



Australian Government

National Health and Medical Research Council

Communicating with Patients

Advice for medical practitioners



INVESTING IN AUSTRALIA'S HEALTH





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Advice for medical practitioners

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CONTENTS

A	Foreword	4
B	Introduction	5
1	The benefits of good communication	5
2	The impact of poor communication	5
3	Obstacles to good communication	6
3.1	Physical environment	6
3.2	Doctor-related obstacles	6
3.3	Patient -related obstacles	6
3.4	Cultural and social diversity	7
C	The advice	8
4	Prior to the consultation	8
5	Initiating the consultation	8
6	During the consultation	8
6.1	Active listening	8
6.2	Assisting the patient	9
6.3	Helping understanding	9
6.4	Communicating to facilitate informed decision making	9
6.5	Providing information about diagnosis	10
6.6	Providing information about interventions	11
6.7	Communicating bad news	12
6.8	Withholding information	12
6.9	Use of interpreters	13
6.10	Use of patient advocates	13
6.11	Brief consultations	14
6.12	Advising patients about additional sources of information	14
6.12	Closing the consultation	14
7	Record keeping	14
8	Communication in emergency situations	15
9	Refusal to treat	15
10	Disclosure of information to others	15
D	Further sources of information for the patient	16
E	Suggested further reading	17
F	Appendices	18
i.	Process report	18
ii.	Members of the working group	19

A FOREWORD

In 1993, the National Health and Medical Research Council (NHMRC) issued *General guidelines for medical practitioners on providing information to patients*. This document (hereafter referred to as the 1993 *General Guidelines*) had its origin in 1989 with the publication of a report by the Australian, Victorian and New South Wales Law Reform Commissions on the issue of informed consent. The report was issued shortly after the landmark High Court of Australia decision of November 1992 in the case of *Rogers v Whitaker*. The principles laid down by the High Court in that case, and the 1993 *General Guidelines*, have clearly established the legal and professional framework under which health professionals now provide information to patients.

NHMRC policy requires that its documents are reviewed five years after publication to ensure that they remain relevant and up to date. In order to review the 1993 *General Guidelines*, NHMRC conducted a public consultation on the document from July to August 2002, and received 31 submissions. The Australian Health Ethics Committee (AHEC), a principal committee of the NHMRC, then formed a working group (see Appendix ii) to consider the submissions.

The working group agreed that the 1993 *General Guidelines* remains a valuable statement of what information needs to be exchanged between patients and doctors, and why. Council re-endorsed this document on 18 March 2004 at its 152nd Session.

The working group also agreed that despite the existence of the 1993 *General Guidelines*, and other documents providing information on the ethical and legal requirements for informed consent, many difficulties remain. Problems around providing information to patients relate to what information is offered to patients, and also to how that process occurs. It was therefore concluded that an additional document should focus on highlighting the importance of good communication between doctors and patients. This view was supported by a number of factors, including the repeated findings of Health Complaints bodies and Medical Boards that poor communication is the catalyst for most complaints; the recognition (especially by medical indemnity organisations) that communication skills can be taught; and the increasing emphasis now being placed on communication skills in medical training.

This document reflects these views. The practice of medicine entails more than just good communication, but good communication is essential to effective practice. Good communication skills need to be accompanied by clinical competence, compassion and ethical conduct. The advice contained in this document is not intended to be a textbook on either the acquiring of communication skills or the effective practice of medicine. However it is hoped that it will both assist medical practitioners to identify and adopt the core elements of effective communication with patients and also inform patients, patient carers and representatives.

B INTRODUCTION

This document aims to help doctors communicate effectively with patients.

While all health professionals communicate with patients, the document is addressed primarily to doctors for two pragmatic reasons. First, it is usually doctors who carry ultimate responsibility for communication and its failure. Second, responsibility for patient care is often shared among various health professionals. Dealing with this division of responsibility adequately would require a much longer document. Not all the specific advice offered here will be relevant to other health professionals. However, it is hoped that they will also find it useful.

The document uses the term 'doctor' rather than 'medical practitioner', and 'patient' to refer to a person seeking health care.

I THE BENEFITS OF GOOD COMMUNICATION

Good communication:

- builds trust between patient and doctor;
- may help the patient disclose information;
- enhances patient satisfaction;
- involves the patient more fully in health decision making;
- helps the patient make better health decisions;
- leads to more realistic patient expectations;
- produces more effective practice; and
- reduces the risk of errors and mishaps.

These benefits in turn strengthen communication between patient and doctor and can contribute to better health outcomes for the patient.

2 THE IMPACT OF POOR COMMUNICATION

Poor communication:

- decreases confidence and trust in medical care;
- deters the patient from revealing important information;
- causes significant patient distress;
- leads to the patient not seeking further care;
- leads to misunderstandings;
- leads to the misinterpretation of medical advice;
- underlies most patient complaints; and
- predicts negligence claims.

These difficulties may lead to poor or sub-optimal outcomes for the patient.

3 OBSTACLES TO GOOD COMMUNICATION

There are many possible obstacles to clear and open communication between doctor and patient.

3.1 PHYSICAL ENVIRONMENT

The physical environment may:

- discourage good communication; or
- fail to provide sufficient privacy.

3.2 DOCTOR-RELATED OBSTACLES

The doctor may be:

- inadequately trained in communication skills;
- lacking in sensitivity or empathy;
- unwilling to recognise patient autonomy;
- unaware of problems arising from differences in language and culture;
- affected by time pressures; or
- distracted by external or personal factors.

3.3 PATIENT-RELATED OBSTACLES

The patient may be:

- affected by the condition, illness or medication;
- anxious, embarrassed or in denial about the medical condition;
- inexperienced in identifying and describing symptoms;
- intimidated by health care settings;
- overawed by the doctor's perceived status;
- disadvantaged by differences in language and culture;
- confused by the use of medical jargon;
- reluctant to ask questions; or
- concerned about time pressures.

All of these factors may impede the patient's capacity to provide, take in and retain information.

3.4 CULTURAL AND SOCIAL DIVERSITY

Doctors see patients from a range of ethnic, cultural and socio-economic backgrounds. Social and cultural factors may determine such matters as why patients attend, and may influence the patient-doctor interaction and compliance. Doctors should strive to ensure good communication regardless of the social or cultural background of patients. Communication is facilitated when the doctor is aware of and sensitive to the background or cultural needs of the particular patient.

All of the advice in this document is relevant but additional measures to reduce the risk of misunderstanding include:

- asking questions to appreciate the patient's understanding of health and disease; and
- explaining the doctor's understanding of health and disease.

In certain situations, the following strategies may also be helpful:

- seeking to establish an environment which welcomes and affirms the different background of the patient;
- in negotiation with the patient, considering the use of assistance of agents such as patient advocates, family members, pastoral care workers or spiritual leaders;
- using local institutional protocols for cross-cultural health care practice; and
- seeking advice from, and developing a working relationship with, community agencies that understand and advocate for patients.

Refer also to Section 6.9 - Use of Interpreters.

C THE ADVICE

4 PRIOR TO THE CONSULTATION

Doctors should strive to reduce obstacles to good communication. In relation to the environment, doctors need to be mindful of the setting, including physical barriers and potential distractions, such as avoidable interruptions and excessive focus on the computer screen.

Guidelines for reception staff who are making appointments should include enquiring whether a standard or long consultation is required, and whether the patient has any special needs, such as the requirement for a carer or advocate, or access to an interpreter.

Where forewarned, longer time should be set aside for those consultations requiring greater attention to providing information and answering questions. In certain situations such as conveying bad news, patients may be advised to bring with them a companion of their choice.

5 INITIATING THE CONSULTATION

The foundations of good communication are establishing rapport and active listening. Personal introductions are an important part of establishing rapport, as is acknowledging issues such as appointment time delays. Evidence indicates that allowing patients to present their opening statements without interruption at the start makes it more likely that the issues of concern will be identified.

If the patient clearly has difficulty indicating the reason for the visit, the doctor should give some guidance by asking specific questions to assist the patient in describing the problem.

6 DURING THE CONSULTATION

Better communication can be fostered by active listening techniques, and by helping patients to express themselves and to understand the information given to them.

6.1 ACTIVE LISTENING

Active listening is closely linked to the doctor's capacity to recognise emotional factors contributing to illness and distress. Active listening includes:

- making appropriate eye contact early in the interview;
 - asking open-ended questions;
 - attending to verbal and non-verbal cues;
 - clarifying the information provided by the patient; and
 - clarifying the patient's understanding of the information provided by the doctor.
-

6.2 ASSISTING THE PATIENT

In addition to active listening, the doctor can also assist the patient in other ways.

The doctor can:

- seek to understand the patient's expectations of the visit;
- be sensitive to the needs and circumstances of the patient (including their beliefs, values, fears and social and cultural backgrounds);
- encourage the asking of questions;
- repeat key information;
- allow for note-taking by the patient;
- ask if the patient would like another person of their choice to be present;
- offer an early follow-up appointment for further discussion;
- provide information in writing;
- enlist the help of patient support organisations and other services; and
- raise the idea of seeking a second opinion, where appropriate.

Positive encouragement may facilitate disclosure of relevant information by patients about their health. One current example is the desirability of encouraging patients to discuss their use of complementary and over-the-counter medicines, and other alternative therapies. Another issue often overlooked is the desirability of asking patients about other opinions they may have been given about their condition.

6.3 HELPING UNDERSTANDING

The provision of information and advice to the patient can be facilitated by:

- establishing what the patient wants and needs to know;
- using plain English;
- providing diagrams; and
- providing written material, including consumer publications (translated if necessary).

Written information should not be excessive in quantity for the patient, taking into account his or her capacity, situation, condition and diagnosis. Written information should be provided to reinforce, not replace, an interactive verbal process.

6.4 COMMUNICATING TO FACILITATE INFORMED DECISION MAKING

Good communication is especially important when patients are faced with the need to make decisions about or give consent to interventions.¹ The type of information a person will require to make a decision will vary according to the individual's needs, the nature of the intervention, and the risks associated with intervening or not intervening.

¹ The general term 'intervention' is intended to cover diagnostic procedures and tests, and all forms of treatment (pharmaceutical, surgical etc). The principles involved in providing information for decision making may extend to other interventions including counselling and screening for diseases (eg genetic screening tests) wherever the intervention brings with it risks be they physical, emotional, financial or other.

As has been emphasised previously, good communication enhances informed decision making, while poor communication increases the likelihood of dissatisfaction with unanticipated outcomes.

Both in this document and in the 1993 *General Guidelines*, general guidance is given about the nature of the information that may need to be provided in any situation. Conveying the necessary information requires skilled communication. Respect for patient autonomy and the right of the patient to accept or reject advice, avoiding any suggestion of coercion, and fostering patient understanding, are all integral parts of this process.

Patients seek many types of information and advice from doctors. To enable them to participate meaningfully in decisions affecting their health care, patients need relevant information presented in a way that they can understand. It is not possible, however, to provide information about every detail of all intervention options, potential benefits or harms, and all possible outcomes. It is also not possible to assess risks with complete certainty, and this uncertainty should be communicated to patients.

Where possible, information about the benefits and risks of interventions should be framed in ways which assist the patient to best understand his or her situation, (for example using absolute, rather than relative, risk data) and to understand the nature of risk. The patient should be advised of material risks, as described by the High Court in *Rogers v Whitaker* in 1992. Material risks are those to which a reasonable person in the patient's position is likely to attach significance, or those to which the doctor knows or ought to know the particular patient is likely to attach significance.

Known risks that reasonable people would regard as significant should be disclosed, whether an adverse outcome is common and the detriment slight, or whether an adverse outcome is severe though its occurrence is rare.

The communication process described in this Advice should enable a doctor to become aware of risks that a particular patient would treat as significant.

6.5 PROVIDING INFORMATION ABOUT DIAGNOSIS

When discussing the diagnosis, the following should be considered:

- the possible or likely nature of the illness or condition;
- the degree of uncertainty of any diagnosis;
- the possible need for referral for diagnostic confirmation or refutation;
- the extent and soundness of medical knowledge about the specific condition;
- the status of the patient's illness, whether temporary, chronic or terminal;
- the involvement of the patient in formulation of the ongoing care;
- patient's requests for information;
- sensitivity to the patient's wishes for information; and
- alternative sources of reliable information.

Section 6.7 addresses additional considerations that should be taken into account if the doctor needs to communicate bad news to the patient.

6.6 PROVIDING INFORMATION ABOUT INTERVENTIONS

When discussing what the proposed intervention involves with the patient, the following information should be conveyed in plain language:

- a description of the intervention;
- what will happen to the patient;
- whether the proposed intervention is critical, essential, elective or discretionary;
- whether the proposed intervention represents current accepted medical practice;
- whether the proposed intervention is conventional, experimental or innovative;
- whether the proposed intervention is part of a clinical trial or other research project;
- the degree of uncertainty about the benefit(s) of the proposed intervention;
- how quickly a decision about the proposed intervention needs to be made;
- who will undertake the proposed intervention, including their status and the extent of their experience, and that of any supervising doctor, where this information is known;
- how long the proposed intervention will take;
- how long until the results of any intervention will be available;
- how long will be needed for recuperation and/or rehabilitation;
- what the estimated costs are (where known), including out-of-pocket costs; and
- what, if any, conflicts of interest the doctor may have, including financial ones.

The potential consequences of any proposed intervention should be conveyed including:

- the expected benefits;
- common side-effects, common complications, contraindications and possible harms, including their likelihood and degree;
- uncommon side-effects to which the particular patient may be exposed, or which are of concern to that patient;
- any outcomes that may require further intervention; and
- any significant long-term adverse outcomes (physical, emotional, mental, social, sexual, financial or other).

The patient should be advised of alternative options including:

- what those options are;
- their availability and potential consequences;
- likely short- and long-term consequences that may arise if they choose not to proceed with the proposed intervention or with any intervention at all.

The patient should be advised of proposed follow-up arrangements including:

- clearly stated arrangements for providing the results of the intervention (usually an investigation); and where relevant
- feasibility and costs of the follow-up arrangements.

Complex interventions usually require the provision of detailed information, as do treatments where the patient has no physical illness, for example cosmetic surgery.

6.7 COMMUNICATING BAD NEWS

Before communicating bad news, the environment and length of consultation require additional consideration, as does the patient's preference for having a person of their choice present. In some circumstances, it may be necessary to suggest immediate or early access to additional counselling and/or support services. A prompt follow-up consultation may be helpful when a condition is diagnosed that is likely to involve hospitalisation, sustained treatment and/or lifestyle change, or risk of permanent impairment or death. This will give the patient an opportunity to absorb the information, and to think of questions they may wish to ask.

6.8 WITHHOLDING INFORMATION

Information should not be withheld from patients. There are very few exceptions to this principle, but these include:

- Situations in which a patient expressly directs the doctor or another person to make the decisions, and does not want the offered information.

Even in these situations, the doctor should give the patient basic information about the illness, proposed treatments and the risks involved, and be satisfied that the patient understands both their right to receive information and that this right is being waived. Such decisions should be documented, along with the patient's consent to proceed without detailed information. The patient's decision should be reviewed over time to ensure that there has been no change of mind.

- Situations where a patient has impaired decision-making capacity, and the legally appropriate person requests that information not be provided either to the patient or to that person.

The doctor should give the legally appropriate person basic information about the illness, proposed interventions and risks involved, and be satisfied that that person understands both the right to receive information and that this right is being waived.

- Situations where there is good reason for the doctor to believe that the patient's physical or mental health might be seriously harmed by the information.

Information should not be withheld simply because the patient might be disconcerted or dismayed, or because the doctor finds giving particular information difficult or unpleasant.

The doctor needs to identify and address the concerns of family and carers about perceptions that the patient will be harmed by full disclosure.

- Situations where there is good reason for the doctor to believe that another person's physical or mental health might be seriously harmed by the information. Examples include issues such as domestic violence and intra-familial child abuse.

Situations as outlined above may have complex ethical, legal and privacy considerations, and doctors are advised to seek expert advice, eg from their medical indemnity organisation.

6.9 USE OF INTERPRETERS

When and wherever possible use should be made of qualified interpreters, including Auslan and telephone interpreters when consulting with patients not fluent in English or those with special communication needs. Accredited interpreters receive formal training and are bound by ethical standards of patient confidentiality and accurate interpreting.

Accredited Auslan interpreters should be used for consultations with deaf or deaf/blind patients, at the patient's request. English may be a second language for some deaf patients and relying on written notes and/or lip reading can lead to misunderstanding.

For privacy reasons it is inappropriate to use family members or friends to interpret at medical consultations. However, not all cultural groups welcome the use of non-family members in such circumstances, and doctors need to be aware of, and sensitive to, such a possibility. When using an interpreter, it is important to address the patient directly rather than the interpreter.

6.10 USE OF PATIENT ADVOCATES

Patient advocates can play an important role in assisting communication and patient decision making. For example, they may be involved in assisting patients with chronic illness, mental illness, intellectual disability or those from different cultural backgrounds. Hospitals may employ Aboriginal liaison officers as patient advocates. The use of patient advocates must be negotiated with each patient as not all patients will want their involvement.

6.11 BRIEF CONSULTATIONS

Many doctor-patient contacts are relatively straightforward and brief, and may primarily involve the provision of information and advice, or repeat prescriptions.

This will usually mean that the exchange of information can be accomplished simply. These contacts are nevertheless significant, and the spirit and intent of this advice still applies.

6.12 ADVISING PATIENTS ABOUT ADDITIONAL SOURCES OF INFORMATION

Many patients will have had, or will seek, access to other sources of information about their condition, including information presented on the Internet. This information will be variable in quality, accuracy and scientific validity. Doctors should be courteous about such material as it can alert them to the patient's desire for additional information and, if possible, offer guidance as to its usefulness and relevance.

Referral to appropriate sources of consumer information developed by the NHMRC and other organisations about different conditions and diseases is useful to some patients.

An increasing number of States and Territories and private medical insurers have also introduced telephone assistance, which patients may find informative and helpful.

Section D provides some reputable sources of information to which the patient could be directed.

6.12 CLOSING THE CONSULTATION

Before ending the consultation, it may be useful to provide a further opportunity for questions. Patients may raise very significant issues in their parting comments.

7 RECORD KEEPING

Adequate, accurate and comprehensible medical records are an important part of good communication. The medical record is an essential part of the communication process because continuity of care involves continuity of communication. In many situations, a patient will communicate with more than one person in a medical practice or hospital, and good medical records facilitate this process. Good medical records will allow another practitioner to take up the care of the patient seamlessly, and be recognised by the patient as a fair report of what was said and done.

8 COMMUNICATION IN EMERGENCY SITUATIONS

Good communication is important during an emergency. Each emergency situation, where immediate intervention is necessary to preserve life or prevent serious harm, will determine what is communicated and how that occurs.

The patient should be offered information about their condition and the interventions undertaken at the earliest opportunity during or after the emergency. If time permits, and where appropriate, efforts should be made to communicate with other persons, such as the patient's next of kin or legal guardian.

9 REFUSAL TO TREAT

There are situations where adequate communication is not possible. It is important to recognise that doctors have the right to refuse to consult and/or treat patients. This might apply when patients are violent or abusive, or when they fail to provide necessary information.

In these circumstances, doctors should communicate this refusal to the patient as courteously as circumstances permit, along with the reasons for the refusal, and ensure that alternative care is offered or made available.

10 DISCLOSURE OF INFORMATION TO OTHERS

There are situations when it may be necessary to discuss sensitive information with people other than the patient, for example:

- in emergencies (see section 8, above);
- when patients have impaired decision-making capacity; and
- when duty of care raises issues about protecting others, as may arise in genetic or HIV counselling.

Such situations have complex ethical, legal and privacy considerations and doctors are advised to seek appropriate expert advice.

D FURTHER SOURCES OF INFORMATION FOR THE PATIENT

The Commonwealth Government has established the website *HealthInsite*. This site contains up-to-date and quality-assessed information on a variety of health topics. Doctors may wish to refer patients to this site, at <http://www.healthinsite.gov.au/> for additional information.

A further source of information is a booklet produced by the Australian Council for Safety and Quality in Health Care, the *10 tips for safer health care booklet*. The booklet aims to assist people to become more actively involved in their health care, and includes questions which they might like to ask their health care professional. It can be downloaded at <http://www.safetyandquality.org.au/>

STATE AND TERRITORY GOVERNMENT AGENCIES

ACT

Health First:
(02)6207 7777
TTY* (02)6207 7770
www.healthfirst.net.au

NSW

Health:
(02)9391 9000
TTY (02)9391 9900
www.health.nsw.gov.au

Northern Territory

Department of Health and
Community Services: (08)8999 2400
TTY (08)8999 5511
www.health.nt.gov.au

Queensland

Queensland Health:
(07)3234 0111 or via TTY (07)3815 7602
Healthy Living Site:
www.health.qld.gov.au/HealthyLiving/default.htm

South Australia

Department of Human Services:
(08)8226 8800
Strategy & Planning –
TTY (08)8226 6044
Disability -TTY (08)8226 6245
www.healthysa.sa.gov.au

Tasmania

Department of Health and Human Services
Helpline:
1800 067 415
www.dhhs.tas.gov.au

Victoria

Better Health Channel:
1800 126 637
www.betterhealth.vic.gov.au

Western Australia

Health Direct:
1800 022 222 TTY 1800 022 226
www.onlinewa.com.au/enhanced/wellbeing

* TTY (Telephone Typewriter) service available for the hearing impaired or vocally disabled.

E SUGGESTED FURTHER READING

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Marvel M K, Epstein R M, Flowers K, Beckman H B, *Eliciting the Patient's Agenda. Have we improved?* *JAMA* 1999; 281(3): 283 – 7.

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F APPENDICES

I. PROCESS REPORT

This document was developed in accordance with NHMRC policies on the development of guidelines and advice.

Public consultation on the review of the 1993 *General Guidelines* (at Appendix iii) was undertaken in July-August 2002, and 31 submissions were received. A workshop was then held on 28 November 2002 with representatives from the Consumers' Health Forum and the Australian Medical Council.

A working group (see Appendix ii) subsequently developed a draft document. The draft was placed on the NHMRC website inviting comments, and it was also distributed extensively to key stakeholders, including all medical colleges, all Divisions of General Practice, health consumer organisations and medical defence associations. During this consultation phase, 42 submissions were received.

The document was then reviewed by the working group to consider the submissions received. This final version was endorsed by Council at its 152nd Session on 18 March 2004.

II. MEMBERS OF THE WORKING GROUP

Dr Sandra Hacker (Convenor)	Member of the NHMRC's Australian Health Ethics Committee (AHEC)
Dr Kerry Breen	Chair of AHEC; Member of the NHMRC
Dr Christopher Cordner	Member of AHEC
Ms Belinda Hope	Member of AHEC
Ms Dell Horey	Consumers' Health Forum (member from October 2003)
Dr Peter Joseph	Member of the NHMRC's Health Advisory Committee; Member of AHEC in the 2000-2003 triennium
Mr David Menadue	Consumers' Health Forum (member until October 2003)
Dr Wendy Rogers	Member of AHEC
Mr Noel Spurr	Member of AHEC
Ms Jennifer Simpson	AHEC Secretariat
Mr John Vidas	AHEC Secretariat

The working group would like to thank all those who commented on the 1993 *General Guidelines* in the initial public consultation phase, and those who provided comments on the draft of this document. In particular, they would like to record the assistance of Dr Heather Munro of the Australian Medical Council, and Ms Sue Lockwood of the Consumers' Health Forum of Australia, in the drafting of this advice.
