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Australian Health Practitioner Regulation Agency (AHPRA)
Medical Board of Australia

Submission: Review of Good medical practice: a code of conduct for doctors in Australia

Australian Medical Professionals Society (AMPS)

Executive summary

Medicine already has a clear ethical framework. It rests on four principles: beneficence (act for the patient's good), nonmaleficence (do no harm), respect for autonomy, and justice [5]. Every doctor learns them. They are the test any code of conduct should meet.

Good medical practice does not name any of them. The words "beneficence", "nonmaleficence", "autonomy" and "justice" do not appear, and neither does "do no harm". The code says it is consistent with the Declaration of Geneva [3], a pledge of about 200 words. The code itself runs to about 11,000 words and more than 200 numbered clauses, and it reaches into doctors' public comment, their "actions outside work" and "the reputation of the profession" [2].

AMPS put AHPRA's own scoping questions, word for word, to our members, along with the issues we have raised with AHPRA for years [6]. This submission answers each AHPRA question with what our members told us:

- **91%** want the code grounded in core medical ethics: "first, do no harm" and respect for patient autonomy.
- **86%** say acting in the patient's best interests matters most in good care.
- **85%** have held back a professional opinion for fear of a complaint or regulatory action, and **47%** do so often.
- Only **22%** feel safe raising a clinical concern or evidence-based disagreement. **69%** do not.
- Only **12%** are confident the guidelines they follow are free from undue commercial or political influence.
- **84%** want regulatory action limited to clinical practice and patient safety. **91%** say the code should not regulate public comment outside clinical practice at all.

We ask AHPRA and the Medical Board to rebuild the code on the four principles of medical ethics, to protect the doctor-patient relationship from political and commercial interference, and to apply justice to doctors as well as patients. Our recommendations are at the end of this submission.

Medicine's oldest promises and today's code

For more than two thousand years doctors have bound themselves by short, clear promises. The Hippocratic Oath pledged treatment "which will benefit my patients according to my greatest ability and judgment, and I will do no harm or injustice to them" [4]. The World Medical Association's

Declaration of Geneva restates that ethic for modern medicine [3]. Good medical practice claims to be consistent with both [2]. Measured against the four principles, it falls short.

Table 1. The four principles of medical ethics in the Oath, the Declaration of Geneva and Good medical practice

Principle	Hippocratic Oath and Declaration of Geneva	Good medical practice (October 2020)
Beneficence	"Which will benefit my patients according to my greatest ability and judgment" (Oath). "The health and well-being of my patient will be my first consideration" (Geneva).	Doctors must make "the care of patients their first concern" (2.1). But they must also tell patients when their opinion "does not align with the profession's generally held views" (3.2.8), and weigh how their comments reflect "on the reputation of the profession" (2.2).
Nonmaleficence	"I will do no harm or injustice to them" (Oath).	"Do no harm" does not appear. The nearest wording is "Considering the balance of benefit and harm in all clinical-management decisions" (3.2.4).
Autonomy	"I will respect the autonomy and dignity of my patient" (Geneva).	The word "autonomy" does not appear. The informed consent section (4.5) has four points, two of them about fees. It does not mention alternatives, the option of no treatment, or freedom from pressure.
Justice	"I will not permit considerations of ... creed ... political affiliation ... or any other factor to intervene between my duty and my patient". "I will not use my medical knowledge to violate human rights and civil liberties, even under threat" (Geneva).	Protects patients from discrimination (3.4.3), but says nothing on fair process for doctors. Cultural safety is "determined by" others (4.7.2) and by "what individual patients and/or their family believe" (4.8). The vexatious complaints clause binds doctors, not the regulator (10.4).
Length and reach	Declaration of Geneva: about 200 words. It governs the doctor's duty to the patient.	About 11,000 words, 13 sections and more than 200 numbered clauses, plus separate guidelines on social media and other topics. Applies "in all settings", including social media and "actions outside work" (1.2, 2.2).

A code that leaves out the principles every doctor is trained in, and adds tests based on reputation, confidence, consensus and other people's feelings, is not a clinical standard. It gives the regulator wide discretion and gives doctors no clear line to stay behind. Members said so directly:

"First Do no harm (to anyone). Fully informed consent. Patient confidentiality. Patient Dr relationship is primary. Individualised attention and care. Personalised individualised care. Drs must do their own research on an individual patient basis and optimise individual care. Respect patient autonomy." AMPS member

"They are too stringent and focused on restricting practitioners, rather than ensuring best possible care." AMPS member

"The codes of conduct should provide a basic guideline as to community expectations but stop short of micromanaging clinician-patient interactions." AMPS member

Our answers to AHPRA's survey questions

AHPRA's scoping survey asks seven questions of organisations [1]. AMPS put them to members, from 1 to 12 October 2026 [6]. 69% have been registered for more than 20 years. Members could choose more than one option, so percentages show the share of members who chose each one. Our answer to each question is the three options members chose most. Results are for AMPS members only. The Nurses Professional Association of Australia (NPAA) has made a separate submission on the nursing and midwifery codes.

1. Which of the following best describes your organisation?

Our answer: Professional association or peak body, responding on behalf of AMPS members.

2. When is clear guidance on professional behaviour most important?

Our answer: When something goes wrong or harm occurs; when someone is vulnerable or needs support; when there are financial or business interests involved.

AHPRA answer option	Members who chose it
When something goes wrong or harm occurs	62%
When someone is vulnerable or needs support	45%
When there are financial or business interests involved	38%
Other	28%
When someone has a disability or needs additional support to access care	24%
When there are cultural or language differences	17%
When care is provided online or through telehealth	17%
When practitioners communicate publicly or on social media	17%

Doctors want guidance where harm and conflicts of interest arise: nonmaleficence and beneficence. Public and social media comment was among the lowest choices.

"Good care includes recognising when further intervention is not in the patient's best interests, even when the patient requests it." AMPS member

3. Thinking about good care, what matters most about how health practitioners behave?

Our answer: Acting in the patient's best interests; clear and honest communication; treating people with respect.

AHPRA answer option	Members who chose it
Acting in the patient's best interests	86%
Clear and honest communication	72%
Treating people with respect	66%
Involving patients and healthcare consumers in decisions about their care	62%
Listening to people	59%
Protecting privacy and confidentiality	59%

AHPRA answer option	Members who chose it
Understanding and supporting the needs of people with disability	38%
Fair and equitable care	34%
Respecting culture, identity and background	28%
Culturally safe care	28%
Other	24%

The clear first choice is beneficence: acting in the patient's best interests. That is the first line of the Declaration of Geneva. Culturally safe care was among the lowest choices.

4. What concerns you most about how health practitioners behave?

Our answer: Not listening to people or taking their concerns seriously; poor or unclear communication; not involving patients and healthcare consumers in decisions about their care.

AHPRA answer option	Members who chose it
Not listening to people or taking their concerns seriously	57%
Poor or unclear communication	47%
Not involving patients and healthcare consumers in decisions about their care	47%
Not obtaining informed consent for care	43%
Privacy breaches	30%
Care decisions influenced by money or business interests	30%
Not responding appropriately when something goes wrong or harm occurs	27%
Disrespectful behaviour	23%
Other	23%
Not understanding or meeting the needs of people with disability	13%
Crossing professional boundaries (e.g. inappropriate relationships)	13%
Poor or unsafe care when using technology (e.g. telehealth or AI)	13%
Bias, racism or discrimination	10%
Unprofessional behaviour online or on social media	7%

Members' concerns are about autonomy: patients not being heard, not being involved and not giving informed consent. Unprofessional behaviour online came last of all options.

"ahpra is overstepping their mandate where no patient harm has occurred and they are censoring doctors and reducing patients' ability to make informed decisions about their own care" AMPS member

5. What areas should be a priority when updating the Codes of conduct?

Our answer: Respectful care for all people; patient and consumer partnership and shared decision-making; communication and consent.

AHPRA answer option	Members who chose it
Respectful care for all people	59%
Patient and consumer partnership and shared decision-making	59%
Communication and consent	55%
Responding to mistakes and harm	52%
Safe use of technology in healthcare	41%
Managing conflicts of interest	24%
Professional boundaries and relationships	24%
Other	24%
Managing power imbalances and protecting vulnerable people	21%
Preventing racism, discrimination and bias	10%
Respectful and culturally safe care for Aboriginal and Torres Strait Islander peoples	7%
Providing safe, inclusive and accessible care for people with disability	7%
Professional behaviour online or on social media	3%

Members want justice in its plainest form: one standard of respectful care for every patient, and decisions made with the patient. Group-specific options and online behaviour were the lowest priorities.

6. Do you have any other feedback or suggestions for the review?

Our answer: Yes. Members raised four themes.

Put medical ethics first. Two members wrote only three words:

"First do no harm!" Two AMPS members

Keep the code to clinical practice.

"A professional's personal opinions and freedom of speech, online or otherwise, should not be dictated by a code of conduct. By all means professional behaviour within the Healthcare setting and representing the workplace should be outlined, but boundaries between professional and personal must be maintained such that each individual's freedom is preserved." AMPS member

"Code of conduct should be restricted to clinical competence." AMPS member

Protect informed consent and clinical judgement.

"The codes should clearly protect informed consent and individual clinical judgement, including when a government or employer issues a blanket directive. Practitioners and health staff should be able to raise evidence-based concerns about a health direction without losing their jobs or registration." AMPS member

Make the complaints process just.

"The Codes should recognise that an adverse outcome or dissatisfaction does not, by itself, establish an error or professional misconduct." AMPS member

"I have seen colleagues wait years for matters to be resolved, with lasting effects on their professional reputation and wellbeing." AMPS member

"Where a complaint is anonymous, vexatious, unsubstantiated, is clinically irrelevant, especially social media complaints need to be dismissed" AMPS member

7. How familiar are you with Codes of conduct?

Our answer: Very familiar, I have read one or more and understand how they apply. 84% of members are very or somewhat familiar with the codes.

Testing the code against the four principles

We also asked members about issues AMPS has raised with AHPRA for several years [6].

Table 2. AMPS member views (agree and strongly agree combined)

Statement	Agree	Neutral	Disagree
Codes should be grounded in core medical ethics, including "first, do no harm" and patient autonomy	91%	0%	9%
Regulatory action should be limited to clinical practice and patient safety	84%	3%	12%
In my workplace, patients get full information on risks, benefits and alternatives	62%	12%	25%
The codes and guidelines let me tailor care to the individual patient	47%	16%	38%
I feel safe raising a clinical concern or evidence-based disagreement	22%	9%	69%
I am confident guidelines are free from undue commercial or political influence	12%	9%	78%

Nonmaleficence: a doctor who cannot speak cannot prevent harm

85% of members have held back a professional opinion for fear of a complaint or regulatory action, and 47% do so often. Only 22% feel safe raising a clinical concern or an evidence-based disagreement. A doctor who stays silent about a risk cannot protect the patient from it. Fear of the regulator is now a patient safety problem and is undermining confidence in public health.

The code makes this worse. Clause 3.2.8 requires doctors to tell patients when their opinion "does not align with the profession's generally held views". Medicine advances when doctors question the consensus with evidence. The code treats that as something to declare, and AHPRA has treated it as something to punish. In March 2021 AHPRA and the National Boards warned that comments contradicting official COVID-19 vaccine advice "may breach the codes of conduct" [7].

Beneficence: the patient, not the protocol or the sponsor

Only 47% say the codes and guidelines let them tailor care to the individual patient, and 38% say they do not. Only 12% are confident the guidelines they work under are free from undue commercial or political influence; 78% are not. Clause 10.12 holds individual doctors to strict conflict of interest rules. Nothing holds the bodies that write the guidelines to the same standard.

"I am afraid to talk about and offer the exploratory therapy to young people with gender confusion that parents are wanting due to the strong lobby group supported push for gender affirming care and potential accusations of conversion therapy under heavy-handed laws being introduced." AMPS member

Autonomy: informed consent without pressure

Only 62% of members agree patients in their workplace get full information about risks, benefits and alternatives; 25% disagree. Informed consent requires honest information about uncertainty, alternatives and the option of no treatment, given freely. In 2021 AHPRA wrote that information given when obtaining consent must be "consistent with public health campaigns" [8]. A patient is entitled to their doctor's honest clinical judgement, not a campaign message. In February 2026 Senator Ralph Babet asked AHPRA in Senate Estimates how a practitioner could meet informed consent obligations without disclosing uncertainty [9].

Justice: fairness for patients and for doctors

84% of members want regulatory action limited to clinical practice and patient safety. Asked whether the code should regulate public or social media comment outside clinical practice, 91% said no, only conduct connected to clinical practice. No member said it should be regulated in the same way as clinical conduct. In 2022 the Senate Community Affairs References Committee recommended that notifications be "limited to clinical issues relating to patient safety" (Recommendation 9) [10]. It has not been implemented.

Instead, AHPRA has confirmed in writing that its jurisdiction "extends to personal conduct that does not occur in connection with practice", and that regulatory action may follow if a doctor's views risk "the public's confidence in their profession" [11]. That is a test of reputation, not of patient safety.

Of members who answered, 71% have been the subject of a notification: 25% about something they said or wrote, 25% about clinical practice and 21% for other reasons. AMPS research over two years shows how those processes feel to doctors:

- In our 2024 Have Your Say on AHPRA survey, more than half of practitioners had received a notification, 79% felt unfairly treated, 83% said AHPRA is not fair and transparent with complaints, and practitioners rated their experience 1.7 out of 10 on average [12].
- In our 2025 survey for the National Health Practitioner Ombudsman, 74% of practitioners subject to immediate action reported a strong presumption of guilt and 71% said the action was completely disproportionate. 32% reported suicidal thoughts, and 59% were offered no support [13].

- At AMPS's Misdeeds of AHPRA conference in Sydney on 3 May 2025, 98% of practitioners polled had no confidence in AHPRA and 100% said it fails to protect practitioners from vexatious complaints [14].

AHPRA has acknowledged that practitioners have died by suicide while subject to its processes [15]. Due process, fixed timeframes and proportionality are not concessions to doctors. They are what justice requires of any regulator.

"A prospective patient didn't like my opinions online and complained to AHPRA even before they had even met me." AMPS member

"Protecting patients should go hand in hand with procedural fairness, accountability for misuse of the complaints process and minimising avoidable harm to practitioners." AMPS member

AMPS has raised these issues repeatedly

Date	AMPS action
September 2024	Human Cost of AHPRA letter to the CEO, Health Minister and Chief Medical Officer, with Have Your Say survey results [12]
January 2025	Submission to the National Health Practitioner Ombudsman and the Dawson review on misuse of emergency suspension powers [16]
May 2025	Misdeeds of AHPRA conference, Sydney, and open letter to Australian leaders with the Australian Doctors Federation [14]
June 2025	Letter to the CEO and Medical Board Chair: Restoring Integrity in Medical Regulation [17]
January 2026	Letter to the CEO, with NPAA support, seeking review of COVID-19-related disciplinary actions where no patient harm was shown [18]
March to September 2026	Letters to the CEO and complaint to the Ombudsman on conditions restricting Dr Andrew Amos's public comment, after action against Dr Jillian Spencer for comparable comment was discontinued [19]
June 2026	Submission with NPAA to the Queensland Parliament Health and Environment Committee on National Law reform [20]
July 2026	Formal objection with NPAA to AHPRA's adoption of the IHRA definition of antisemitism as a regulatory reference tool without consultation [21]

Recommendations

1. **Build the code on the four principles.** Open the code with beneficence, nonmaleficence, respect for autonomy and justice, and "first, do no harm", consistent with the Declaration of Geneva.
2. **A shorter, clinical code.** Reduce the code to clear clinical and ethical standards a doctor can apply at the bedside, grounded in scientific and biological reality.
3. **Remove reputation, confidence and consensus tests.** Delete "reputation of the profession" (2.2) and the duty to declare divergence from "generally held views" (3.2.8) as grounds for

regulatory concern. Judge conduct against clinical standards, evidence based practice and patient outcomes.

4. **Regulation limited to clinical practice.** Confine the code and notifications to clinical practice and conduct with a direct link to patient safety (Senate Recommendation 9). State that lawful public comment, political communication and evidence-based dissent are not misconduct. Withdraw the IHRA definition as a regulatory reference tool.
5. **Protect speaking up.** Protect doctors who raise patient safety concerns or evidence-based disagreement in good faith from detriment by employers or regulators.
6. **Strengthen informed consent.** Rewrite section 4.5 to require honest disclosure of benefits, risks, uncertainty and alternatives (including no treatment), free of coercion, including when a government or employer issues a blanket directive.
7. **Clinical judgement.** Recognise documented, evidence-based departure from a guideline in the patient's interest as professional judgement, not misconduct.
8. **Guideline integrity.** Require bodies that write guidelines doctors are judged against to publish funding sources and declare conflicts of interests.
9. **Justice for doctors.** Add a section on the regulator's own duties: fixed timeframes, disclosure of evidence, early dismissal of vexatious and clinically irrelevant complaints, and proportionality, consistent with the guiding principle that restrictions be imposed only if necessary (National Law s 3A(2)(c)).
10. **Equal care.** Replace group-specific and subjective cultural safety tests with one standard of respectful, non-discriminatory care for every patient.
11. **Consultation.** Consult AMPS and other medical bodies on any draft code, hold a written submission stage, and publish submissions.

Yours sincerely,

Dr Duncan Syme

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