# Referral to complementary practitioners

Medicolegal barrister **Elizabeth Brophy** explores the ethical and legal issues that arise when a GP refers a patient to a CM therapist.

Many GPs refer patients to other GPs skilled in a complementary modality for treatment whilst maintaining the primary care role of the patient. There is evidence that GPs differentiate between medical and non-medical practitioners of complementary medicine (CM) and have expressed greater confidence in medical colleagues who practise CM.[1] While GPs do also make referrals to complementary practitioners (CP), is it ethically appropriate and legally prudent to do so?

Medical Boards have begun to provide some guidance about the practice of complementary and alternative medicine but only the Queensland Medical Board has set out a position in relation to referral to CPs: '[w]hen appropriate and where there is no reason to believe such a referral would expose the patient to harm there is no barrier to making a referral to an unconventional practitioner.'[2]

From the legal perspective, the scope of a GP's legal duty of care to a patient encompasses biomedicine and there is no legal duty for a GP to provide direct treatments of CM to a patient or to refer a patient for such treatments. Indeed it would be unwise for a GP to do so without proper education and training.

On the other hand, it is likely that a GP has an obligation to provide advice and information about reasonably available complementary treatments (CTs) [see *JCM* 2003;2(4):23–8]. If, after receiving advice, a patient chooses a CT and the GP does not have the skill necessary to provide the care, then the question of referral inevitably arises. In these circumstances, referral for CM is arguably a necessary concomitant of providing such advice when a patient chooses a CT.

To assist GPs with decisions related to referral, there is a need for pathways to be developed, including guidelines about when and to whom it is appropriate to refer patients and how a referral should take place. The AMA has called for the regulation of CPs, education for medical practitioners and research of CM and these initiatives will all play a role in developing the pathways that are necessary to facilitate the integration of evidence-based CM into health care.[3]

## The reasonable GP

In Australia, there is a lack of decisions on which to confidently define the approaches that the courts will take in relation to referral of a patient to a CP. In the absence of specific principles that have evolved in response to CM, it is the law of negligence — as it has evolved in relation to biomedical practice — that must shape the response of GPs.

A GP owes a duty of care to each patient in all areas in which a GP exercises skill and judgement including in the process of referring patients to other health practitioners. A GP is required to take reasonable steps to avoid harm that is reasonably foreseeable. There are a number of factors to consider when assessing what the reasonable GP would do to avoid harm that is reasonably foreseeable:

- the magnitude of the potential harm;
- the probability of the occurrence of the risk;
- the expense, difficulty and inconvenience of taking alleviating action; and
- any other conflicting responsibilities that you may have.[4]

The greater the probability of a risk and the greater the magnitude of the harm, the greater the need to take steps to minimise that risk, particularly where the cost of doing so is reasonable.

In practice, referral by a GP exercising reasonable care will clearly require that the referral be to a competent practitioner and for treatment that is appropriate for the patient's medical condition.

In the recent decision of *McGroder v Maguire*[5], a GP was found to be negligent after referring a patient with neck pain to a chiropractor when the patient suffered harm as a result of the chiropractic treatment. The patient had been diagnosed by a neurosurgeon as suffering from left sided brachialgia with radiating pain in his arm. This together with an X–ray report that indicated osteophytic impingement at the c5/6 foramina bilaterally and the patient's symptoms of numbness in the arms, and pins and needles in the fingers, pointed to nerve root irritation in the patient's

cervical spine. The Court accepted the evidence of the treating neurosurgeon and an orthopaedic surgeon that it was not acceptable medical practice to refer a patient with such a condition to a chiropractor.[6]

Assessing the suitability of CM for a patient's condition involves an understanding of the patient's medical condition from a biomedical point of view and sufficient knowledge about the complementary modality for that medical condition. The conduct of a biomedical examination and diagnosis is therefore an essential first step in any referral process.[7]

The informed consent process is also key.[8] It involves setting out the risks and benefits of any biomedical treatment and evidence-based CT, to enable the patient to make an informed choice, including whether any chosen CT is to be an adjunctive or an alternative to biomedical treatment.

### Choosing the appropriate CM

A GP must act reasonably in advising or recommending a CM treatment for a patient. The AMA states in its *Position Statement on Complementary Medicine* that medical practitioners should be sufficiently informed about CM to advise patients about the benefits of such treatments and the potential for adverse events.[9] If a GP is not qualified to advise about CM, an initial step is to acquire sufficient knowledge about evidence-based CM modalities — see At Work, pp 36–37.

Before advising the patient about a CM treatment, the following steps will assist in ascertaining if the treatment is appropriate for a patient's medical condition:

1 **Establish** whether there is evidence available in relation to safety and efficacy.
   - **Safety** of a CT is a prime consideration, as harm suffered by a patient is central to any negligence action and the ethical obligation of a GP to 'first do no harm.' CMs are generally recognised as low-risk substances by the Therapeutic Goods Administration but they are not entirely without risks, as all substances that have pharmacologically active ingredients have the potential for adverse events stemming from inherent risks, risks of interaction with other pharmacologically active ingredients and the possibility of idiosyncratic reactions.[10] However, the number of adverse events from the use of CMs is considered to be very low, particularly when compared to those for prescription drug use.[10] There is, however, a question about whether the system for recording adverse events for CMs in Australia has been sufficiently implemented to provide a completely accurate picture.
   - Knowledge of the **efficacy** of a CT is also essential to prevent a patient suffering financial loss through referral for costly, ineffective treatments or loss of an opportunity or delay in accessing efficacious biomedical treatment.
   - Where there is **no evidence** available, the guidance of the South Australian Medical Board is relevant: a medical practitioner 'who chooses to recommend an unproved or experimental treatment ahead of one with proved effectiveness must have broad professional support in doing so as well as the fully informed patient's acceptance.'[11]

**When scientific and traditional evidence is conflicting, the scientific should outweigh the traditional evidence**

2 **Consider** the quality of the available evidence, as there is considerable variation. Consider the source of evidence — science or tradition — and where it fits in the evidence hierarchy. The use of the best external evidence available[12] does not exclude sources on the lower end of the hierarchy or based on traditional use. Where there is both scientific and traditional evidence that is conflicting, however, the scientific should outweigh the traditional evidence.[10] Determine whether the evidence supports:
   - both safety and efficacy — the CT could be recommended;
   - serious risk or inefficacy — the CT should be avoided and actively discouraged;
   - safety but efficacy is inconclusive — cautious use with close monitoring of effectiveness may be appropriate for some CTs;
   - efficacy but safety is inconclusive — consider cautious use with close monitoring for safety for some CTs.[13]

   The Medical Practitioners Board of Victoria advises that 'when alternative therapies pose risks of serious side effects, the patient should be advised to seek a second independent medical opinion.'[14]

3 **Consider** other dimensions that will be relevant to making a reasonable decision including:
   - the patient's medical condition;
   - whether there is an efficacious biomedical treatment available;
   - whether the CT is to be an adjunctive or an alternative treatment.

   If, for example, the patient's condition is not serious or there is no biomedical treatment or it has been tried unsuc-

cessfully or the treatment is to be adjunctive to biomedical treatment, lower levels of evidence in relation to efficacy may be appropriate.
On the other hand if the patient's condition is serious, there is an effective biomedical treatment and the CT is being accessed as an alternative treatment, the increased risks of forgoing a standard treatment will likely require higher levels of evidence. The Medical Practitioners Board of Victoria advises that 'patients who are offered alternative remedies must not be denied access to standard proven therapies of a type which would be provided by medical peers'.[14] As a rule of thumb it has been suggested that the quality of evidence should increase proportionally to the seriousness of the medical condition.[10]

## Choosing an appropriate practitioner

The next task of the GP is to identify qualified and competent practitioners who practice in the modality to whom the patient can be referred. The GP must also act reasonably in making this decision.

Referral to CPs regulated by statute, such as osteopaths and chiropractors in most States and Territories and designated traditional Chinese medicine practitioners in Victoria, simplifies the task of selection, as it will usually be sufficient for a GP to ascertain that the CP is currently registered under the relevant Act. It is reasonable for a GP to rely on such registration, as it is notice that the practitioner has the required level of training.

Voluntary membership of professional bodies, such as the Australian Acupuncture and Chinese Medicine Association Ltd (AACMA), the Australian Natural Therapists Association (ANTA), the Australian Traditional-Medicine Society (ATMS), the Federation of Natural and Traditional Therapists (FNTT) and the National Herbalists Association of Australia (NHAA), provides evidence that the CP has some training. Membership requirements may vary but there are typically minimum educational requirements, codes of professional practice and disciplinary processes.[15]

In 2002, the Commonwealth Government provided a grant to these associations to assist them in establishing national professional registration systems for acupuncture, naturopathy and herbal medicine practitioners for the purpose of avoiding GST in relation to these services. Notwithstanding this initiative, the Commonwealth apparently has no plans to assume the State and Territory role in relation to regulation of health practitioners.[16]

**Direct communication with a CP should minimise problems that may arise from making the patient the medium of the communication, such as misunderstanding about the purpose of the referral.**

At the State level, the NSW government is about to finalise a consultation on the question of whether regulation of CPs is required and, if so, what models of regulation should be developed.[17] We can expect that other States may engage in similar processes in relation to the regulation of CPs over the next few years. Not surprisingly, the AMA supports the appropriate regulation of CPs, including the need for training in accredited programs and enforcement of codes of ethics.[18]

In addition to the regulatory status of the CP you may also want to know how long the CP has been in practice, if the CP regularly assesses the progress of a patient, understands the limitations of his or her role and knowledge base, and importantly knows when and how to refer on for medical management.[19] It has been recommended, for example, that the less competent the GP is in the area of CM, the more competent the CP needs to be and one way of measuring competence is in years of experience.[20] See 'Working with a complementary therapist', *JCM* 2003;2(1):30–2.

## The process of referral

While there may be circumstances where it is appropriate to leave the patient to utilise his or her own resources to find a CP, given the primary care role of the GP, it is likely to be inappropriate in most circumstances.

Direct communication with a CP should minimise problems that may arise from making the patient the medium of the communication, such as a misunderstanding about the purpose of the referral. Written forms of communication such as letters and reports may therefore be necessary. They are not only a vehicle for information but also a powerful educational tool that can lead to familiarity and trust — essential ingredients for developing an open referral system.[20]

It is reasonable to suggest that the more serious the condition, the more information that should be provided with the referral. This may include the case history, clinical examination, findings, biomedical diagnosis, current biomedical treatments, the ongoing role of the GP, the goals of treatment, planned duration and alternative treatment options should the treatment be ineffective.[20] Information about ongoing biomedical treatment is necessary to minimise the potential for drug–complementary therapy interactions.

A phone call to the CP may also be appropriate in some cases, particularly

in the early stages of establishing a relationship with a CP. A conversation should facilitate a mutual understanding about what is expected from the referral and once again assist in minimising any risks.

## Conclusion

In advising patients about CM and making referrals a GP must consider what the reasonable GP would do in the circumstances. An understanding of what the reasonable GP would do in the circumstances is established by reference to the state of medical knowledge at the time, clinical guidelines and professional standards, policy, procedure and practice manuals and employer directives, as well as the practise of other GPs. In medical litigation, at common law, the expert opinions of medical practitioners are given significant weight by a Court but are not conclusive as it is the Court that is the final arbiter as to whether what was done by the GP was reasonable in the circumstances.

As a result of recommendations made in the Review of the *Law of Negligence Report*, however, a 'peer test' is gradually being introduced around Australia.[21] Under one version of this test, a person providing a professional service does not incur liability in negligence if it is established that the he or she acted in a manner that, at the time of the services, was widely accepted in Australia by peer professional opinion as competent professional practice.[22] The peer test does not apply, however, where the professional opinion is considered to be irrational and where the negligence relates to the provision of advice about risks of a professional service.[23] Setting aside the exceptions, it can be seen that the statutory peer test places greater emphasis on medical judgement, theoretically making it easier for GPs to appreciate the legal standard of care required.

The difficulty for GPs is that the interface of biomedicine and CM is marked by uncertainty at this time and there is little guidance for GPs about referral for CM. There is an urgent need for professional bodies to develop guidelines and to define the professional standards of care for GPs to facilitate the responsible and competent practice of referrals to CPs. ◗

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4 Wyong Shire Council v Shirt (1980) 146 CLR 40, 47; F v R (1983) 33 SASR 189, 192; Rosenberg v Percival (2001) 205 CLR 434, 455. See also s 5B Civil Liability Act 2002 (NSW), s 9 Civil Liability Act 2003 (Qld).
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