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POSITION STATEMENT

Role of the doctor

2026

This document outlines the Australian Medical Association's position on the role of the doctor in the Australian health system. It outlines the core knowledge, skills and unique qualities of medical practice that make medical practitioners a pivotal part of Australia's health system. In this position statement the term 'doctor', which is the term commonly used in the community, refers to a medical practitioner, and the terms are used interchangeably. References to prescribing relate to the prescription and ongoing medicines management of Schedule 4 and Schedule 8 medications.

Doctors define and uphold the scope of medical practice, including diagnosis, prescribing, clinical risk management, and stewardship of resources. These responsibilities require the breadth and depth of medical education, supervised training, and continuing professional development.

Doctors are medical experts who assess undifferentiated problems, synthesise complex information, make and explain diagnoses, estimate prognosis, provide treatment, and manage risk under uncertainty. They lead clinical teams and are ultimately clinically accountable for patient care.

Doctors teach, lead, and advocate — educating the next generation, improving systems, upholding professionalism, and speaking on behalf of patients and communities to secure safe, equitable, and sustainable care.

1. Trust and the patient-doctor relationship

1.1. Doctors partner with patients based on trust. They communicate risks, benefits, uncertainties, and alternatives clearly, and they support patients in making informed choices that reflect each person's values and circumstances.

1.2. Doctors are advocates for their patients. Doctors support patients to navigate the health system, to understand options and risks, and to access timely, appropriate care — particularly when patients face barriers related to cost, geography, disability, culture, language, or complexity.

1.3. The doctor–patient relationship is founded on acting in the patient's best interests and maintaining mutual trust, as outlined in the codes of practice and ethics.

1.4. Doctors respond to their patients' needs and are prepared to take responsibility for their care. If they cannot fulfil these roles, they are expected to refer the patient to a colleague who can.

1.5. The knowledge and judgement of doctors is trusted. Doctors possess the ability to interpret complex information and support patients in understanding their condition, possible causes,

and appropriate preventive or treatment options. They explain risks, benefits, and uncertainties, supporting patient decision-making whenever possible.

1.6. Doctors have a duty to strengthen health literacy among their patients by communicating clearly, checking understanding, and proactively countering misinformation, particularly online. As medical information evolves, doctors clarify medical guidance and research, and seek further assistance for the patient when required.

1.7. Doctors may decline to provide tests or treatments that offer little or no clinical benefit or that may cause harm. They explain the reasons for this approach and support patients with evidence‑based alternatives, recognising that digital misinformation and consumer pressure can drive requests for low‑value care.

1.8. Doctors and health services must provide clear, timely information about fees, rebates, and likely out‑of‑pocket costs, using the AMA's informed financial consent (IFC) templates and guidance to support patient decision‑making and financial health literacy.

1.9. Doctors practise stewardship at the patient level by supporting informed decision-making about risks, benefits, uncertainties, alternatives, and (where relevant) financial implications, helping patients avoid unnecessary tests, treatments, and harms.

2. Diagnosis, prognosis and complex decision-making

2.1. Diagnosis is a key feature of a doctor's unique expertise in medical practice. This core skill is based on both knowledge and judgement. It involves responding to a patient's presentation of illness, prioritising and synthesising information, making a clinical assessment, and then taking responsibility for that assessment and following it through, including continual reassessment considering new information.

2.2. The adequate application of history taking, physical examination, and interpreting investigations requires knowledge and understanding of the full range of clinical sciences. This allows trained medical practitioners to consider the full breadth of possible diagnoses in assessing and treating a patient. Knowledge of the natural history of disease allows doctors to discuss likely clinical course and prognosis (including uncertainties), inform patients and their carers and underpin treatment options and choices.

2.3. Doctors manage complexity and risk in situations characterised by uncertainty and where error can have serious consequences. The skills required for such management are achieved through broad, deep training and rigorous certification.

2.4. Doctors are trained to apply clinical guidelines and protocols but also to exercise judgement and decision-making beyond clinical protocols or where clinical guidelines are inappropriate or unavailable. Adapting clinical guidelines to individual patient circumstances by assimilating scientific knowledge, evidence-based practice and individualised context is a defining skill of medical practitioners.

2.5. Digital tools, including clinical decision support and AI can enhance care but cannot replace clinical judgement. Doctors must oversee their use, ensure data quality, safeguard privacy, and remain accountable for clinical decisions. Systems must embed medical governance of algorithms, transparency about capabilities and limitations, robust escalation pathways when

outputs conflict with clinical assessment, and interoperability to reduce administrative burden and improve continuity of care.

3. Scope of practice and clinical governance

3.1. Doctors lead team-based care and are ultimately clinically accountable for diagnosis, risk management, and coordination of the patient's overall care.

3.2. Scope of practice is contextual, and dependent on skills and training, as well as factors such as geography, local resources and supports — both infrastructure and human.

3.3. Policy settings must prioritise medically-led care and collaborative requirements. Health services should embed systems that improve communication, reduce duplication, provide clear accountability frameworks and support continuity and high-value care.[1]

3.4. Diagnosis of undifferentiated illness, prescribing, and clinical risk management are medical functions performed by doctors. Other clinicians contribute their expertise within clinically governed teams.

3.5. Only doctors are trained and certified to autonomously undertake the full scope of medical functions. Independent access to MBS/PBS outside collaborative arrangements risks fragmented care, delayed diagnosis, and adverse medication events.

3.6. Doctors have a responsibility to accurately convey their qualifications and training, so patients are able to clearly identify whether the person providing their clinical care is a medical practitioner. All health providers (individuals and employers) clearly identify their role, qualifications and training. Misuse or dilution of the title "doctor" in clinical settings compromises safety and trust.

4. Professionalism

4.1. Doctors must maintain high personal ethical standards, including abiding by codes of ethics, and show respect to others. Professional standards are enforced by accreditation and registration bodies.

4.2. Doctors are responsible for maintaining their professional development to competently perform their role, including remaining current with medical advances relevant to their scope of practice, and recognising where referral may be necessary to ensure patients receive expert care.

4.3. Doctors are stewards of healthcare resources. Stewardship is responsible, equitable use of health resources to maximise outcomes and reduce waste.

4.4. Doctors should actively avoid recommending tests or treatments that offer little or no benefit and may cause harm — clinical, psychological or financial. The doctor's stewardship role includes

[1] AMA submissions to the Scope of Practice Review call for an independent process with explicit criteria, cautioning against shortcuts that erode training, collaboration and safety.

resisting “indication creep” for new technologies where effectiveness is unproven and avoiding defensive medicine that promotes low-value activity.

5. Leadership in health services in the community

5.1. Doctors take responsibility for clinical outcomes and are uniquely placed to take on leadership roles, including management and leadership of health services, while remaining in active clinical practice.

5.2. Doctors should be supported to use their clinical experience to continuously improve the quality of healthcare, including through audits, and development of clinical standards and guidelines.

5.3. Doctors advance and apply evidence. Doctors practise evidence-based medicine and, where appropriate, contribute to research, clinical audit and evaluation that improve patient care, safety, and health outcomes. Participation in research must be ethical, with informed consent and appropriate governance.

5.4. Doctors advocate locally and nationally for a health system that delivers safe, high-quality, affordable and accessible care, and equity in both access to healthcare and health outcomes. This advocacy includes speaking with and for First Nations peoples, and for communities experiencing disadvantage or under-service, to remove structural barriers and improve health outcomes.

6. Teaching and professional development

6.1. Both initial training and ongoing education are of fundamental importance to doctors’ professional endeavours and patient safety.

6.2. Doctors are trained in basic and clinical sciences, behavioural and social sciences, procedural skills, and complex cognitive skills. Basic training covers all specialty areas and postgraduate training provides expertise in each specialty. Training is certified through demanding examinations and registration.

6.3. There is no substitute for the extensive knowledge of clinical science and the range of clinical skills that underpin medical practice.

6.4. Doctors agree to maintain technical competency through continuing professional development and recency of practice.

6.5. Doctors teach, supervise, mentor and assess doctors-in-training and other learners, model professional conduct, and ensure patients receive safe care while learners develop competence. Doctors sustain the profession through lifelong teaching and learning. Doctors value the mentoring tradition of medical learning where senior or more experienced colleagues pass on their knowledge and skills.

6.6. Doctors-in-training must have clear supervision arrangements, safe delegation boundaries, and access to escalation support when clinical risk increases.

6.7. Doctors need proactive wellbeing programs and confidential support, with employers managing rostering, minimising administrative overload and enforcing zero tolerance for bullying and harassment.

See also:

AMA position statement on Doctors' role in stewardship of healthcare resources 2023

AMA position statement on Data governance and patient privacy 2022

AMA position statement on Immunisation 2025

AMA position statement on Conscientious Objection 2019

AMA position statement on Nurse Practitioners 2022

AMA position statement on Complementary and Alternative Treatments 2025

AMA position statement on Health Literacy 2021

AMA Guide on Informed Financial Consent (IFC) 2024

AMA Code of Ethics 2025

10 Minimum Standards for Prescribing (2019)

Vision for Australia's Health (2024 – 27)