMPS does not support division 7A and recommends it be rejected from the National Law amendments.

Division 11 Subdivision 6 section 136 Directing or inciting unprofessional conduct or professional misconduct

Section 136 as currently in force under the National Law reads:

> *(1) A person must not direct or incite a registered health practitioner to do anything, in the course of the practitioner's practice of the health profession, that amounts to unprofessional conduct or professional misconduct. Maximum penalty—*
>
> > *(a) in the case of an individual—$30,000; or*
> >
> > *(b) in the case of a body corporate—$60,000.*
>
> ***(2) Subsection (1) does not apply to a person who is the owner or operator of a public health facility.***

A public health facility under the National Law is defined as:

> *(a) a public hospital; and*

[29] https://www.ahpra.gov.au/about-ahpra/who-we-are.aspx

(b) a public health, teaching or research facility.

The explanatory notes outline that:

> "*Direct and incite offences were included in the National Law to address concerns about the increased corporatisation of health services and the potential for non-practitioner directors and managers to influence employee health practitioners*[30]*."*

The statement of compatibility goes on to state :

> *The objective of section 136 of the National Law is to prevent people from influencing health practitioners to practise in a way that compromises client care and clinical independence.*[31]*'*

On behalf of their citizenry, State and Territory governments own and operate the lion's share of health facilities and hospitals throughout Australia.

By any reading of subsection 136(2) and it should be immediately apparent to all, that State and Territory governments have been granted immunity from *directing or inciting unprofessional conduct or professional misconduct* in those Health Professionals they employ.

This is a dangerous and indeed potentially lethal privilege granted to health bureaucrats and administrators responsible for the running and maintenance of public health facilities.

Bestowing such a dangerous privilege upon bureaucrats and administrators opens the door for abuse by those who direct them, chiefly Health Ministers and Chief Health Officers.

Over the last 18 months there has been clearly seen across Australia a concerted campaign conducted in unison, by Health Ministers and Chief Health Officers and State Premiers and Chief Ministers, for marketing and promoting Covid-19 'vaccines' as *Safe and Effective*.

Yet Australia's own Therapeutic Goods Administration still continues to only Provisionally Approve these gene-therapy drugs, while acknowledging there is no medium or long term Safety Data in respect of these drugs, as they are each still the subject of Clinical Trials, and as such, are properly deemed experimental, meaning in truth Australians who have received them, have themselves participated in a Clinical Trial, which the former Federal Health Minister Greg Hunt publicly acknowledged[32].

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[30] Health-Practitioner-Regulation-National-Law-and-Other-Legislation-Amendment-Bill-2022---Explanatory-Notes-8010.pdf (parliament.qld.gov.au)

[31] https://documents.parliament.qld.gov.au/tp/2022/5722T634-6AD2.pdf

[32] https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/interview-with-david-speers-on-abc-insiders-on-the-covid-19-vaccine-rollout

Public hospitals and public health facilities were never intended to serve as Clinical Trial sites, to be used for the promotion and administration of unproven and potentially dangerous drugs to the general public. But this is exactly what has occured in respect of Covid-19 gene-based therapies, which as detailed further above, have now been shown to produce catastrophic injuries and deaths across those communities that received them, both here and internationally.

Is this why subsection 136(2) was created? In order to shield State and Territory governments from liability, after having directed their Health Professionals to essentially perform the role of Clinical Trial staffers, for the promotion and administration of an unknown and novel form of a so-called new ‘vaccine’, particularly to protect these Public Hospitals and facilities from liability, for directing their Doctors and Nurses to administer experimental substances, for which no Doctor or Nurse could assist any patient with full Safety information, for the purpose of ensuring full and complete Informed Consent?

The roll-out of the Covid-19 ‘vaccines’ has and continues to demonstrate a real world example of public health facilities and the State and Territory governments who control them, directing and inciting professional misconduct and unprofessional conduct in the Health Professionals who staff them.

The continuing tragedy of the Covid-19 ‘vaccines’ also demonstrates the dangerous use and effect subsection 136(2) can achieve, for assisting and facilitating Public Health Orders requiring mandatory vaccination in segments of the workforce, where to date throughout all Australian States and Territories, not one responsible Health Minister or Chief Health Officer has provided to their citizens, the evidence-based science supporting, explaining, and justifying these historically unprecedented violations of bodily autonomy.

With these so called Public Health Orders in hand, and aided by the protection afforded by subsection 136(2), State and Territory Health Professionals staffing public hospitals and facilities have been ordered to assist with the promotion and administration of these experimental drugs to the community, for achieving Public Health Order objectives, to the derogation and indeed demise of the ethical duties owed by these Health Professionals, towards each patient, to Do No Harm, when it was clearly known that no Health Professional could ever know if these drugs would result in deaths and injuries across the community, which they have subsequently proven to have in fact caused.

Consequently subsection 136(2) has enabled State and Territory governments to incite and direct unprofessional conduct, in the Health Professionals employed through public hospitals and facilities, freed from liability and responsibility constraints normally found at law. Thus we have witnessed a Master Class in government health messaging, though failing at every turn to provide the evidential scientific basis behind the messaging, and concurrent Health Orders, proceed unabated towards achieving its objectives, by this secure ability to direct Health Professionals to do government bidding, freed from liabilities that would otherwise give every other private sector organisation pause, before proceedings down such a reckless, unknown, and dangerous path.

This one subsection epitomises everything our oaths and codes were designed to protect the public from. Political and Governmental intrusion into the medical field resulting in patient compromise and a lack of clinical independence through a blatant overriding of freedom of

speech, conscience, informed consent and bodily autonomy. Public confidence, health, and safety can never be achieved while the Government and their bureaucrats have legislative protection to direct and incite practitioner misconduct, overriding human rights and medical ethics.

Recommendation:

AMPS does not support subsection 136(2) under the National Law and submits subsection 136(2) must be deleted from the National Law.

Conclusion

This review of proposed amendments places onto the public record many serious concerns AMPS and its members have towards the manner in which '*public health and safety*' is being interpreted and applied in Australia.

While the intent of the proposed amendments may be amiable, the broad and discretionary nature of many of the proposed changes in practice allow for catastrophic outcomes for public health and safety.

Historical evidence suggests laws which enforce compliance with state laws through the muzzling of free speech, breaching multiple human rights, often are found to facilitate gross human rights abuses. The Declaration of Geneva, the Hippocratic oath, the International Code of Ethics and our Codes of Conduct, create a framework that prioritises our patients as our primary concern using all scientific evidence available to advocate for their best interests.

While AMPS supports the inclusion of transparency and accountability in the guiding principles we cannot in good conscience support broad discretionary '*public health and safety*' provisions, in the unchecked hands of quasi-judicial National Boards and AHPRA, which rather than increasing trust and honesty in the profession, will further erode public confidence, by enshrining in law compliance with government public health narratives, over their individual well being and best interests.

There must be provisions within the legislation that allow Health Practitioners to publicly debate the public health orders where they reasonably believe there is a risk of harm.

Expertise in emerging disease is not confined to Public Health Bureaucrats. Engagement with the frontline in an open and transparent manner, without threats of reprisal, should form part of the public consultation process.

Consultation with our members has demonstrated near consensus views and a belief that Health regulation is not being used to protect the public from legitimate professional

misconduct, but being used to silence Health Professionals from questioning government policy as a matter of routine, not exception.

A litany of recent and continuing so called Public Health Orders have demonstrably infringed and violated human rights and medical ethics, and appear to Health Professionals to have caused arguably more harm than benefit to the public health of this nation.

To legitimately protect the Australian public AMPS believes practitioners must be free to advocate for their patients without threat or intimidation.

Instead and as is still seen in the context of SARS-CoV-2, when practitioners have sought to advocate for their patients about whom only they possess intimate health knowledge, National Boards and AHPRA instead adopted a zero discourse policy, without any consultation, and went on the offensive, branding any practitioner voicing their concerns or seeking to protect their patients, as being the few who were acting counter '*to generally accepted views*'. This approach by National Boards and AHPRA was trite, disingenuous, and dismissive of the skills and expertise held by not a few but many Health Professionals, who bravely stood to express truths not in keeping with government messaging, particularly the government messaging that feared and continues to fear providing its evidence and reasoning, for Public Health Orders and a dangerous insistence with the '*Safe and Effective*' sloganeering.

AMPS members demand their implied right to political communication to publicly advocate for what they believe is in the best interests of their patients and communities, using peer reviewed scientific evidence and objective data, especially if scientific evidence and data undermines government public health messaging that consistently fails to produce scientific evidence in support of its assertions - *Safe and Effective* - or Public Health Orders directing the community to participate in a Clinical Trial for an untested drug.

Truth, transparency and open scientific discourse in medicine and throughout the greater health system, is the only way to provide Health Professionals and patients with safe and efficient healthcare.

Right now public confidence and trust in our institutions needs to be rebuilt, after the recent and continuing failings of Australian governments and health bureaucrats in response to SAR-CoV-2.

Seeking at this time to award the Queensland Health Ombudsman, AHPRA, and National Boards with even more discretionary and misguided powers to oppress Health Professionals, and thereby their patients, is not the path to take for the necessary rebuilding confronting every organisation and Health profession.

AMPS respectfully submits the above for the Committee's due considerations.