



Public consultation

29 January 2018

Draft revised guidelines 'Sexual boundaries in the doctor-patient relationship'

Summary

This public consultation paper released by the Medical Board of Australia seeks feedback on draft revised guidelines '*Sexual boundaries in the doctor-patient relationship*'.

The National Law¹, empowers the National Boards to develop and approve codes and guidelines to provide guidance to health practitioners. The National Law requires National Boards to ensure there is wide-ranging consultation on the content of any proposed registration standard, code or guideline.

The Medical Board of Australia (the Board) is inviting general comments on draft revised guidelines '*Sexual boundaries in the doctor-patient relationship*'. There are also specific questions which you may wish to address in your response.

Making a submission

Please provide written submissions by email, marked: 'Draft revised guidelines Sexual Boundaries in the doctor-patient relationship' to medboardconsultation@ahpra.gov.au by close of business on **29 March 2018**.

Submissions for publication on the Board's website should be sent in Word format or equivalent.²

Submissions by post should be addressed to the Executive Officer, Medical, AHPRA, GPO Box 9958, Melbourne 3001.

Publication of submissions

The Board publishes submissions at its discretion. The Board generally publishes submissions on its website to encourage discussion and inform the community and stakeholders. Please let us know if you do not want us to publish your submission, or want us to treat all or part of it as confidential.

We will not place on our website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the subject of the consultation. Before publication, we may remove personally-identifying information from submissions, including contact details.

¹ Health Practitioner Regulation National Law, as in force in each state and territory

²You are welcome to supply a PDF file of your feedback in addition to the word (or equivalent) file, however we request that you supply a text or word file. As part of an effort to meet international website accessibility guidelines, AHPRA and National Boards are striving to publish documents in accessible formats (such as word), in addition to PDFs. More information about this is available at www.ahpra.gov.au/About-AHPRA/Accessibility.aspx

The views expressed in the submissions are those of the individuals or organisations who submit them and their publication does not imply any acceptance of, or agreement with, these views by the Board.

The Board accepts submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. Any request for access to a confidential submission will be determined in accordance with the *Freedom of Information Act 1982* (Cth), which has provisions designed to protect personal information and information given in confidence.

Published submissions will include the names of the individuals and/or the organisations that made the submission, unless confidentiality is requested.

Background

Under section 39 of the National Law, the National Boards may develop and approve codes and guidelines to provide guidance to health practitioners and which may be about matters relevant to the exercise of the National Board's functions.

An approved registration standard, code or guideline is admissible in proceedings under the National Law or the law of a co-regulatory jurisdiction against a medical practitioner as evidence of what constitutes appropriate professional conduct or practice of the profession.

The Board's current guidelines '*Sexual boundaries: guidelines for doctors*' came into effect on 28 October 2011. The current guidelines are due for review and in keeping with good regulatory practice the Board is reviewing the guidelines and has developed draft revised guidelines for consultation.

Both the current and draft revised guidelines complement the Board's code '*Good Medical Practice: A code of conduct for doctors in Australia*' and provide specific guidance for medical practitioners on the importance of maintaining sexual boundaries in the doctor-patient relationship.

The development of the revised draft guidelines has been informed by Professor Ron Paterson's report of the '[Independent review of the use of chaperones to protect patients in Australia](#)', February 2017 (the Chaperone Review) and the Board's experiences of notifications relating to sexual boundary violations.

Proposed changes

The content of the current and revised guidelines is largely the same. The Board is not proposing any significant changes to the professional and ethical conduct expected of medical practitioners. The guidelines have been restructured and reworded to improve readability and to make clear the Board's expectations of medical practitioners. The proposed changes are:

1. editorial in nature, including restructuring to improve readability and clarification of terms and definitions used
2. a change in the title to clarify the scope of the guidelines
3. alignment of the guidelines with the advice and principles contained in the Chaperone Review, including:
 - a. a re-titled and expanded section 2 (section 4 of the current guidelines) on 'Why breaching sexual boundaries is unethical and harmful' to incorporate key messages from the Chaperone Review
 - b. revising section 8 of the current guidelines on the 'Use of chaperones when conducting intimate examinations' (section 7.1 of the revised guidelines) including to replace the term 'chaperone' with the term 'observer'

4. a new section (section 4 of revised guidelines) on maintaining sexual boundaries with current patients, including guidance confirming that patients cannot consent to a sexual relationship with their treating practitioner due to the inherent power imbalance in the doctor-patient relationship
5. a new section (section 6 of revised guidelines) on maintaining sexual boundaries with individuals close to the patient
6. revising the section on physical examinations (section 7 of revised guidelines and section 8 of current guidelines) to:
 - a. confirm that doctors should only conduct physical examinations if they are clinically warranted and highlighting that unnecessary physical examinations may constitute sexual assault or abuse. This includes conducting or allowing others, such as students, to conduct examinations on anaesthetised patients, when the patient has not given explicit consent for the examination
 - b. include a provision on assessing the capacity of a child patient or young person to give consent
7. a new section on social media (section 8 of revised guidelines) which complements the National Boards current Social media policy accessible at: www.medicalboard.gov.au/Codes-Guidelines-Policies/Social-media-policy.aspx
8. a new definitions section, including definitions from section 3 of the current guidelines that have been updated and clarified.

Options

The Board has considered the following options in developing this proposal.

Option 1 – Maintain the status quo

Option 1 is to continue with the existing guidelines.

Option 2 – Proposed revised guideline

Option 2 is to consult on proposed changes to the current guidelines. Under this option, the revised guidelines will continue to define the professional and ethical conduct expected of medical practitioners by the Board, peers and the community. The proposed revisions are mostly editorial in nature, restructuring to improve readability and updated where necessary to ensure currency of content, such as aligning the guidelines with the advice and principles contained in the Chaperone Review and by adding a section on social media.

Preferred option

The Board prefers Option 2.

Issues for consultation

Potential benefits and costs of the proposal

The benefits of the preferred option are that the draft revised guidelines:

1. maintain the balance between protecting the public and the impact on medical practitioners
2. provide specific guidance for medical practitioners on the importance of maintaining sexual boundaries in the doctor-patient relationship
3. clearly set out the standards of ethical and professional conduct expected of medical practitioners by the Board, their professional peers and the community

4. have been updated to address any emerging issues i.e. the increasing use of social media and the advice and principles contained in the Chaperone Review
5. have been restructured to improve readability.

The Board's preferred option does not propose any changes to the current standards of ethical and professional conduct expected of medical practitioners. Therefore the costs of the preferred option will be minimal and confined to medical practitioners becoming familiar with the new guidelines.

Estimated impacts of the draft revised guidelines

The Board does not propose any significant changes to the current guidelines, although more significant changes may emerge through consultation. There is little impact anticipated on practitioners, business and other stakeholders arising from the changes proposed.

Relevant sections of the National Law

The relevant sections of the National Law are sections 39, 40 and 41.

Questions for consideration

The Board is inviting general comments on the draft revised guidelines as well as feedback on the following questions.

1. From your perspective, how are the current guidelines working?
2. Is the content and structure of the draft revised guidelines helpful, clear, relevant and more workable than the current guidelines?
3. Is there any content that needs to be changed or deleted in the draft revised guidelines?
4. Is there anything missing that needs to be added to the draft revised guidelines?
5. Do you have any other comments on the draft revised guidelines?

Attachments

1. Draft revised *Guidelines: Sexual boundaries in the doctor-patient relationship*
2. The Board's statement of assessment against AHPRA's Procedures for the development of registration standards, codes and guidelines and Council of Australian Governments (COAG) principles for best practice regulation.

The current guidelines '*Sexual Boundaries: Guidelines for doctors*' is published on the Board's website, accessible from www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx.



Medical Board of Australia

Guidelines: Sexual boundaries in the doctor-patient relationship

[Effective Date]

Summary

Good medical practice involves *'never using your professional relationship to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under your care. This includes those close to the patient such as their carer, guardian or spouse or the parent of a child patient'*.¹

Sexual misconduct is an abuse of the doctor-patient relationship.² It undermines the trust and confidence of patients in their doctors and of the community in the medical profession. It can cause significant and lasting harm to patients.

These guidelines aim to provide guidance to doctors about establishing and maintaining sexual boundaries in the doctor-patient relationship. These guidelines complement *'Good medical practice: A code of conduct for doctors in Australia'* (*Good medical practice*). *Good medical practice* describes what the Board expects of all doctors who are registered to practise medicine in Australia.

Doctors who breach these guidelines are placing their registration at risk and in some cases could also be committing a criminal offence.

- Sexual misconduct is an abuse of the doctor-patient relationship and can cause significant and lasting harm to patients.
- It is never appropriate for a doctor to engage in a sexual relationship with a patient.
- A doctor must only conduct a physical examination of a patient when it is clinically indicated and with the patient's informed consent.
- Good, clear communication is the most effective way to avoid misunderstandings in the doctor-patient relationship.
- Doctors are responsible for maintaining professional boundaries in the doctor-patient relationship.

¹ Medical Board of Australia, *Good medical practice: A code of conduct for doctors in Australia*, (as revised from time to time).

² Doctor/s means registered medical practitioner/s.

Sexual boundaries in the doctor-patient relationship

1 The foundation of the doctor-patient relationship

1.1 Trust

Trust in the relationship between doctors and patients is a cornerstone of good medical practice. Sexual misconduct is a flagrant abuse of that trust. Patients have a right to feel safe when they are consulting a doctor.

Patients need to trust that their doctor will act in their best interests, treat them professionally, not breach their privacy and never take advantage of them. Exploitation of the doctor-patient relationship undermines the trust that patients have in their doctors and the community has in the profession. It can cause profound psychological harm to patients and compromise their medical care.

1.2 Good communication

Good, clear communication is the most effective way to avoid misunderstandings in the doctor-patient relationship. Good medical practice includes:

- listening to patients, asking for and respecting their views about their health, and responding to their concerns and preferences
- informing patients of the nature of, and need for, all aspects of their clinical management, including examination and investigations, and giving them adequate opportunity to question or refuse intervention and treatment
- trying to confirm that your patient understands what you have said
- responding to patients' questions and keeping them informed about their clinical progress.

2 Why breaching sexual boundaries is unethical and harmful

Doctors are expected to act in their patient's best interests and not use their position of power and trust to exploit patients physically or sexually. Breaching sexual boundaries is always unethical and usually harmful for many reasons including:

- **Power imbalance:** The doctor-patient relationship is inherently unequal. The patient is often vulnerable and in some clinical situations may depend emotionally on the doctor. To receive health care, patients are required to reveal information that they would not reveal to anyone else and may need to allow a doctor to conduct a physical examination. For a doctor to engage in sexualised behaviour with a patient exploits this power imbalance.
- **Trust:** Patients place trust in their doctor. They have a right to expect that examinations and treatment will only be undertaken in their best interests and never for an ulterior, sexual motive.
- **Safety:** Patients subjected to sexualised behaviour from their doctor may suffer emotional and physical harm.
- **Quality:** A doctor who sexualises patients is likely to lose the independence and objectivity needed to provide them with good quality health care.
- **Public confidence:** Members of the community should never be deterred from seeking medical care, permitting intimate examinations or sharing deeply personal information, because they fear potential abuse.

3 Breaches of sexual boundaries (spectrum of behaviours)

There is a wide range of behaviours that breach sexual boundaries, from making unnecessary comments about a patient's body or clothing to criminal behaviour such as sexual assault. Unnecessary physical examinations or touching during a consultation and examinations without informed consent are criminal offences. AHPRA will advise and support notifiers³ to report criminal behaviour to the police.

3.1 Spectrum of behaviours

Breaches of sexual boundaries include:

- engaging or seeking to engage in a sexual relationship with a patient regardless of whether the doctor believes the patient consented to the sexual relationship

³ Notifier/s means a person who has made a notification (complaint) to AHPRA about the alleged conduct of a health practitioner.

- conducting a physical examination which is not clinically indicated or when the patient has not consented to it. An unnecessary physical examination may constitute sexual assault or abuse.
- sexualised behaviours, meaning, any behaviour of a sexual nature that also includes:
 - making sexual remarks
 - flirtatious behaviour
 - touching patients in a sexual way
 - engaging in sexual behaviour in front of a patient
 - using words or acting in a way that might reasonably be interpreted as being designed or intended to arouse or gratify sexual desire
- asking a patient about their sexual history or preferences, when these are not relevant to the patient's clinical issue
- sexual exploitation or abuse⁴
- sexual harassment⁵
- sexual assault.

3.2 Other behaviours that may breach sexual boundaries

Other behaviours that may breach sexual boundaries include:

- asking a patient to undress more than is necessary or providing inadequate privacy screening or cover for a physical examination
- engaging in sexualised behavior with an individual who is close to a patient under the doctor's care, such as a patient's carer, guardian, spouse, family member or the parent of a child patient.
- engaging in sexualised behaviour with a former patient.

4 Guidance on maintaining sexual boundaries with current patients

Doctors are responsible for establishing and maintaining sexual boundaries with their patients, regardless of their patient's behaviour. A patient cannot give their informed consent to

a sexual relationship with their doctor because of the power imbalance in the doctor-patient relationship and their reliance on the doctor for their health care. Patient consent is never a valid reason for doctors to engage in sexualised behaviour.

The start of a sexual relationship between a doctor and a patient may not always be immediately obvious to either the doctor or patient. Doctors need to be alert to warning signs that could indicate that boundaries are being, or are about to be crossed.

Warning signs include but are not limited to:

- patients requesting or receiving non-urgent appointments at unusual hours or locations, especially when other staff are not present
- patients asking personal questions, using sexually explicit language or being overly affectionate
- patients attempting to give expensive gifts
- patients and doctors inviting each other out socially
- a doctor revealing to a patient intimate details of their life, especially personal crises or sexual desires or practices
- a doctor who finds themselves daydreaming or fantasising about a patient.

If a doctor senses any of these warning signs, or if a patient talks about or displays inappropriate feelings towards a doctor or exhibits sexualised behaviour, the doctor should consider whether this is interfering with the patient's care and/or placing the doctor or the patient at risk. In these situations, the doctor should try to constructively re-establish professional boundaries and seek advice from an experienced and trusted colleague or their professional indemnity insurer about how to best manage the situation.

If there is a possibility that sexual boundaries could be breached, or that the doctor may not remain objective, the doctor should transfer the patient's care to another doctor. This should be done sensitively so that a potentially vulnerable patient is not further harmed.

5 Guidance on maintaining sexual boundaries with former patients

It may be unethical and unprofessional for a doctor to engage in sexualised behaviour with a

⁴ See 'Definitions' in these guidelines.

⁵ See 'Definitions' in these guidelines.

former patient, if this breaches the trust the patient placed in the doctor. Doctors should recognise the influence they have had on patients and that a power imbalance could continue long after the professional relationship has ended.

A doctor should consider carefully whether they could be exploiting the trust, knowledge and dependence that developed during the doctor-patient relationship, before they decide whether or not to pursue or engage in a relationship with a former patient.

When deciding whether a doctor used the doctor-patient relationship to engage in or pursue an inappropriate relationship with a former patient, the Board will consider a range of factors including:

- the duration and type of care provided by the doctor; for example, if they had provided long-term emotional or psychological treatment
- the degree of vulnerability of the patient
- the extent of the patient's dependence in the doctor-patient relationship
- the time elapsed since the end of the professional relationship
- the manner in which, and reason why, the professional relationship ended or was terminated
- the context in which the sexual relationship started.

6 Guidance on maintaining sexual boundaries with individuals close to the patient

A patient usually has a personal or emotional relationship with the individual⁶ involved or interested in their health care. This individual may provide them with support and advice. In some cases, such as when they are the parent of a child patient, they may make decisions on behalf of the patient about their health care. The individual close to the patient also relies on the doctor and trusts that the doctor is acting in the best interests of the patient.

Engaging in sexualised behaviour with an individual close to a patient may affect the judgement of both the doctor and the other

⁶ An individual close to a patient includes a parent of a child patient, a spouse, carer, guardian or family member.

individual and as a result, may undermine the patient's health care. A sexual relationship between a doctor and an individual close to the patient may be unethical if the doctor has used any power imbalance, knowledge or influence obtained as the patient's doctor to engage in the relationship.

When deciding whether a doctor used the doctor-patient relationship to engage in or pursue an inappropriate relationship with an individual close to the patient, the Board will consider a range of factors including:

- the duration and type of care provided by the doctor to the patient; for example, if they had provided long-term emotional or psychological treatment
- the degree of emotional dependence on the doctor by the individual close to the patient
- whether the doctor used any knowledge or influence obtained as the patient's doctor to engage in a sexual relationship with the individual close to the patient
- the importance of the patient's clinical treatment to the patient and to the individual close to them
- the extent to which the patient is reliant on the individual close to them.

7 Physical examinations

Doctors should only conduct a physical examination if it is clinically warranted. An unnecessary physical examination may constitute sexual assault. This includes conducting or allowing others, such as students, to conduct examinations on anaesthetised patients, when the patient has not given explicit consent for the examination.

Before conducting a physical examination, good medical practice involves:

- explaining to the patient why the examination is necessary, what it involves and providing an opportunity for them to ask questions or to refuse the examination
- obtaining the patient's informed consent
- assessing whether a patient who is a child or young person is capable of giving informed consent and if they are not capable, seeking consent from their legal parent or guardian.

When conducting a physical examination, good medical practice involves:

- being aware of any sign the patient has withdrawn consent
- not continuing with an examination when consent is uncertain, has been refused or has been withdrawn
- allowing the patient to undress and dress in private. A doctor should not assist a patient to undress or dress unless the patient is having difficulty and asks for assistance
- providing suitable covering during an examination so that the patient is covered as much as possible, to maintain their dignity
- using gloves when examining genitals or conducting internal examinations
- not allowing the patient to remain undressed for any longer than is needed for the examination
- obtaining the patient's permission if medical students or anyone else is to be present during an examination or consultation
- allowing a patient to bring a support person who may be a parent, carer, guardian, spouse, family member or friend.

7.1 Use of observers

Patients may find intimate examinations stressful and embarrassing. The definition of an intimate examination⁷ depends on the patient's perspective, which may be affected by cultural values and beliefs. Intimate examinations usually include examination of the breasts, genitalia or an internal examination. Doctors should be sensitive and respectful of a patient's views when discussing the reasons for an intimate examination and should ensure the patient's comfort, dignity and privacy when conducting an intimate examination.

A doctor may choose to have an observer present during an intimate examination of a patient or in any consultation. The observer is essentially a witness to the consultation and may be a registered nurse employed in the practice. An observer can provide an account of the consultation if later there is an allegation of improper behaviour. Their presence may also provide a level of comfort for the patient.

⁷ See 'Definitions' in these guidelines.

A patient has the right to decline having an observer present. In that case, the doctor can proceed with the consultation without the observer, or choose not to proceed and instead help the patient to find another doctor. The patient has the right to ask to be accompanied by a support person of their choice.

8 Social media

The principles in *Good medical practice* apply to the use of social media as well as to face-to-face consultations with patients. The Board expects doctors to maintain professional boundaries when using social media to communicate with patients. Doctors must not use social media to pursue a sexual, exploitative or other inappropriate relationship with a patient.

If a patient tries to engage with a doctor through social media about matters outside the professional relationship, the doctor should politely decline to interact with them and direct them instead to the doctor's usual professional health care communication channels.

For more information, the Board's Social Media policy is accessible from www.medicalboard.gov.au.

9 Obligation to report allegations of sexual misconduct

The National Law requires registered health practitioners, employers and education providers to report 'notifiable conduct' to AHPRA (or the relevant authority in a co-regulatory jurisdiction), to prevent the public being placed at risk of harm⁸.

'Notifiable conduct' includes engaging in sexual misconduct in connection with the practice of the profession. This means engaging in sexual misconduct with individuals under a doctor's care or linked to a doctor's practice of their profession.

Mandatory notification requirements aim to prevent the public being placed at risk of harm. The law requires health practitioners to notify AHPRA (or the relevant authority in a co-regulatory jurisdiction) if they believe that another health practitioner has behaved in a way which presents a serious risk to the public.

⁸ There are some limited exceptions to the requirement of health practitioners to report 'notifiable conduct' in Western Australia and Queensland in certain circumstances. The requirement of education providers to make a mandatory notification relates to students and only applies where a student has an impairment that may place the public at substantial risk of harm.

Health practitioners also have a professional and ethical obligation to protect and promote public health and safety and may therefore make a voluntary notification.

For more information about the obligations of health practitioners, employers and education providers to report 'notifiable conduct', refer to the Board's *Guidelines for mandatory notifications* accessible from www.medicalboard.gov.au.

How will the Board use these guidelines?

Section 41 of the National Law states that an approved registration standard, or a code or guideline approved by the Board, is admissible as evidence of what constitutes appropriate professional conduct or practice of the profession, in proceedings against a registered health practitioner under this law or a law of a co-regulatory jurisdiction.

The Board or the relevant authority in a co-regulatory jurisdiction will investigate a doctor who is alleged to have breached these guidelines. If the allegations are substantiated, the Board or the relevant authority in a co-regulatory jurisdiction will take action to protect the public.

Definitions

AHPRA means the Australian Health Practitioner Regulation Agency.

Intimate examination means an examination that a patient or a member of the public may reasonably regard as intimate, which usually means examination of the breasts, genitals or an internal examination.

National Law means the Health Practitioner Regulation National Law as in force in each state and territory.

Sexual exploitation or abuse in the doctor-patient relationship means a doctor using the power imbalance, knowledge or influence developed in the doctor-patient relationship to abuse or exploit the patient's trust or vulnerability for sexual purposes or sexual gratification, including by conducting unnecessary physical examinations.

Sexual harassment means any unwanted or unwelcome sexual behaviour, which makes a person feel offended, humiliated or intimidated. Sexual harassment is a type of sex discrimination and the *Sex Discrimination Act 1984 (Cth)* makes

sexual harassment unlawful in some circumstances.

Sexual harassment includes:

- making an unsolicited demand or request for sexual favours, either directly or by implication
- irrelevant mention of a patient's or doctor's sexual practices, problems or orientation
- ridicule of a patient's sexual preferences or orientation
- comments about sexual history that are not relevant to the clinical issue
- requesting details of sexual history or sexual preferences not relevant to the clinical issue
- conversations about the sexual problems or fantasies of the doctor
- making suggestive comments about a patient's appearance or body
- sending sexually explicit emails or text messages
- making inappropriate advances on social media
- behaviour that may also be considered to be an offence under criminal law, such as physical assault, indecent exposure, stalking, obscene communications or sexual assault.

Acknowledgements

The Board acknowledges the following documents, codes and guidelines, which informed the review of the Board's guidelines:

- Professor Ron Paterson, *Independent review of the use of chaperones to protect patients in Australia*, February 2017
- The Medical Council of New Zealand, *Sexual Boundaries in the doctor-patient relationship: A resource for doctors*, 2009
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Guidelines for Gynaecological Examinations and Procedures*, March 2016

⁹ Definition adapted from the Australian Human Rights Commission definition of sexual harassment, <https://www.humanrights.gov.au/our-work/sex-discrimination/guides/sexual-harassment>, accessed 16 June 2016

Review

Date of effect: <date>

These guidelines will be reviewed from time to time as required. The Board will review these guidelines at least every five years.

These guidelines replace the guidelines that came into effect from 28 October 2011.

DRAFT



Statement of assessment

Draft revised guidelines: Sexual boundaries in the doctor-patient relationship

Board's statement of assessment against AHPRA's *Procedures for the development of registration standards, codes and guidelines and COAG principles for best practice regulation*

The Australian Health Practitioner Regulation Agency (AHPRA) has *Procedures for the development of registration standards, codes and guidelines* which are available at: www.ahpra.gov.au

These procedures have been developed by AHPRA in accordance with section 25 of the Health Practitioner Regulation National Law as in force in each state and territory (the National Law) which requires AHPRA to establish procedures for the purpose of ensuring that the National Registration and Accreditation Scheme (the National Scheme) operates in accordance with good regulatory practice.

Below is the Medical Board of Australia's (the Board) assessment of their proposal for its draft revised guidelines against the three elements outlined in the AHPRA procedures.

1. The proposal takes into account the National Scheme's objectives and guiding principles set out in section 3 of the National Law

Board assessment

The Board considers that the draft revised guidelines meet the objectives and guiding principles of the National Law.

The proposal takes into account the National Scheme's key objective of protecting the public by setting out the ethical and professional standards of conduct expected of medical practitioners and against which they will be measured to ensure that only those who practise in a competent and ethical manner are registered.

The draft revised guidelines also support the National Scheme to operate in a transparent, accountable, efficient, effective and fair way. The proposal gives clear guidance on the Board's expectations of medical practitioners and there are protective actions that can be taken under the National Law if a practitioner does not fulfill these expectations.

2. The consultation requirements of the National Law are met

Board assessment

The National Law requires wide-ranging consultation on proposed guidelines. The National Law also requires the Board to consult the other National Boards on matters of shared interest.

The Board is ensuring there is public exposure of its proposals and the opportunity for public comment by undertaking an eight week public consultation process. The process will include the publication of the consultation paper on its website and informing medical practitioners via the Board's electronic newsletter sent to more than 95% of registered medical practitioners.

The Board will also draw this paper to the attention of key stakeholders including the other National Boards.

The Board will take into account the feedback it receives when finalising its draft guidelines.

3. The proposal takes into account the COAG Principles for Best Practice Regulation

Board assessment

In developing the draft revised guidelines, the Board has taken into account the Council of Australian Governments (COAG) *Principles for Best Practice Regulation*.

As an overall statement, the Board has taken care not to propose unnecessary regulatory burdens that would create unjustified costs for the profession or the community.

The Board makes the following assessment specific to each of the COAG principles expressed in the AHPRA procedures.

COAG Principles

a. Whether the proposal is the best option for achieving the proposal's stated purpose and protection of the public

Board assessment

The Board considers that its proposal is the best option for achieving the stated purposes. The draft revised guidelines do not propose any significant changes to the current ethical and professional standards of conduct expected of medical practitioners and the revised guidelines continue to complement the principles contained in the Board's current code of conduct '*Good medical practice: A code of conduct for doctors in Australia*'.

The proposal protects the public by making clear the standards of ethical and professional conduct expected of medical practitioners by the Board, their professional peers and the community. The proposal also provides specific guidance for medical practitioners about their obligations in maintaining sexual boundaries in the doctor-patient relationship.

b. Whether the proposal results in an unnecessary restriction of competition among health practitioners

Board assessment

The proposal will not restrict competition as it will apply to all registered medical practitioners.

c. Whether the proposal results in an unnecessary restriction of consumer choice

Board assessment

The proposal will not result in any unnecessary restrictions of consumer choice as the revised guidelines will apply to all registered medical practitioners.

The proposal should potentially improve a consumer's confidence that all registered medical practitioners are held to the same ethical and professional standards of conduct.

d. Whether the overall costs of the proposal to members of the public and/or registrants and/or governments are reasonable in relation to the benefits to be achieved

Board assessment

The Board considered the overall costs of the draft revised guidelines to members of the public, medical practitioners and governments and concluded that the likely costs are minimal as the Board is not proposing to make any significant changes to the current standards of ethical and professional conduct expected of all registered medical practitioners.

Subject to stakeholder feedback on the proposed revised guidelines, the benefits of having clear guidelines for medical practitioners on the principles that underpin good medical practice outweigh any minimal costs related to medical practitioners and other stakeholders being required to become familiar with the revised guidelines, if approved.

e. Whether the proposal's requirements are clearly stated using 'plain language' to reduce uncertainty, enable the public to understand the requirements, and enable understanding and compliance by registrants

Board assessment

The Board considers the draft revised guidelines have been written in plain English that will help practitioners to understand the standards of good medical practice expected by the Board, their professional peers and the community. The Board has reworded and restructured the guidelines to improve readability and to make clearer the standards expected of medical practitioners.

f. Whether the Board has procedures in place to ensure that the proposed registration standard, code or guideline remains relevant and effective over time

Board assessment

If approved, the Board will review the revised guidelines at least every five years, including an assessment against the objectives and guiding principles in the National Law and the COAG principles for best practice regulation.

However, the Board may choose to review the guidelines earlier, in response to any issues which arise or new evidence which emerges to ensure the guidelines continued relevance and workability.