

10-1-2003

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Recommended Citation

Michael Weir. (2003) "Obligation to Advise of Options for Treatment – Medical Doctors and Complementary and Alternative Medicine Practitioners" ,, .

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Obligation to Advise of Options for Treatment – Medical Doctors and Complementary and Alternative Medicine Practitioners

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An important aspect of health professional's duty of care is to advise patients of the available options of treatment so that the patient can choose the form of treatment that suits her or his requirements. As CAM becomes more evidence-based and accepted, medical doctors need to consider the extent to which they should provide patients with information about those types of treatments. If a CAM treatment option is evidence-based, there is a strong argument that medical doctors should advise of this option for treatment to satisfy their duty. CAM practitioners should also provide details of options for treatment within their own modality but are not obliged to advise of medical options.

Complementary and alternative medicine (CAM) is now a significant element in the provision of health care services in Australia and the Western world generally.¹ This level of usage of CAM and its increasing use by medical practitioners² requires

an assessment of how CAM and orthodox medicine (OM) practitioners fit into the ethical and legal structure of the health care sector.

This article deals with the legal and ethical obligations of medical practitioners to advise patients of options for treatment and the extent to which this extends to CAM options. The article then discusses the obligation of a CAM practitioner to inform patients of OM remedies as part of his or her duty of care to patients.

Complementary and alternative medicine is defined as those parts of the health sector that rely primarily upon holistic, homeopathic, traditional or natural therapies rather than the allopathic approach that characterises Western or orthodox medicine. Examples of CAM modalities include chiropractic, osteopathy, Traditional Chinese Medicine,

¹ In Australia in 1996 it was estimated that at least one in five persons used at least one form of CAM, while half the South Australian population has used alternative medicine and one in five visits a CAM practitioner each year: A MacLennan, D Wilson and A Taylor, "Prevalence and Cost of Alternative Medicine in Australia" (1996) 347 *Lancet* 569; A Bensoussan and S P Myers, *Towards a Safer Choice: The Practice of Traditional Chinese Medicine in Australia* (Victorian Department of Human Services, New South Wales Department of Health and Queensland Department of Health, Nov 1996), p 22. It has been calculated that Americans spend approximately US\$4 billion annually on herbal medicines, with the market increasing by 18% per annum: J E Brody, "Americans Gamble on Herbs as Medicine: With Few Regulations No Guarantee of Quality", *New York Times*, 9 Feb 1999.

² Recent survey evidence suggests that 20% of Victorian general practitioners used one CAM modality, the most popular being acupuncture, meditation, and vitamin and mineral therapy: M V Pirota, M M Cohen, V Kotsirilos and S J Farish, "Complementary Therapies: Have They Become Accepted in General Practice?" (2000) 172 *MJA* 105. This study also showed

that many general practitioners impliedly endorse CAM by referring patients for CAM: 10% of those surveyed said they referred a client to acupuncture weekly and 5% referred a client for chiropractic.

acupuncture, herbal medicine, therapeutic massage, homeopathy and naturopathy.

Medical practitioners' obligation to advise of options for treatment

Based on the ethical principle of autonomy, the common law and statute, medical doctors have an obligation to provide patients with sufficient information to allow them to determine what is, for them, the best course of treatment. This obligation is reflected in professional guidelines, including those of the National Health and Medical Research Council.³ The NHMRC Guidelines indicate that doctors should discuss with patients the proposed approach to treatment and other options for investigation, diagnosis or treatment. The *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s 15(a)-(c), requires the doctor to advise of treatment options that are available (including the option of no treatment). The relevant legal issues are discussed in a number of significant High Court decisions.⁴ These sources are directed to providing an information-rich environment that gives the patient the opportunity to exercise his or her personal autonomy. There is a surprising paucity of case law on the specific issue of the extent of the duty to advise a patient on the options for treatment available to them. Much of the case law in this area relates to claims that a patient was not properly informed of a material risk of treatment where this risk has, in fact, eventuated to the detriment of the patient.⁵

The High Court in *Rogers v Whitaker* provided the often-quoted test for what is a material risk as follows:⁶

“[A] doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be

likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.”

An important causation issue in these types of cases is whether or not the patient is able to satisfy the court that, if appropriately warned of the potential risk, he or she would have opted not to undertake the procedure.⁷ Although the High Court in *Rogers v Whitaker* has not emphasised the question of discussing options for treatment, the principles discussed by the High Court might be applied more broadly to give guidance on this point.

The High Court indicated in *Rogers v Whitaker* that the level of information that should be provided by a medical doctor is influenced by:⁸

- the nature of the matter to be disclosed;
- the nature of the treatment;
- the patient's desire to be informed;
- the patient's character; and
- other surrounding circumstances.

These principles could encompass a duty to discuss the various options for treatment, including not providing treatment at all. This duty is emphasised where the contemplated procedure has substantial attendant risks and there is evidence that no treatment, or a less risky or non-interventionist treatment, may prove successful even if it produces a lower rate of success. A client complaining of back pain would not be well served if one safe but often successful alternative to surgery, namely bed rest and exercise, was not canvassed. The obligation to advise of this option would apply even if this procedure did not have the same degree of success or permanency as surgery. The necessity to discuss the less dramatic intervention is further emphasised if the riskier procedure is still possible after the more conservative option has proven unsuccessful. To deny a patient the information to be able to choose the appropriate procedures offends the ethical principle of autonomy.

Case law on options for treatment

The Canadian case of *Haughian v Paine*⁹ involved a claim against a doctor for negligence and

³ National Health and Medical Research Council, *General Guidelines for Medical Practitioners on Providing Information to Patients* (1993), p 5.

⁴ See *Rogers v Whitaker* (1992) 175 CLR 479; *Chappel v Hart* (1998) 195 CLR 232; *Rosenberg v Percival* (2001) 205 CLR 434.

⁵ R Mulheron, “Observations upon Causation in Recent Failure to Warn Cases” NLR 2000 NLR 2 and “Twelve Tests to Identify Whether a Medical Risk Is Material” 2000 NLR 1.

⁶ (1992) 175 CLR 479 at 490.

⁷ *Chappel v Hart* (1998) 195 CLR 232 at 239-241, 273; *Rosenberg v Percival* (2001) 205 CLR 434.

⁸ (1992) 175 CLR 479 at 493.

⁹ (1987) 37 DLR (4th) 624.

for not obtaining informed consent for spinal surgery. The claimant was diagnosed with a cervical disk herniation. The doctor warned the patient of the risks of surgery to relieve the condition, such as infection, bleeding, neurological dysfunction or some weakness. Complications arose during surgery when surgical gauze passed into the dura, compressing the spinal cord and causing paralysis. After this gauze was removed, the claimant recovered from the paralysis. He was discharged from hospital over two months later. He was described as having changed from a healthy, normal person to a person with the movements of an old man, suffering from severe depression which resulted in two suicide attempts. The court determined that the doctor was not negligent in how the operation was performed but was at fault in not advising the patient of the more conservative option of bed rest, traction, muscle relaxants, physical therapy and analgesics. These treatments came with a lower rate of adverse events, though not with the same rate of success. The court concluded:

“In order to enable a patient to give informed consent, a surgeon must also, where the circumstances require it, explain to the patient the consequences of leaving the ailment untreated, and alternative means of treatment and their risks.”¹⁰

The court concluded that the evidence indicated “there was no adequate discussion, if any at all, of the consequences of leaving the ailment untreated or of undergoing conservative management, and that the consequences were, at worst, a continuation of pain and discomfort and possible need for surgery in the future. The appellant was not told that the prospect was that the condition might, in a matter of months, very well improve, albeit with the prospect of recurrence from time to time. If the condition deteriorated, surgery was always an option in the future. In the absence of such information having been given to the appellant, he was not in a position to give informed consent.”¹¹

The obligation to advise of options for treatment will normally require some particularity in advice. Although the High Court has acknowledged the impracticality of requiring “a professional person to

communicate the detail of every tiny complication that may accompany medical procedures”,¹² this advice should deal with the nature of the procedure, the apparent risks and success rates. Without that detail it would be difficult for a doctor and a patient properly to compare the virtues and risks of different therapies and procedures. Without that information, if a court is subsequently asked to consider whether the patient would have proceeded with the treatment if armed with the relevant information, it would be difficult to ascertain the patient’s likely decision. Kirby J stated in *Rosenberg v Percival* that health providers have a duty

“to inform patients contemplating invasive procedures (such as surgery) of the material risks involved in the treatment proposed, and any available alternatives. Any ‘choice’ by the patient, in respect of such procedures, without the provision of such information, is meaningless.”¹³

The issue for medical doctors is whether this obligation extends to advice on CAM remedies. There is currently no authority that gives clear guidance on this specific issue.

Alternative therapies: A matter of semantics?

The question may be resolved as a matter of definition. The medical profession’s emphasis upon evidence-based medicine requires a reconsideration of the categorisation of distinct OM and CAM remedies. The Medical Council of New Zealand, in its *Guidelines on Complementary, Alternative or Unconventional Medicine*,¹⁴ stated:

“There cannot be two kinds of medicine – conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work. Once a treatment has been tested rigorously, it no longer matters whether it was considered alternative at

¹⁰ (1987) 37 DLR (4th) 624 at 639.

¹¹ (1987) 37 DLR (4th) 624 at 639.

¹² *Rosenberg v Percival* (2001) 205 CLR 434 at 478 per Kirby J.

¹³ *Rosenberg v Percival* (2001) 205 CLR 434 at 465.

¹⁴ Medical Council of New Zealand, *Guidelines on Complementary, Alternative or Unconventional Medicine* (April 2000); The Medical Board of Queensland has adapted these guidelines for their Board Policy on Complementary, Alternative and Unconventional Medicine: see http://www.medicalboard.qld.gov.au/files/policies_alternative.html.

the outset. If it is found to be reasonably safe and effective, it will be accepted. But assertions, speculation and testimonials do not substitute for evidence. Alternative treatments should be subject to scientific testing no less rigorous than that required for conventional treatments.”¹⁵

These Guidelines indicate that a doctor who recommends an unproved or experimental treatment (for example, some CAM remedies) ahead of a proven treatment (such as surgery or pharmaceuticals) must either:¹⁶

- have broad professional support to do so (the example given is the first renal transplant) with the patient’s fully informed acceptance and consent and the sanction of a formally constituted ethics committee (hardly a likely scenario for the use of CAM remedies); or
- “must be prepared to argue, with evidence, that the experimental or unproved treatment is safe, and that the patient is not harmed by withholding the standard therapy”. This emphasises the issue of safety for the therapy itself and the importance of not delaying the standard treatment with the result that the condition worsens and becomes untreatable. The extent of the required evidence is not indicated but the context suggests it would be something less than randomised, double-blind scientific evidence and could conceivably encompass traditional or anecdotal evidence.

The Guidelines indicate that, where no treatment is effective, any treatment must be sanctioned by the general opinion of the profession; or where any risk to patient safety is present, it should be treated as a new therapy requiring the written consent of the patient to its use and formal approval from an ethics committee.¹⁷

Despite this provision, the Guidelines insist that “any doctor who embarks upon a mode of investigation or treatment of patients that is not based upon evidence of effectiveness acceptable to the Colleges and the Council will: ... (d) advise the patient of the evidence-based and conventional treatment options, their risks, benefits and efficacy, as reflected by current knowledge”.¹⁸

The Guidelines endorse a referral of a client to a CAM practitioner “where there is no reason to believe such a referral would expose the patient to harm”.¹⁹

These provisions illustrate a number of points:

- If a CAM procedure is supported by scientific evidence of efficacy and safety, then there is no ethical reason for a medical doctor, if properly trained, not to use it in clinical practice. According to the Australian Medical Association, “evidence-based aspects of complementary medicine are part of the repertoire of patient care and may have a role in mainstream medical practice”.²⁰
- There is no specific indication that it is necessary, when discussing treatment options, to advise of unproven CAM therapies.
- If a CAM procedure is evidence-based, this should be one of the potential options discussed with a client: it should not be seen as “alternative” in nature.
- There is scope for a medical practitioner to use a CAM remedy where there is no concern about its safety based upon less than scientific evidence.

The dichotomy between evidence-based and unproven or experimental treatment is significant. Not all treatments provided in the ordinary course of practice by medical doctors are based upon good scientific evidence.²¹ If the dichotomy discussed in the New Zealand Guidelines is accepted, then these treatments are in the same category as CAM

¹⁵ M Angell and J P Kassirer, “Alternative Medicines – The Risks of Untested and Unregulated Remedies” (1998) 339 *NEJM* 839.

¹⁶ Medical Council of New Zealand, n 14, p 2.

¹⁷ The *Medical Practitioners Act 1995* (NZ), s 109(4), provides that a doctor will not be deemed guilty of professional misconduct merely because he or she ascribes to a particular theory of medicine or healing and has acted honestly and in good faith. This provision has proven a bulwark against prosecution of doctors using unorthodox methods: see also K Dew, “Limits on the Utilization of Alternative Therapies by Doctors in New Zealand: A Problem of Boundary Maintenance” (1997) 32 *Australian Journal of Social Issues* 181.

¹⁸ Medical Council of New Zealand, n 14, p 2.

¹⁹ Medical Council of New Zealand, n 14, p 3.

²⁰ Australian Medical Association, *Position Statement: Complementary Medicine* (2002), para 1.1.

²¹ E J Mulligan, I Rower and J Sackett, “Inpatient Medicine is Evidence Based” (1995) 346 *Lancet* 407; R Smith, “Where is the Wisdom...? The Poverty of Medical Evidence” (1991) 303 *BMJ* 798.

procedures, except perhaps that they may enjoy the support of the medical profession.

Does a medical practitioner have an obligation to discuss CAM options with a patient?

One form of CAM that has been readily accepted by the medical profession is acupuncture. Its acceptance is reflected in the fact that Medicare provides benefits for acupuncture treatments by medical doctors.²²

The efficacy of acupuncture is supported by a substantial degree of scientific evidence, particularly in the areas of pain management, nausea and vomiting.²³ There are risks associated with acupuncture but these risks are considered to be less than the risks associated with Western medicine.²⁴ Consistent with the position discussed above, one could conclude that a medical doctor should discuss acupuncture as an option for treatment in those cases where it has proven to be effective. If the practitioner is not able to perform acupuncture for want of training, a referral to a medical acupuncturist could be made if the patient indicates a preference for that form of treatment.

Chiropractic, homeopathy and herbal medicine

The crux of the legal and ethical issue for medical practitioners is whether they are entitled or obliged to advise of CAM modalities as treatment options when their efficacy and safety may be in dispute. Complementary and alternative medicine treatments range from those that are totally unproven, to those reliant upon anecdotal and traditional use, to those based upon scientific proof of variable quality. There is a substantial body of scientific evidence (often disputed) for the efficacy of chiropractic,²⁵ homeopathy²⁶ and herbal

medicine²⁷ that could arguably provide the basis for an obligation to discuss these treatment options where there is scientific evidence of efficacy and safety.

The legal authorities on this point do not differentiate between the types of remedies that should be discussed as options for treatment so as to indicate the necessity to discuss CAM options. It would appear necessary to draw a line around the type of treatment options that a medical practitioner would not be obliged to discuss with a client. Haigh suggests that

“perhaps the time is ripe for a more expansive conception of a patient’s right to make decisions. In fact, statutory provisions regarding disclosure and information are drafted widely and can be interpreted in this way. A vastly different, or wider, view of disclosure could extend the idea that patient information, to be meaningful, must be based on the provision of *all* necessary information. Competent adult patients should be entitled to decide (and refuse) not simply between competing orthodox treatments, or between treatment and no treatment, but also between the specific form of medical procedure, including orthodox or alternative.”²⁸

chiropractic may be more effective than hospital outpatient treatment, resulting in savings.

²⁶ J Kleijnen, A JM de Ceanen, J van Everdingen and L Krol, “Placebo Effect in Double-blind Clinical Trials: A Review of Interactions with Medication” (1994) ii *Lancet* 1347 have described 108 controlled homeopathy trials (68 randomised) for a number of ailments. Of these studies, 81 had positive effects and 24 lacked positive effects. Most were completed using fastidious techniques and with placebo controls. C Hill and F Doyon, “Review of 38 Randomized Trials of Homeopathy” (1990) *Revue D’Epidemiologie et de sante Publiquemede* 139 in 1990 made a meta-analysis of 40 randomised clinical trials but did not find evidence for homeopathy efficacy. From a fastidious perspective, success over placebo has not been demonstrated but there may be methodological problems and some doubt as to whether the party providing the therapy has sufficient knowledge of the therapy. The scientific evidence for homeopathy has been criticised on the basis it often deals with illnesses that are highly subjective in nature: T J Kaptchuk, R A Edwards and D M Eisenberg, “Complementary Medicine: Efficacy Beyond the Placebo Effect” in E Ernst (ed), *Complementary Medicine: An Objective Appraisal* (Reed Educational and Professional Publishing, Oxford, 1996), pp 46-47, 50.

²⁷ E Ernst, “The Risk-Benefit Profile of Commonly Used Herbal Therapies: Gingko, St John’s Wort, Gingseng, Echinacea, Saw Palmetto and Kava” (2002) 136 *Annals of Internal Medicine* 42.

²⁸ R A Haigh, “Alternative Medicine and the Doctrine of Patient Disclosure” (2000) 8 *JLM* 197 at 203.

²² *Health Insurance Act 2000* (Cth); *General Medical Services Table Regulation* (Cth), Item 173, Sch 1, Group A7.

²³ Bensoussan and Myers, n 1, pp 260-315.

²⁴ Bensoussan and Myers, n 1, p 83.

²⁵ There is good scientific evidence for the effectiveness of chiropractic, especially for lower back pain: J W Spencer and J J Jacobs, *Complementary/Alternative Medicine: An Evidence-Based Approach* (Mosby, St Louis, 1999), p 5. Other sources of evidence, eg, T W Meade, “Low Back Pain of Mechanical Origin: Randomized Comparison of Chiropractic and Hospital Outpatient Treatment” (1990) 300 *BMJ* 1431, indicate that

Haigh acknowledges the practical difficulties in requiring Western medical practitioners to provide that advice as they may lack the requisite training. He summarises the issue as follows:

“In essence, we could ask ourselves whether a reasonable doctor, practising medicine in the 21st century, in light of increasing knowledge regarding patient behaviour and alternative medicines, should be aware of, and advise patients of, the presence of alternative approaches.”²⁹

Autonomy and CAM options

Haigh argues strongly that the principle of autonomy supports the maximum level of information to allow people to make decisions about their health. He suggests this should be reflected in the obligation of medical practitioners to discuss the orthodox and the alternative forms of treatment. Presumably he would consider that a medical practitioner not versed in a CAM remedy could obtain the necessary information or refer the patient to a person who practises that therapy.

The greater emphasis upon personal autonomy is well founded. Too often the cultural authority wielded by scientific medicine has seen it make assumptions about its ability to sift what is appropriate for a patient to digest as part of the decision-making process. The concept of therapeutic privilege is an example of this.³⁰

If the question is whether a medical practitioner currently has an obligation to discuss a wide range of alternative forms of therapy, the answer would be in the negative – but with a rider. There appears to be no reason why a CAM therapy should not be discussed by a doctor with a patient if it is based upon well-researched scientific evidence of efficacy and safety. This criterion applies to acupuncture for certain ailments and procedures and arguably chiropractic, homeopathy and herbal medicine. Without such advice, a client has not been provided with the full range of options, each with their own risks, success rates and advantages.³¹ With the

history of criticism and suspicion between OM and CAM,

“[t]o demand that such therapies receive general medical acceptance before requiring their inclusion in informed consent disclosure effectively will cut off many patients from access to information about the therapies’ risks and benefits. To broaden the disclosure obligation, in contrast, would counter the historical medical parochialism toward complementary and alternative medicine and enhance patient access to the information being filtered through their physicians about such therapies.”³²

In regard to some forms of CAM, such as spiritual healing, that do not have this level of scientific acceptance, it is not possible to provide clients with this information. The advice on this issue could offer only generalisations or vague references to traditional, anecdotal use and safety issues. This dearth of scientific evidence may reduce in the future as further research continues.

Doctors should provide information about CAM options if asked by the patient and should proffer the evidence that exists for a particular treatment. The AMA supports further education in CAM for medical practitioners for this purpose.³³ A medical practitioner could provide information on the CAM options for treatment and give his or her view of their dangers and advantages. If the use of unproven remedies was contemplated by a patient, an important consideration would be whether attempting such a remedy in the case of a progressive illness would decrease the chances of successful orthodox treatment if the CAM remedy proved unsuccessful.

Any such advice should indicate the limitations on the extent of scientific evidence and safety issues. Although it is unlikely that the medical practitioner would be in a position to provide these therapies, respect for a patient’s autonomy (even if the patient was contemplating a step the doctor might consider unwise) would suggest not dismissing his or her interest. In the words of the Medical Council of New Zealand guidelines:

“Where patients are seeking to make a choice between evidence-based medicine or alternative medicine, the doctor should present all the

²⁹ Haigh, n 28, at 203.

³⁰ *Rogers v Whitaker* (1992) 175 CLR 479 at 490, 494.

³¹ M H Cohen, *Beyond Complementary Medicine: Legal and Ethical Perspectives on Health Care and Human Evolution* (2000), p 33.

³² Cohen, n 31, p 39.

³³ Australian Medical Association, n 20, para 4.4.

information available concerning his or her recommended treatment thus allowing the patient, as a competent and consenting adult, to make an informed choice which should then be treated respectfully.”³⁴

Do CAM practitioners have an obligation to advise of the OM options for treatment?

This was an issue raised in a review by Freckelton³⁵ of the author’s book entitled *Complementary Medicine: Ethics and Law*.³⁶ This text³⁷ stated that it would be unreasonable for CAM practitioners, when fulfilling their obligation to advise of options for treatment, to advise on OM forms of treatment. For example, a chiropractor would not be obliged to discuss the risks and advantages of surgery for a back complaint when discussing the various options for treatment within the chiropractic model; nor would a homeopath be obliged to discuss the varying risks and success rates of antibiotics for ear infections. Freckelton commented:³⁸

“It is probable that Weir undervalues the extent of the obligations of health care practitioners in this regard. He does so in an important way. If complementary practitioners are what their name suggests, they ‘complement’ orthodox medicine. A key part in their training is, and should be, awareness not just of their own limitations but of what orthodox medicine can offer to the provision of co-ordinated or variegated treatment. The same applies to their actual provision of treatment. Few patients are in a position to evaluate their treatment modality options scientifically. They rely upon health care practitioners for the provision of sufficient reliable, dispassionate information for them to be able to exercise their decision-making in an informed manner. If this information is not made available to patients, their ability to discern amongst their options is compromised and their

autonomy diminished. At this point the civil law is likely to intervene and hold them culpable.”

Haigh appears to support this type of obligation for alternative medicine practitioners.³⁹

There are a number of reasons for rejecting this proposition.

Medical doctors are unlimited practitioners

The obligation of medical doctors to advise of potential options for treatment including, arguably, some CAM options, derives from the role of medical doctors and the assumption that they are entitled to perform any medical procedure. There may be practical, ethical and professional reasons why a general practitioner does not perform brain surgery but there is nothing legally to stop him or her doing so.

A registered medical practitioner is exempted from the scope of practice provisions of the Health Practitioner Registration Acts that specify those persons entitled to perform particular health-related activities such as:

- dentistry;⁴⁰
- physiotherapy;⁴¹
- chiropractic and osteopathy;⁴² and
- podiatry.⁴³

Most doctors are not trained to perform these disciplines or are trained at a less sophisticated level than the specifically trained health professional. Few would argue that a medical doctor is better trained to perform chiropractic procedures than chiropractors. The health sector is arranged so that a medical practitioner is entitled to supply the full gamut of services. All other registered health professions are given a subset of the medical profession’s whole.

This hegemony supports a broad ethical and legal obligation upon medical doctors to outline the various options for treatment. If a medical practitioner is assumed to be entitled to provide virtually any form of therapy, it is not unreasonable

³⁴ See n 14, p 1.

³⁵ See (2000) 8 JLM 224.

³⁶ See also *The Law Report*, “Health Law under the Microscope”, Radio National, 6 Dec 2000.

³⁷ M J Weir, *Complementary Medicine: Ethics and Law* (Prometheus Publications, Brisbane, 2000), p 97.

³⁸ (2000) 8 JLM 224 at 225.

³⁹ Haigh, n 28, at 205.

⁴⁰ For example, s 57(4) of the *Dentists Act 1989* (NSW): the practice of dentistry in accordance with the ordinary course of practice of a medical practitioner.

⁴¹ *Public Health Act 1991* (NSW), s 10AC.

⁴² *Chiropractors and Osteopaths Registration Act 1997* (Tas), s 56(2).

⁴³ *Podiatrists Act 1989* (NSW), s 4(2).

to expect a broad discussion of treatment options. If a general practitioner is not sufficiently experienced or knowledgeable to discuss the various options for treatment and their risks, the general practitioner would be expected to refer the patient to a specialist. Patients will usually expect medical doctors to indicate what medical science currently considers is the appropriate form of treatment, whether it be surgical, pharmaceutical or nutritional.

Physiotherapy: Comparison of obligations

If a CAM practitioner is said to have an obligation to advise of orthodox medicine options for treatment, does this also apply to a physiotherapist? A physiotherapist is an allied health professional trained from an orthodox medicine perspective. A physiotherapist relies upon referrals from medical doctors or receives patients directly as a primary health practitioner without referral. This means that physiotherapists will deal with matters that could require medical intervention. If the obligation to advise patients of treatment options is applied consistently, then physiotherapists should discuss options for treatment, such as surgery, with a patient.

There is no such practice, protocol or understanding that physiotherapists are obliged to advise of the various orthodox medicine treatment options. They may be in breach of their professional duty if they do not refer to a medical doctor when a condition requiring medical assistance arises.

The scope of practice of physiotherapists was discussed in *Re Ward*,⁴⁴ involving an appeal by a physiotherapist against his suspension from practice for unprofessional conduct. The physiotherapist treated a child with cancer outside the scope of his training and in breach of the statutory scope of practice provisions. Abbott J held that the definition of physiotherapy provided a statutory limit to the practice of physiotherapy.

This approach has an expansive aspect in that, within the statutory scope of practice, a registered physiotherapist is not limited by a lack of training. For example, if the statutory definition permitted the use of ultrasonic equipment, the practitioner could provide this treatment even if he or she had no

training in that equipment. The limiting aspect of this approach is that a physiotherapist could not use techniques outside that statutory definition. Abbott J stated:⁴⁵

“[I]t is immaterial what the previous training of the practitioner may have been; when practising as a physiotherapist and holding himself out as so practising, he is confined to the forms of treatment comprised in the definition of physiotherapy laid down in the Act.”

This suggests a narrow obligation to give advice on medical treatment options but a broad obligation to refer to a medical practitioner in appropriate cases.

The limited role of a CAM practitioner in law

A CAM practitioner may not be entitled by law to perform the broad range of treatments that may be available for a particular malady. In South Australia, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory, only medical doctors are entitled to “practise medicine” or “to provide medical treatment”.⁴⁶ In these jurisdictions, it is an offence for a CAM practitioner to provide medical services, to practise medicine and in some cases to give medical advice. The equivalent Queensland and Victorian statutes do not prohibit medical practice by unregistered persons, suggesting that the common law entitlement to practise medicine continues other than a statutory prohibition against “holding out”.⁴⁷

Definition by the courts

There is no clear authority on what constitutes “the practice of medicine” in the context of complementary medicine.

Any treatment of human ailments might arguably constitute the practice of medicine, but common sense suggests that this term requires some limitation. The *Macquarie Dictionary*⁴⁸ defines medicine as “the art or science of restoring or preserving health or due physical condition, by

⁴⁴ (1953) SASR 308.

⁴⁵ (1953) SASR 308 at 320-321.

⁴⁶ *Medical Practitioners Act 1983* (SA), s 31(1); *Medical Act 1894* (WA), s 19; *Medical Practitioners Act 1996* (Tas), s 63; *Medical Act 1995* (NT), s 56; *Medical Practitioners Act 1930* (ACT), s 46.

⁴⁷ *Younghusband v Luftig* [1949] 2 KB 72.

⁴⁸ Macquarie University, New South Wales, 1988.

means of drugs, surgical operations or appliances, manipulations etc (often divided into medicine proper, surgery and obstetrics)". This broad definition covers virtually all Western medicine modalities. The practice of a profession may require some habitual or customary exercise of a craft,⁴⁹ suggesting that isolated activities might not constitute the practice of medicine.

The constant concern for a CAM practitioner is to avoid the implication that he or she is "practising medicine". There appears to be a reluctance by professional boards to commence actions in regard to those provisions because of the difficulty in proving that the practice of medicine has occurred.⁵⁰ This concern is probably greatest in South Australia where the prohibition is in regard to medical treatment and it is defined to include "all medical or surgical advice". This provision would suggest that advice as to options for treatment could breach this provision if the advice canvassed CAM and medical options.

In addition to the specific provisions relating to the "practice of medicine", all States provide that it is an offence to "hold out" as a medical practitioner.⁵¹ This is a separate offence from the practising of medicine by an unregistered person. This provision continues to be enforced by the various medical boards and is problematic for CAM practitioners. These provisions cover not only the obvious case of a CAM practitioner using the term "MD" or "Dr" falsely to suggest that he or she is a registered doctor. A "holding out" could occur where "medical" titles are not used based upon the act of providing medical treatment.⁵²

Shakoor v Situ

The current statutory background supports the role of CAM practitioners who are obliged to advise of treatment options within the range of their modality but remain cognisant that they are practising within an OM context. This was the sentiment in *Shakoor v Situ*,⁵³ the most significant common law case on CAM practitioners.

Shakoor v Situ involved a claim by the widow of Abdul Shakoor who died after receiving a course of Chinese herbal medicine from the defendant. She contended that his death was caused by the negligence of the defendant thereby entitling her to claim for damages under the *Fatal Accidents Act 1976* (UK) and the *Law Reform (Miscellaneous Provisions) Act 1934* (UK).

The defendant was trained in China in both traditional and modern medicine and had been practising in the United Kingdom for a number of years. He was not a registered medical practitioner but was a member of a relevant TCM professional association.

The deceased consulted the defendant about multiple benign lipomata (fatty deposits below the skin). He had been told by his general practitioner that the only remedy for this condition was surgery. The defendant prescribed a decoction of 12 herbs to be taken on alternate days. After taking the herbs, the deceased became ill and eventually suffered liver failure. He died after a liver transplant.

The judge, Bernard Livesey QC, summarised the case as follows:⁵⁴

"The case for the claimant must therefore stand and fall on the allegation that it was negligent of the defendant to prescribe the decoction; alternatively to do so without warning the deceased of the risk of the injury to which ingestion of the decoction would expose him."

The significant argument presented by the plaintiff was that the defendant had held himself out as the equivalent of a general medical practitioner specialising in skin complaints and should be judged by the standards of reasonably competent medical practitioners in that field in the United Kingdom. It was argued that, on that test, he should have known about the possibility of injury as medical journals such as *The Lancet* had warned of the known risk of liver damage and, in one case, of death involving the ingestion of similar herbal medicine.

If accepted, this type of test could expose a CAM practitioner to liability for negligence even if he or she was acting in accordance with the requirements of the profession. This approach, if generally adopted, would confirm the superior status of OM over alternative forms of healing.

⁴⁹ *Knott v Physiotherapists Registration Board* [1961] WAR 70.

⁵⁰ Queensland Health, *Health Review of Medical and Health Practitioner Registration Acts*, Draft Policy Paper (1996), pp 55-56.

⁵¹ For example, *Medical Practice Act 1994* (Vic), s 62.

⁵² *Smith's Newspapers v Becker* (1932) 47 CLR 279.

⁵³ [2000] 4 All ER 181.

⁵⁴ [2000] 4 All ER 181 at 185.

The defendant also argued that, as the plaintiff had not provided evidence of appropriate professional practice from a TCM practitioner, it was not possible to find negligence against the defendant as evidence from a similar area of expertise was required.⁵⁵

The judge did not accept that TCM practitioners should be judged by the same standards as medical doctors:

“The Chinese herbalist, for example, does not hold himself out as a practitioner of orthodox medicine. More particularly, the patient has usually had the choice of going to an orthodox practitioner but has rejected him in favour of the alternative practitioner for reasons personal and best known to himself and almost certainly at some personal financial cost. Those reasons may include a passionate belief in the superiority of the alternative therapy or a fear of surgery or reliance (perhaps dependence) on orthodox chemical medications which may have known undesirable side-effects either short or long term or both. (In the instant case, where the deceased was not known have been predisposed to favour alternative medicine, his motivation may, for all we know, have been a fear of surgery or merely a desire to avoid the delays attendant nowadays on non-urgent surgical cases.) The decision of the patient may be enlightened and informed or based on ignorance and superstition. Whatever the basis of the decision, it seems to me that the fact that the patient has chosen to reject the orthodox and prefer the alternative practitioner is something important which must be taken into account. Why should he later be able to complain that the alternative practitioner has not provided him with skill and care in accordance with the standards of those orthodox practitioners whom he has rejected?”⁵⁶

While rejecting the application of the OM standard of care, the judge acknowledged:

“[I]t will ... often (perhaps invariably) not be enough to judge him by the standard of the ordinary practitioner ‘skilled in that particular art’, it will often be necessary to have regard to the fact that the practitioner is practising his art alongside orthodox medicine, the court will need

to consider whether the standard of care adopted by the alternative practitioner has taken account of the implications of this fact. The implications may vary depending upon the area of expertise and specific art or omission which is under scrutiny in the individual case.”⁵⁷

The judge then continued with the question of what the content of the duty of an alternative medicine practitioner is in the context of this case. He considered there were three important points that needed to be made in the context of a practitioner prescribing a chemical or herbal remedy for internal consumption:

1. Practitioners need to recognise they are holding themselves out to practise within a system of law and medicine which will review the standard of care that has been taken in relation to a client.
2. Where a remedy is prescribed, it is not enough to say that the remedy is traditional and considered not harmful: it is the practitioner’s duty to ensure the remedy is, in fact, not harmful or potentially harmful.
3. Practitioners must recognise the probability that any person suffering an adverse reaction to such a remedy is likely to find his or her way into an orthodox hospital and the incident may be written up in an orthodox medical journal. Practitioners should take steps to ascertain this evidence which could be satisfied by being a member of an association that searches the relevant literature and reports any relevant material to the practitioner.⁵⁸

The judge then said a claimant could succeed in a claim against an alternative practitioner either by calling an expert in the modality specialty in question (this was not done in this case) or by proving that the prevailing standard of care and skill in the art in question was deficient in regard to the risks that should have been taken into account. The latter argument was what the plaintiff relied upon in this case.

In regard to the obligation to warn of the possible side-effects, the judge considered:

“[T]he adverse reaction of the type which occurred is such a rare event that I do not believe that a doctor would be obliged to give a warning

⁵⁵ [2000] 4 All ER 181 at 187.

⁵⁶ [2000] 4 All ER 181 at 188.

⁵⁷ [2000] 4 All ER 181 at 188-189.

⁵⁸ [2000] 4 All ER 181 at 189.

and, if a warning were to be given, the risk could legitimately have been presented as so small that I do not believe that an appropriate warning would have had the effect of dissuading anyone, let alone the deceased, from making the treatment.”⁵⁹

The significance of this decision is that:

- It confirms the approach taken in the Full Court of the Supreme Court of South Australia in *Bawden v Marin*⁶⁰ that a similar test applied to medical doctors will be applied to CAM practitioners but based upon the expertise not of a medical practitioner but a reasonably competent member of the CAM specialty under consideration.
- That practitioners are not able to ignore scientific evidence that may be provided by OM which should impact upon the content of their duty of care to their client.
- It is important in any proceedings brought against a CAM practitioner to obtain expert evidence of what is or is not competent practice for that modality.
- A court will assess whether a particular professional practice is appropriate. This case echoes the principles discussed by the High Court in *Rogers v Whitaker* which does not accord the medical profession the role of the sole arbiter of competent practice.

A CAM practitioner should be appropriately trained to reflect high standards for his or her modality. Where appropriate, this training should incorporate sufficient biomedical education to assist in identifying conditions that should be attended to by a medical practitioner with a clear understanding that in no case should a patient be dissuaded from attending a medical practitioner. A CAM practitioner should understand that if the condition does not respond or worsens, a referral to a medical practitioner should occur.

Boundaries between CAM and OM: The United States example

The appropriate professional boundaries between medical practitioners and CAM practitioners has been an important issue for chiropractors in the

United States. If a patient attends at a chiropractor and it becomes obvious that the complaint is more appropriately dealt with by a medical practitioner, a chiropractor is obliged to refer the patient to a medical practitioner.

Chiropractors are educated in anatomy, chiropractic diagnosis and the treatment of spinal-related conditions.⁶¹ Their level of training is usually at a university bachelor degree standard for a period of five to six years. Although the type of training and education provided to chiropractors has been criticised by OM and may lack the sophistication of medical training in some respects, chiropractors are registered health professionals in virtually all Western countries.⁶²

Despite this background, chiropractors are not normally considered to have an obligation to indicate OM options for treatment. Chiropractors are regarded as having an obligation to:⁶³

- identify problems that are medical and those that are amenable to chiropractic;
- withhold treatment when they should reasonably be aware that chiropractic is not indicated and may aggravate the condition; and
- refer patients to a medical practitioner when medical treatment is indicated.

In the United States, closely defined and enforced definitions of “the practice of medicine” make attempts at medical diagnosis legally hazardous. Once the chiropractic diagnosis is made, the chiropractor should determine if chiropractic can assist. If not, the chiropractor should explain this to the client. If chiropractic treatment is deemed likely to be beneficial, the limits of chiropractic should be explained and the client encouraged not to abandon medical options after advice from a medical practitioner.

⁶¹ D Chapman-Smith, *The Chiropractic Profession: Its Education, Practice, Research and Future Directions* (NCMIC Group Inc, West Des Moines, Iowa, 2000), p 46; A M Kleynhans, J D Sweaney and R G Hunt, “Chiropractic”, in I Freckleton and H Selby (eds), *Expert Evidence* (subscription service, Lawbook Co., Sydney, 1993-), Ch 42.

⁶² Chapman-Smith n 61, p 30.

⁶³ H M Rian, “An Alternative Contractual Approach to Holistic Health Care” (1983) 44 *Ohio State Law Journal* 186 at 192; *Mostrom v Pettibon* 25 Wash App 158; 607 P 2d 864 (1980); *Kelly v Carroll* 36 Wash Ed 482; 219 P 2d 79 (1950).

⁵⁹ [2000] 4 All ER 181 at 191-192.

⁶⁰ Unreported, Full Court, SA, 1447 of 1989.

Different categories of CAM

There is a wide range of modalities that are, for the purposes of discussion, placed under the heading of CAM. Within this designation there is an extraordinary continuum of sophistication in training and healing philosophy. Some modalities such as therapeutic massage, reflexology and feldenkrais are inherently limited in scope. Practitioners of these modalities generally do not make broad claims about the potential benefits of their modality. It is most difficult to apply with any practicality any broad obligations to advise on the broad range of treatment options. These practitioners have no pretensions to being trained for that purpose and their aim is to provide non-invasive techniques often with no more specific therapeutic goal than the promotion of health and harmony. To require these types of practitioners to undertake the onerous task of advising on treatment options would be unrealistic and potentially dangerous. Despite this, a strong appreciation of their limitations and obligations to encourage continuing contact with OM and the need to refer on when appropriate is important.

Slightly different considerations might apply for those CAM modalities that have a claim to be an entire healing system or where practitioners' level of training and education is long and at a high level. Chiropractic, osteopathy and TCM might be deemed to satisfy this description. Although most practitioners in these disciplines would state that their purpose is to promote harmony for the patient, these practitioners will apply specific techniques to achieve clear therapeutic goals in relation to diagnosed maladies. For the reasons discussed above, this group should not be burdened with the same level of obligation to describe the options for treatment within another school of healing. This group of practitioners needs to understand their

legal and ethical obligations to refer to a medical practitioner, however, when the patient does not respond to treatment or the condition is outside their scope of practice.

Conclusion

The trend towards the use of CAM as a health treatment option is likely to increase. With this increase will come integration of CAM into the health sector through further statutory regulation of CAM practitioners.⁶⁴ For this reason, some rationalisation of the relationship between CAM and OM is necessary so that both practitioners and clients understand their entitlements and obligations. Part of this reform should involve further education of CAM practitioners to understand their role and obligations for the benefit of patients. The elimination of the long-term distrust that has developed between OM and CAM would assist both OM and CAM to maximise the delivery of healing and autonomy to the consumers of health services.

Instead of attempting to apply a "one-size-fits-all" approach to the question of options for treatment, the niche provided by CAM practitioners should be respected. Complementary and alternative medicine practitioners, though, should also respect the need to educate themselves about the limits of their modality and the obligation to work within a broad framework that does not ignore the role of OM in some cases. This may involve referral to OM practitioners, co-treatment or co-operative treatment. It is to be hoped that the professionalisation and legitimacy which comes with higher standards of education in CAM professions and the contribution of advances in scientific evidence will forge these connections for the benefit of avoiding maleficence and promoting beneficence for an autonomous client.

⁶⁴ Australian Medical Association, n 20, para 2.2.