

The Medical Act and the Role of Physicians in the Care Process

Joint FEMS–AEMH Working Group on the Medical Act
(Ver 1.0)

Discussion Framework

1. Purpose of the Working Group

European healthcare systems are undergoing profound changes driven by demographic trends, workforce shortages, technological innovation, new models of care, and the evolving roles of healthcare professionals.

These developments raise fundamental questions concerning both the definition of the Medical Act and, as a direct consequence, the role of physicians within the overall process of care.

The purpose of this Working Group is therefore not be limited to establishing which activities can be defined as Medical Acts. It should also explore how medical responsibility, clinical leadership, professional autonomy and collaboration with other healthcare professions should evolve within modern European healthcare systems.

Rather than starting from predetermined conclusions, the Working Group should provide a forum in which different national experiences, professional models and perspectives can be compared.

Its objective is to identify areas of consensus, areas where different models may legitimately coexist, and principles that could provide a common European framework for the future.

2. What Do We Mean by “Medical Act”?

Several sources in the literature offer different definitions of the Medical Act. The most directly relevant supranational reference is the UEMS (European Union of Medical Specialists) European Definition of the Medical Act. Alongside it, several national legal systems and professional organisations have developed definitions or regulatory approaches that place different emphasis on physicians’ activities, responsibilities, competences, reserved acts, or the decision making process.

UEMS — European Definition of the Medical Act (2005; amended 2006)

The UEMS definition takes a broad approach. The Medical Act encompasses professional actions of a scientific, teaching, training, educational, clinical and medico-technical nature, aimed at promoting health and functioning, preventing disease, and providing diagnostic, therapeutic and rehabilitative care. The definition links these activities to physician responsibility and provides that they may be performed by a registered physician or under his or her direct supervision or prescription.

Conceptual model: Medical Act = professional actions + health/care purpose + physician responsibility.

Relevance to the Working Group: It is the main European starting point, although it does not clearly develop the distinction between the execution of a professional performance and clinical deliberation.

Spain — Organización Médica Colegial

The Spanish formulation describes a Medical Act as any lawful activity carried out by a duly qualified medical professional, aimed at treating disease, relieving suffering, or promoting health in a comprehensive sense. It also encompasses care-related, teaching, research, expert and other professional activities.

Conceptual model: Medical Act = activity performed by a qualified physician + medical purpose.

Relevance to the Working Group: This is a strong profession-based definition and is useful for comparing the criterion of professional qualification with those of responsibility or deliberation.

France — Académie Nationale de Médecine / French professional tradition

The French formulation considers a Medical Act to be an act carried out through verbal, written, physical or instrumental means by a member of the medical profession, within the scope of professional practice and within the limits of that professional's competence.

Conceptual model: Medical Act = modality of the act + medical professional + limits of competence.

Relevance to the Working Group: It highlights that the Medical Act is not limited to a technical procedure: intellectual, communicative and prescriptive activities may also form part of it.

Portugal — Ordem dos Médicos / Statute

The Portuguese approach is more regulatory and identifies activities belonging to medical practice, including diagnosis, prognosis, surveillance, research, medico-legal expertise, clinical coding and audit, prescribing, pharmacological and non-pharmacological therapeutic measures, medical, surgical and rehabilitative techniques, health promotion and prevention.

Conceptual model: Medical Act = a set of professional activities belonging or reserved to medical practice.

Relevance to the Working Group: It provides a clear example of a “reserved acts” model, which can be compared with a European definition based primarily on principles and responsibility.

Italy — OMCeO Roma, Ethics and the Medical Act (2026)

The document proposes that the Medical Act encompasses actions, behaviours, judgments and deliberations undertaken by a person who is qualified and licensed to practise medicine. It distinguishes three dimensions: professional performance; clinical deliberation; and research, training, education and organisation. Under certain conditions, professional performance may be carried out by qualified professionals who remain responsible for the own actions; clinical deliberation, by contrast, is characterised by the document as exclusive and non-delegable.

Conceptual model: Medical Act = professional performance + clinical deliberation + broader professional activities.

Relevance to the Working Group: It shifts the question from “Which acts does the physician perform?” to “Which component of the care process is specifically medical?”, proposing clinical deliberation as a distinctive element.

Comparative overview

Document / Country	Central element	Delegation	Distinctive medical element
UEMS 2005/06	Professional actions	Possible under supervision/ prescription	Responsibility

Spain	Activity of the qualified physician	Not central to the definition	Qualified physician
France	Verbal, written, physical or instrumental act	Not central	Competence
Portugal	Professional / reserved activities	Regulatory model	Reserved professional acts
Peru	Overall process of care	Medical responsibility	Competence + responsibility
OMCeO Roma 2026	Performance + deliberation	Performance potentially delegable	Clinical deliberation

Possible interpretation for the Working Group

The formulations considered represent different approaches rather than a single universally accepted model. Some define the Medical Act through the activities performed by physicians; others emphasize professional qualification, competence, responsibility, or reserved acts. The 2026 OMCeO Roma document makes the distinction between professional performance and clinical deliberation particularly explicit.

Central question for the Working Group: not only “What activities constitute a Medical Act?”, but also “What is the specifically medical contribution within the broader act of care?”

Questions for discussion

Should a distinction be made between the performance of a healthcare intervention and the clinical deliberation leading to that intervention? **What is done and/or what is decided?**

Should the Medical Act be understood as a single act, or as a process made up of different components with different levels of responsibility?

3. Clinical Deliberation and the Specific Contribution of the Physician

The OMCeO Roma document places particular emphasis on clinical deliberation, described through intentionality, independence and autonomy of judgment.

This perspective raises an important question for the Working Group: is the distinctive contribution of the physician primarily the performance of particular procedures, or the capacity to integrate scientific knowledge, professional experience, the patient's narrative and values, and the concrete organisational context into an individualized clinical decision?

One potentially useful concept is the physician's role in linking universal medical knowledge with the singularity of the individual case: evidence, guidelines and best practices on one side, and "this patient, in this context, at this moment" on the other.

This approach should be discussed rather than assumed as a conclusion.

Questions for discussion

Is clinical deliberation, rather than technical performance, the distinctive core of the physician's role?

Can clinical deliberation itself be shared, and if so, under what conditions and with what allocation of responsibility?

4. From the Medical Act to the Role of the Physician in the Act of Care

Defining the Medical Act inevitably leads to a broader question: **what is the role of the physician within the overall act of care?**

Modern patient care rarely consists of an isolated interaction between one physician and one patient. It increasingly involves multidisciplinary and multiprofessional teams, different levels of care, digital technologies, clinical pathways and multiple professionals contributing at different stages.

The Working Group should therefore examine whether the role of the physician should primarily be defined by the performance of specific acts, by clinical decision-making, by coordination of care, by responsibility for complex cases, or by a combination of these functions.

5. Physicians and Other Healthcare Professions

Modern healthcare depends on collaboration between physicians, nurses, pharmacists, physiotherapists, psychologists, technicians and many other healthcare professionals. Each profession contributes specific expertise and carries its own professional responsibilities.

The discussion should therefore avoid framing the Medical Act as a conflict between professions. A more productive approach is to ask how different professional competencies can complement one another while maintaining clear, transparent and verifiable responsibility.

The recent Italian document is useful in this respect because it simultaneously recognizes the autonomous responsibility of other healthcare professions and identifies the need to clarify which components of medical decision-making may or may not be delegated.

Professional competencies, delegation and shared responsibility

Which activities require specifically medical education and training?

Which activities may appropriately be performed by other healthcare professionals, independently or within shared pathways?

Is there a meaningful distinction between delegating a technical task and delegating a clinical decision?

When an activity is delegated, how should responsibility be distributed between the professional performing the task and the physician involved in the patient's care?

How can medical leadership coexist with the autonomy and expertise of other healthcare professions?

6. Appropriateness, Resources and Responsibility

Appropriateness is the result of balancing three elements: scientific evidence, the concrete needs of the individual patient, and the resources that are realistically available.

This introduces an important system-level dimension into the discussion. Medical decisions are never made in isolation: they take place within organisations, under resource constraints, and within legal and ethical frameworks.

The Working Group should therefore consider whether the physician's role includes a specific responsibility for balancing scientific evidence, individual patient needs and the practical conditions of care.

Questions for discussion

To what extent is assessment of appropriateness part of the Medical Act?

How should physicians respond when the clinically preferable option is limited by organisational or resource constraints?

How should responsibility be allocated when institutional rules, economic limits or access barriers influence the final clinical decision?

7. Professional Autonomy and Accountability

Professional autonomy has traditionally been regarded as a defining feature of medical practice. However, contemporary physicians operate within increasingly structured healthcare systems characterised by clinical guidelines, protocols, economic constraints, organisational targets and digital decision-support systems.

The relationship between autonomy and accountability should therefore form a central part of the discussion.

A European framework should explore how much autonomy is necessary for appropriate clinical judgment and how that autonomy should interact with evidence-based guidance, organisational standards and the legitimate autonomy of other professionals.

8. The Fiduciary Relationship and the Human Dimension of the Medical Act

The fiduciary relationship between physician and patient is a fundamental basis of the Medical Act.

This adds an important dimension that should not be lost in definitions focused only on competencies, procedures and responsibility. The Medical Act may also be understood as a relational act, grounded in trust, communication, ethical responsibility and attention to the individual person.

The Working Group should consider whether the physician-patient relationship remains a defining component of the Medical Act in settings increasingly characterised by team-based care, telemedicine and digital technologies.

9. Artificial Intelligence and the Medical Act

Artificial intelligence introduces another dimension to this debate. AI systems can already support image interpretation, risk prediction, diagnosis, treatment selection and clinical documentation.

The Italian framework distinguishes between functions that technology may support—such as data analysis, information organisation and comparison of options—and functions linked to supervision, interpretation of the individual case, clinical decision-making and professional responsibility.

For the Working Group, this distinction should be treated as a question to explore rather than as a predetermined conclusion.

Questions for discussion

Which components of clinical decision-making may be supported or performed by AI?

Which components require identifiable human professional accountability?

If a physician follows an AI-supported recommendation, how should responsibility be allocated?

If technology becomes capable of performing activities traditionally considered medical, does this change the definition of the Medical Act, or does it reinforce the distinction between technical performance and professional responsibility?

10. Towards a European Framework

Given the diversity of healthcare systems and professional regulation across Europe a European consensus should probably not try to draw up an exhaustive list of procedures reserved to physicians. Instead the WG should explore what conceptual elements a European definition could be built on.

A more useful objective may be to identify common principles capable of remaining valid despite differences between national healthcare systems.

This structure allows the Group to address performance, clinical deliberation, responsibility, professional relationships and technological change without assuming in advance that one national model should prevail.

Against this background the following key questions are proposed to guide the WG's discussion and subsequent methodological work:

1. What defines a Medical Act in contemporary healthcare?
2. Should a distinction be made between professional performance and clinical deliberation?
3. Is clinical deliberation the distinctive core of the physician's role, or only one component of it?
4. Which components of the act of care require the specific knowledge and competencies of a physician (medical act)?
5. Which responsibilities should remain specifically medical and which may be shared with other healthcare professionals?
6. How should delegation of clinical and technical activities be organised?
7. How should responsibility be allocated within multidisciplinary and multiprofessional teams?
8. How should doctors balance evidences, patient needs and available resources ?
9. How can medical leadership coexist with the professional autonomy of other healthcare professions?
10. What role should the fiduciary relationship with the patient play in defining the Medical Act?
11. How should professional autonomy and accountability be balanced?
12. How will artificial intelligence and digital technologies affect the definition of the Medical Act and the role of physicians?
13. Which common principles could form the basis of a European framework while respecting differences between national healthcare systems?

Methodological and Timeline

The discussion paper sets out the right questions but does not yet say how the Working Group will actually gather and compare national experience, or on what timescale. This note proposes a concrete working method and a realistic 12-month timeline, so the Working Group can move from open questions to a shared European statement without losing focus and practice relevance.

This is a joint undertaking between FEMS and AEMH. FEMS brings a primarily industrial-relations and workforce perspective — the lived reality of shortage, workload and working conditions that makes task delegation an operational necessity. AEMH brings a primarily medical-leadership perspective — the concern that clinical responsibility and physician leadership of the care process must not be diluted as tasks are redistributed. The methodology below is designed so that this is treated as a productive tension to be resolved jointly, rather than as two separate agendas running in parallel.

2.1. Guiding Principles

- **Comparative, not adversarial:** gather national experience systematically — through a structured questionnaire and selected case studies — rather than debate the topic in the abstract.
- **Evidence-informed:** ground conclusions in available safety and outcomes literature on task-shifting and delegation, not only in professional opinion.
- **Two-track output:** distinguish explicitly between principles the group can agree on, and areas where different national models may legitimately continue to coexist.
- **Realistic pace:** match the pace of the work to the urgency created by workforce shortage (Section 1 of the discussion paper), while still allowing time for genuine consultation.
- **Joint ownership:** every deliverable (questionnaire, case studies, drafts) is reviewed jointly by FEMS and AEMH representatives before circulation, so that neither the workforce/ industrial-relations framing nor the medical-leadership framing dominates by default.

2.1. Methodological Components

- **Structured national questionnaire:** A short, structured questionnaire sent to every national member association, covering the legal/regulatory status of the Medical Act, existing delegation models, and current use of AI in clinical practice.

- **Rapid evidence review:** A rapid, non-exhaustive review of existing literature and reports (WHO, OECD, professional bodies) on outcomes and safety when clinical tasks are delegated.
- **Selected country case studies:** Deeper follow-up with 4–6 countries selected to represent a spread of regulatory models, once questionnaire results are in.
- **Drafting subgroup + full-group plenaries:** A small drafting subgroup does the actual writing between plenaries, which then meet twice (mid-point and pre-consultation) to steer and approve direction.
- **External consultation:** The draft statement is shared with other relevant professional bodies (e.g. nursing, pharmacy) before adoption, consistent with the paper's own commitment to avoid framing this as an inter-professional conflict.
- **Formal adoption:** The final statement goes through each federation's normal governance process (e.g. General Assembly or Board) for formal adoption, and is then published jointly.

3. Governance and Roles

Governance is structured as a genuine partnership: every leadership and drafting role is co-held or balanced between the two organisations, so that decisions require agreement rather than being made by either organisation alone.

Both federations share the same basic structure: a General Assembly of dues-paying national member associations acts as the ultimate governing body, while an elected Board acts as the executive that runs the approved activity plan between Assemblies. This has two practical consequences for the Working Group. First, day-to-day steering (approving the questionnaire, the case-study shortlist, and successive drafts) can be handled at Board level through the Co-Chairs, since it falls within the Working Group's existing mandate. Second, because the final Statement will represent a policy position of each federation — not merely the completion of an internal task — we recommend it be presented to each Board for endorsement and then formally ratified by each federation's General Assembly, rather than adopted by either Board alone. Section 5 reflects this two-step adoption process.

- **Co-Chairs (2):** One Co-Chair appointed by FEMS and one by AEMH, chairing plenaries jointly, approving minor drafting decisions between meetings by joint agreement, and acting as the joint point of contact with each organisation's own Board.
- **Co-Rapporteurs (2):** One from each organisation, jointly coordinating the questionnaire, evidence review and drafting process, and jointly keeping the running log of open issues. Where the two Rapporteurs cannot agree on a drafting point, the issue is escalated to the Co-Chairs rather than resolved unilaterally.

- **Drafting subgroup:** 4–6 members with balanced representation from FEMS and AEMH (aim: no more than a 1-person difference between the two), who prepare the successive drafts of the statement between plenaries.
- **National focal points:** Ideally one per national member association of each federation. Note that within a federation, a single country is sometimes represented by more than one member association (e.g. two different trade unions within FEMS); in that case all member associations for that country are invited to nominate a focal point. Where possible they are encouraged to submit one coordinated national response, but separate responses reflecting genuinely different positions are equally valid and will be recorded as such rather than forced into a false consensus. Where a country has both a FEMS and an AEMH member association, the two are likewise encouraged, but not required, to coordinate their input.
- **FEMS and AEMH Secretariats:** Handles logistics jointly — questionnaire distribution and reminders, scheduling, and circulation of documents — with a single shared document repository so neither secretariat is working from a different version.

4. Proposed Timeline (12 Months)

The timeline below mirrors the phased approach already reflected in Section 9 of the discussion paper (interim conclusions within roughly twelve months, full statement to follow once national input has been gathered).

Month	Phase	Activities & Deliverable	Lead
0	Kick-off	FEMS and AEMH each appoint their Co-Chair and Co-Rapporteur; each federation's member associations name their national focal points; joint discussion paper (v1.0) circulated as the starting reference; single shared document repository set up.	FEMS + AEMH Secretariats
1–2	Questionnaire design & launch	Drafting subgroup finalises a structured questionnaire covering: national definition/legal status of the Medical Act; existing delegation and task-shifting models; AI use in clinical practice; known safety concerns. Questionnaire sent to all national focal points. Deliverable: Questionnaire launched; response deadline set.	Drafting subgroup
2–4	Evidence review (parallel track)	Rapid review of existing literature and grey literature on outcomes and safety of task-shifting/delegation (WHO, OECD, professional-body sources). Questionnaire responses collected and compiled. Deliverable: Evidence briefing note; questionnaire response summary.	Co-Rapporteurs + 1–2 volunteer members

Month	Phase	Activities & Deliverable	Lead
4	Case-study selection	Based on questionnaire responses, select 4–6 countries representing a spread of regulatory models (e.g. highly centralised vs. devolved, high vs. low use of non-physician prescribing) for deeper follow-up. Deliverable: Shortlist agreed by the Co-Chairs.	Co-Chairs + Drafting subgroup
4–6	Case studies & Plenary 1	Structured follow-up (short interviews or written input) with the selected countries. First full Working Group plenary to review questionnaire and evidence findings and agree the direction of the draft statement. Deliverable: Case-study notes; Plenary 1 minutes and agreed direction.	National focal points / Full WG
6–8	First draft	Drafting subgroup prepares a first draft European Statement (definition of the Medical Act + role/responsibility of physicians), distinguishing (a) areas of consensus, (b) areas of legitimate national variation, and (c) open questions. Deliverable: Draft v0.1 circulated to full Working Group for written comment.	Drafting subgroup
8–9	Plenary 2	Second full plenary to discuss written comments, resolve disagreements where possible, and confirm what is ready for external consultation. Deliverable: Draft v0.2; log of unresolved issues.	Full Working Group
9–10	External consultation	Draft shared with other relevant professional bodies (e.g. nursing, pharmacy, allied health associations) and, if agreed, published for wider comment. Deliverable: Consultation feedback log.	FEMS + AEMH Secretariats
10–11	Final revision	Drafting subgroup incorporates consultation feedback; legal/regulatory language checked for adaptability across national systems. Deliverable: Final draft v1.0.	Drafting subgroup
12	Board endorsement	Final draft (v1.0) presented to the FEMS Board and the AEMH Board for endorsement as each federation's policy position. Deliverable: Board-endorsed Statement.	FEMS + AEMH Boards

Month	Phase	Activities & Deliverable	Lead
Next available GA(s)	General Assembly ratification & publication	Endorsed Statement formally ratified by the General Assembly of each federation and published jointly. Because Assemblies typically meet on their own annual cycle, this step follows as soon as each federation's next ordinary or extraordinary General Assembly allows — see the note on confirming Assembly dates early (Section 7). Deliverable: Adopted and published European Statement on the Medical Act and the Role of Physicians.	FEMS + AEMH General Assemblies

6. Risks and Mitigations

Risk	Likelihood / Impact	Mitigation
Low or uneven response rate to the national questionnaire	Medium likelihood / High impact — weakens the comparative evidence base	Set a firm deadline with one reminder cycle; ask the FEMS and AEMH Secretariats to follow up directly with non-responding associations; accept partial responses rather than delaying the whole timeline.
Wide legal/regulatory heterogeneity makes common principles hard to agree	High likelihood / Medium impact	Explicitly split conclusions into 'consensus principles' and 'areas of legitimate national variation' (as already framed in the discussion paper), rather than forcing a single model.
Perception that 'delegation' language is being used to justify under-staffing	Medium likelihood / High impact — could undermine buy-in from members	Keep the explicit safeguard language already added to Section 4 of the discussion paper; ensure the evidence-review track (safety/outcomes) is genuinely completed before conclusions are drafted, not treated as a formality.

Risk	Likelihood / Impact	Mitigation
Timeline slippage around Plenary 2 / consultation	Medium likelihood / Medium impact	Build a two-week buffer into months 9–11; empower the Co-Chairs, acting jointly, to approve minor drafting decisions between plenaries so the full group is not a bottleneck.
Other health professions perceive the process as exclusionary	Medium likelihood / High impact on external legitimacy	Run the external consultation step (month 9–10) as a genuine two-way exchange, not a courtesy notification; consider inviting 1–2 non-physician observers to relevant plenary sessions.
FEMS's industrial-relations framing and AEMH's medical-leadership framing pull the draft in different directions, or one federation's priorities dominate by default	Medium likelihood / High impact — could produce a statement one federation does not fully own	Keep all leadership and drafting roles co-held (Section 4); require joint Co-Chair sign-off before any draft is circulated; treat unresolved tension between the two framings as an explicit agenda item at both plenaries rather than something to be smoothed over in the text.
The two federations' General Assembly calendars do not align with the month-12 target, delaying formal ratification	High likelihood / Low-Medium impact — affects publication date, not substance	Confirm both federations' next scheduled General Assembly dates during Kick-off (month 0) and plan backwards from them; treat month 12 as delivery of the Board-endorsed Statement, with General Assembly ratification following at the next available Assembly rather than forcing an extraordinary one unless both Boards judge it worthwhile.

7. Immediate Next Steps (First 30 Days)

- FEMS and AEMH each confirm their Co-Chair and Co-Rapporteur, and ask their national member associations to name focal points.
- Circulate a first draft of the national questionnaire to the Drafting subgroup for comment.
- Agree the criteria for later case-study country selection (e.g. range of regulatory models, availability of English-language documentation).
- Confirm the date of each federation's next scheduled General Assembly, so the final ratification step can be planned realistically rather than assumed.
- Schedule the Kick-off and Plenary 1 dates so the full 12-month timeline can be calendared in advance.

Background References for Discussion

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