Does a doctor have a duty to provide information and advice about complementary and alternative medicine?[1]

by

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Introduction

Current legal thinking emphasises the critical role of patient autonomy in health care decision-making.[2] Does this emphasis extend as far as creating an obligation for a doctor to advise a patient about complementary and alternative health care treatments? In what circumstances, if any, would a court hold that a doctor had not acted reasonably by failing to provide information about complementary and alternative medicine (CAM)? Should a doctor: advise a patient suffering from depression about St John's wort, a herb that has been found to be effective in the treatment of mild to moderate depression but costs less and produces few side effects; advise a patient suffering from dementia of gingko biloba, a herb that has been found to improve functioning in vascular and possibly Alzheimer's type dementia; advise a patient suffering from benign prostatic hypertrophy of the benefits of the herb saw palmetto?[3]

The question as to whether and when a doctor should provide information and advice about CAM is one of a number of unresolved legal issues in relation to CAM and its integration into the health care system.[4]

The increasing legitimacy of CAM

While there is no agreed definition, complementary and/or alternative medicine has been described as a subset of more than 350 discrete medical and health care practices not readily integrated into the dominant health care mode of conventional Western medicine including nutritional and herbal medicine, homoeopathy, acupuncture, chiropractic, mind/body medicine and traditional Chinese medicine.[5] The terms complementary and alternative medicine appear to be used synonymously.

The statistics[6] behind the phenomena of CAM are significant. One of the more frequently cited surveys was a study of more than 1500 adults in the United States of America in 1990. The results showed that 34% of the group, who were representative of all socio-demographic groups, had used one of 16 alternative therapies during the previous year. Six years later an identical survey of 2000 respondents showed that 42% had used an alternative therapy. The therapies included herbal medicine, homoeopathy, energy healing and megavitamins and the respondents had mostly paid for the treatments out of their own pockets, 64% in 1990 and 58% in 1997. When extrapolated these figures show a 47% increase in visits to practitioners of alternative medicine during the seven years with 629 million visits in 1997. In 1997 there was an estimated $27 billion out of pocket expenditure for

alternative therapies. What is perhaps most striking is that out of pocket expenses for CAM equalled those for all physician care, and visits to practitioners of alternative medicine exceeded total visits to all US primary care physicians.[7] Other American surveys show higher rates of use amongst those with cancer and human immunodeficiency virus.[8]

In the United Kingdom 33% of the population had used some form of complementary medicine in 1993 with surveys of patients with chronic and difficult to manage diseases such as cancer and multiple sclerosis showing usage rates of double the general population.[9] The National Health Service provides access to complementary medicine and that access has increased over the last decade.[10] General practices (39%) also facilitate access to CAM for NHS patients.[11] The UK has five homeopathic hospitals, including the London Homeopathic Hospital. The later provides a variety of CAM modalities by conventionally trained health carers.[12]

In Australia studies show that more than 47% of the Australian population used CAM in 1993 and that spending on CAM in the same year was almost double what patients contributed for other pharmaceutical medications.[13] It was estimated that spending and consultations would double from 1993 to 2001 with a $2 billion industry.[14] While at least half of the population is using CAM, access is often self-help and only one third of patients using CAM inform their medical practitioner.[15] Indications are that doctors are increasingly responding to the consumer demand.

A University of Queensland study showed that the number of Australian general practitioners incorporating alternative medicine into their practice doubled during the period 1992 - 1996.[16] A Victorian study of 800 GPs, with a 64% response rate, found widespread acceptance by GPs of acupuncture, meditation, hypnosis and chiropractic with 80% of GPs having referred patients to practitioners of these therapies. Other practices - herbal medicine, vitamin and mineral therapy, osteopathy and homeopathy are accepted by a significant minority of GPs. It is claimed that given the type of sampling used in the study the picture probably reflects what is happening around Australia.[17] A 1998 Western Australia study of Perth GPs showed that 38% had practiced a complementary therapy in addition to conventional medicine,[18] most commonly acupuncture, 47% had undertaken postgraduate studies on one or more of the 10 CAM treatments studied and 63% expressed a desire for future training in the therapies.[19] Ninety per cent of the doctors had been approached by more than 30 patients seeking advice

on CAM and 68% of the doctors were in favour of referring patients to CAM practitioners as part of their medical care.[20] Seventy five per cent had already formally referred a patient for one or more of the listed therapies.[21] It appears that GPs are incorporating CAM to treat patients suffering chronic conditions who are unresponsive to conventional treatment, as an adjunct to conventional treatment or adopting CAM as the main treatment approach.[22]

In May 2001 Kerryn Phelps, the AMA Federal President, referring to the growth of complementary medicine and emerging evidence that complementary medicines are effective, stated that '*...it becomes ethically impossible for the medical profession to ignore them ...It is clear that the medical profession and the AMA must consider its position concerning complementary medicine.*' [23] The AMA has issued a discussion paper and established an Advisory Committee in Complementary Medicine chaired by Dr Rosanna Capolingua-Host. The role of the Advisory Committee is to '... *revise and develop AMA policy on this topic, to provide AMA members with evidence based information about complementary medicines, to advocate to government in relation to key issues on an informed basis and to promote informed debate, as well as to investigate issues such as the role and place of complementary medicine in mainstream practice.*'[24]

Also indicative of the emerging role for CAM in mainstream medicine is the support and attention that CAM is receiving from the Commonwealth government. In the late 1990s the Australian government put in place a Complementary Medicine Reform package. The reforms include the establishment of the Office of Complementary Medicine (OCM) as a discrete administrative group within the Therapeutic Goods Administration and the Complementary Healthcare Consultative Forum (CHCF). The OCM was set up to focus exclusively on the regulation of complementary healthcare products. The CHCF is a high-level policy forum to facilitate consultation between relevant stakeholders - the government, the industry and consumers. The third component of the Commonwealth package is the Complementary Medicines Evaluation Committee (CMEC) an expert committee established in December 1997.[25]

The Commonwealth's reform package follows the establishment of the Office of Alternative Medicine at the National Institutes of Health in the United States in 1992. This US office, now known as the National Centre for Complementary and Alternative Medicine (NCCAM) funds

13 academic centers dedicated to researching alternative medicine at major institutions.[26] At a state level the Victorian Government was the first in the world, outside China, to regulate the practice of traditional Chinese medicine.[27] On the education front there are now courses in complementary medicine in undergraduate medical curriculums in Australian universities and post graduate courses to educate doctors in a number of complementary modalities.[28] Professional and peak bodies have emerged.[29] The Australian Integrative Medicine Association provides a vehicle for peer support and education for what is emerging as a new branch of medicine - '*Integrative Medicine*'. The term *'integrative medicine'* denotes the practice of doctors trained in conventional western medicine integrating CAM into the medical care they provide. To assist in the provision of education for such practitioners the first Australian Department of Integrative Medicine was established in 1998 at Swinburne University of Technology. Private health insurance funds are also increasingly reimbursing services provided by complementary therapists such as acupuncturists, naturopaths, homoeopaths and chiropractors.[30] CAM practitioners lobbied and were successful in getting GST exemption for acupuncture, herbal medicine and naturopathy. These developments are all indicative of the increasing legitimacy given to CAM. It is a trend that will continue into the future and a trend that doctors - general practitioners and specialists cannot afford to ignore or fail to understand.

The duty to provide information and advice

It has been argued that a doctor's duty to provide information needs to be refashioned in the form of legislative based patients' rights to incorporate the obligation to disclose information relating to CAM treatments.[31] To what extent can the existing common law obligation - a doctor's duty to provide information and advice be interpreted to include the obligation to provide information about alternative CAM treatment options?

The law imposes on a medical practitioner a duty to exercise reasonable care and skill not only in examination, diagnosis and treatment but also in the provision of professional information and advice, that duty being a '*single comprehensive duty*'.[32]

The lack of judicial guidance in relation to the doctor's duty to provide information and advice was remedied significantly with the High Court decision of *Rogers v Whitaker* in 1992.[33] Their Honours held that a doctor has a duty to provide information about the material risks of any planned procedure. Decisions since *Rogers v Whitaker*

have provided further clarification about the obligation of a doctor to provide information about material risks.[34]

Although the broader parameters of a doctor's duty to provide information and advice remains uncertain it is clear from the judgments of *Rogers v Whitaker* that the content of a doctor's duty to provide information and advice involves more than the obligation to provide information about material risks.[35]

The majority judgment of the High Court acknowledged the importance of a patient's right to choose as to whether to undergo medical treatment, a choice that is *'...meaningless unless it is made on the basis of relevant information and advice.'*[36] It is the patient who must make the decision but the medical practitioner who holds the information on which the decision must be made.[37] The broader duty was also clear from the judgment of Gaudron J when her Honour stated that the doctor patient relationship gives rise to the duty to provide information and advice in addition to duties arising in respect of diagnosis and treatment.[38]

What amounts to relevant information and advice? How much information and what types of information are necessary to make a meaningful choice? The types of information encompassed by the duty to provide information and advice include the benefits and likely outcomes of treatment, risks involved in the treatment, the possibility and probability of complications and side-effects and alternative treatment options.[39] Such information is reflected in the *'General guidelines for medical practitioners on providing information to patients'* developed by the National Health and Medical Research Council (NHMRC Guidelines).[40] The guidelines recognise that patients are entitled to make their own decisions about their medical treatment, based on information and advice provided by the doctor. While the guidelines are just that, guidelines on the provision of information to patients, and not mandatory standards, they reflect good medical practice and a doctor's current common law responsibility to take reasonable care and may be evidence in civil or disciplinary proceedings to assist the court in deciding if what the doctor did was reasonable in a particular case.[41] Statutory obligations are also relevant to the obligation to provide information and advice and may also be evidence in civil or disciplinary proceedings, to assist the court in deciding if what was done was reasonable.[42]

The duty to provide information and advice about alternative treatment options

In *Rogers v Whitaker* Gaudron J made reference to other types of information outlined in *Canterbury v Spence*[43] as being within the duty of disclosure, including the need for or desirability of alternative treatment promising greater benefit.[44] In *F v R* King C J stated that *'[t]he existence of reasonably available alternative methods of treatment must be an important factor in determining what reasonableness demands in the way of disclosure and advice.'*[45] His Honour, Cox J, in *Gover v State of South Australia* found that the plaintiff was not adequately warned of the alternatives (eye drops and ointment) to eye surgery.[46] In *Haughian v Paine* the Saskatchewan Court of Appeal held that a doctor had a duty to disclose information in addition to material risks, including alternative means of treatment.[47]

To determine if a doctor would be acting reasonably by failing to provide information about alternative treatment options, particularly CAM options, it is necessary to consider the relevant test.

The test for determining if a doctor has acted reasonably

'The standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill...' however, this standard only provides a general framework when seeking to understand a doctor's duty. Is materiality, held by their Honours in *Rogers v Whitaker* to be the test for determining if a doctor acted reasonably in providing information about the risks of a procedure, applicable to the general duty to provide information and advice? Materiality is likely to be the test for the general duty to provide information[48] and therefore applicable to all types of information, including alternative treatment options. To take an alternative view is to contemplate different tests for different types of information and advice. The overriding consideration of their Honours in *Rogers v Whitaker* was a patient's right to choose. There was a clear intent to create an environment of meaningful choice in adopting the test of materiality, a patient-focussed test. There is no basis and it would be contrary to the overriding intent of the High Court to suggest that the courts would adopt some other test for information other than risks.

If materiality is the appropriate test, a doctor should advise a patient about material alternative treatment options and treatment options will be material if *'...a reasonable [or ordinary] person in the patient's*

position, ...[if given the information about alternative treatment option/s], would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if ...[given the information about alternative treatment option/s] would be likely to attach significance to it.'[49] The duty to provide information and advice *'...takes its precise content, in terms of the nature and detail of the information to be provided, from the needs, concerns and circumstances of the patient.*[50] Particular needs or concerns of the patient, known to the medical practitioner, would indicate the need for particular information but where no specific inquiry is made '*...the duty is to provide the information that would reasonably be required by a person in the position of the patient.*'[51] The test of materiality is from the perspective of the *'particular patient'* or the '*reasonable person in the patient's position' ('hypothetical prudent patient').*[52]

In *F v R* King C J held that the amount of information that a reasonable doctor would disclose depended on a number of factors: the nature of the matter to be disclosed; the nature of the treatment; the desire of the patient for information; the temperament and health of the patient; and the general surrounding circumstances.[53]

In *F v R* the court was concerned with the duty to warn of risks but set out the five factors as relevant circumstances in determining what a careful and responsible doctor would disclose in respect of the duty to provide information and advice.[54] The High Court in *Rogers v Whitaker* held that the factors must be considered as a part of the materiality test and it is therefore likely that the factors are also applicable when applying the materiality test to other aspects of the duty to provide information and advice.[55] The *F v R* factors are also reflected in the NHMRC guidelines. Applying the materiality test and the *F v R* factors assists in determining whether a doctor would be acting unreasonably by failing to disclose alternative CAM treatment options although as discussed later the test is probably subject to the doctor first ascertaining just what alternative options are reasonably available for a particular condition.

Applying the materiality test and F v R factors

The purpose of providing information is to give the patient the information necessary to enable him or her to make an informed decision about whether to pursue proposed treatment. What information and how much information will be significant to a reasonable person in the position of the patient? [56] All aspects of the duty to inform interact - risks, benefits, alternative treatment options with related risks and

benefits, and the outcome if the health problem remains untreated. It is a cluster of the various types of information that will make a health decision meaningful for a particular patient at a particular time. As held in *Haughian v Paine* '*[o]ne cannot make an informed decision to undertake a risk without knowing the alternatives to undergoing the risk.*'[57]

A reasonable person is more likely to attach significance to an alternative treatment option, including a CAM alternative, if the risks of the proposed treatment are high and where the risks are low but the magnitude of the harm would be great. Of course, the availability of an alternative CAM option is only meaningful if information about risks and expected benefits of that option are also provided so that they can be compared with those of the proposed conventional treatment. It could be argued that where a CAM option offers an outcome similar to the proposed treatment with no risks or fewer risks this information would be significant to a hypothetical patient.

Complex procedures such as major surgery call forth a greater necessity for the patient to be fully informed as to the risks and likely consequences of treatment.[58] Complex procedures such as surgery are more likely to have greater risks and it is in this environment that a reasonable person is likely to place significance on the availability of CAM treatment options. It has been identified that one context where patients seek out CAM options is where the available conventional treatment is associated with side effects or significant risk.[59]

It is also a doctor's knowledge of a patient's condition that may make particular information material.[60] Consider, for example, the case of someone with a terminal illness where conventional treatments offer little hope of relief from the condition or enhancement of the patient's quality of life. In such a case a CAM option, that offers some relief and has few if any risks or side effects, may be of significance to the particular or even the reasonable person.

The amount of information to be disclosed depends greatly on the patient's expressed or apparent desire for information[61] - *'[a] patient may have special needs or concerns which, if known to the doctor, will indicate that special or additional information is required.*'[62] A patient's direct questions about alternative options, including CAM treatments, should make the doctor aware of what is important to the patient[63] and that the patient attaches significance to this information.[64] Even if a patient does not ask direct questions some evidence of a preference for or knowledge of a patient's use of CAM treatments would create

a circumstance where a doctor should reasonably be aware that the patient would attach significance to such information.

While it would appear that specific requests for information, including information about CAM treatments *'...will ordinarily place the doctor under an obligation to give a truthful and careful answer'*[65] is a doctor expected to inquire as to whether a patient has an interest in or preference for CAM treatments where available so that information can be tailored specifically to the needs of the patient?[66]

Research indicates that most patients do not tell their doctors about their use of CAM treatments. There are a number of reasons why a doctor should seek such information from a patient. For example, the failure to communicate with the patient about the use of CAM can potentially endanger a patient's health given the potential for complications such as herb/drug interactions.[67] While it has been suggested that there are particular circumstances where a doctor should consider asking a patient about complementary medicine use[68] doctors would be well advised to ask every patient about CAM use as a part of standard practice.[69] Of course where a patient indicates that they are already taking CAM or have an interest in such treatments this creates a circumstance where a doctor should reasonably be aware that the patient would attach significance to such information and the doctor should tailor the information provided to the special needs of the patient.

Costs, including out of pocket costs, are according to the NHMRC guidelines information that should normally be given to a patient.[70] The costs may be relevant where there are, for example, considerable out of pocket expenses for a CAM treatment but the proposed treatment attracts Medicare or pharmaceutical benefits.

The general surrounding circumstances, such as where what is proposed is a minor intervention and straightforward matter, where the information is self evident or if the context for care is a busy emergency Department where there is little time to discuss the pros and cons of the intervention, will also be relevant as to what needs to be disclosed in the circumstances.[71] Is it likely, for example, that a doctor would be required to advise a patient suffering from a cold about the risks of antibiotics and about alternative CAM options such as zinc treatment?[72]

The *F v R* factors are to assist a doctor in deciding what information is material but they are not exhaustive. Other matters may be relevant in particular cases.

When applying the test of materiality it is clear that there will be circumstances where a hypothetical or particular patient would consider

information about alternative CAM treatment options significant. But is this the only consideration? Is there a preliminary step before applying the materiality test? What about a doctor's obligation to act in the best interests of the patient? For some CAM treatments, where there are unknown risks and uncertain benefits, it would appear to be irresponsible to pass on such information to a patient,[73] creating hopes that cannot be realised or deterring patients from conventional medical care.

Establishing the cluster of reasonably available alternative treatment options

His Honour Gummow J in *Rosenberg v Percival*[74] referred to Guadron J's statement about the need for a risk to be real and foreseeable.[75] His Honour explained that the first task when deciding whether a doctor had acted reasonably in disclosing information was to identify the actual risk and to the extent that the test for materiality does not deal with the foreseeability of the risk in question the general law of negligence applies.[76] If the first task (before applying the test of materiality) is to identify the actual risk relating to a procedure then it is argued that it is also a necessary preliminary step to identify the alternative treatment options relevant to a patient's condition. It is about identifying the cluster of options that are not *'far fetched or fanciful'* in that it would be unreasonable to expect that a doctor would be aware or consider such options. It is a consideration *'...from the point of view of what a reasonable medical practitioner in the position of the defendant ought to have foreseen at the time.'*[77] In *Canterbury v Spence,* Sherstobitoff J A narrowed the range of options by referring to alternatives offering *greater benefit* than the treatment proposed.[78] In *F v R* King C J referred to *'reasonably available'* alternative methods.[79]

Establishing the cluster of reasonably available treatment options, including CAM options, involves considerations as to the state of medical knowledge at the time.

The current status of CAM in mainstream practice is uncertain but it is clear from the research that some modalities are in the process of becoming part of standard practice. One of the problems in establishing CAM's current place within medical practice is that while in conventional practice new procedures are normally introduced by professional bodies or industries, CAM is seen to be consumer driven with the public adopting the practice and the health professions and industry following[80] and of course different practices may be at different points along the continuum of integration into mainstream medicine.[81]

The difficulty for the medical profession in dealing with CAM is straddling the fence so as not to marginalize and eliminate CAM approaches that have benefits to offer patients while not throwing open the doors of medicine to practices that compromise the quality of health care encouraging reliance on CAM that is inappropriate and discouraging the appropriate use of conventional care. [82] Patients want to be protected from inappropriate treatments and unqualified practitioners.[83]

The dilemma is not as simple as it is sometimes articulated - scientific (conventional) versus non-scientific (CAM) medical practices. While CAM practitioners have faced criticism for failing to offer scientific proof to support practices considerable research has been undertaken around the world and credible research continues.[84] Relevant information about trials and studies on CAM is available in major peer reviewed journals.[85] The Cochrane Collaboration also maintains a list of randomised trials in CAM as does Medline.[86] In addition, it has been argued that many conventional practices have not been scientifically proven.[87]

The future therefore is not about a medical divide between complementary and conventional medicine but viewing all available therapies (conventional and complementary) across a multi dimensional spectrum that takes into account '*...safety, efficacy, practicality, availability, utility and cost effectiveness as well as other dimensions*'[88]

Professor Chris Silagy, former Chair of the Cochrane Collaboration within Australia, stated that '[w]*here clear evidence is available, this should be presented for all treatment options and not just those which reflect the paradigm or particular viewpoint of the treatment practitioner.*'[89] Professor Silagy has also argued that it is the move towards the use of evidence based medicine that can erase the boundary between conventional and complementary medicine as it directs practitioners towards the use of treatments where there is evidence that the benefits outweigh the harms, regardless of the category of treatment.[90]

What level of evidence should doctors look for when assessing if the benefits of a treatment outweigh the harms? Is a specific level of scientific validation required before an obligation to disclose a treatment option arises, regardless of whether or not it would be material to an individual or hypothetical patient? Are observational studies, case studies and qualitative research all acceptable evidence or

are randomised control trials or even systematic reviews of randomised controlled trials necessary?[91]

It is reasonable to suggest that only those treatments that have been the subject of the highest level of scientific validation should be considered. To the extent that the preliminary step of identifying reasonably available alternatives and the materiality test interact one can also argue that the reasonable person will consider CAM treatments that have been shown to be safe and efficacious for the patient's condition at the higher end of the evidence hierarchy significant. In *Shakoor v Situ* Livesey J adjudicating on the standard of care given by an alternative CAM practitioner (traditional Chinese Medicine) held that where a practitioner chose to prescribe a remedy there were three implications to be considered including the safety of the remedy. In establishing safety he held that it was not sufficient to rely on the traditional use of the remedy and a belief that it was not harmful.[92] However, this decision can be contrasted with current therapeutic goods regulation within Australia, which permit low to medium level claims (which can include relief of symptoms of a named disease, disorder or condition) to be made about complementary medicines[93] on the basis of evidence that includes documented traditional use.[94] The provision for some complementary medicines to be evaluated under less rigorous criteria than conventional medicines under the *Therapeutic Goods Act 1989* (Cth) and Therapeutic Goods Regulations (Cth) is recognition of the low risk of these complementary medicines.[95] The lack of rigorous scientific evidence about some CAM treatments is also not constraining some GPs incorporating CAM into practice. They are adopting the therapies because of their clinical success and the history and traditional use underlying the treatments.[96] There is some legal support for such a position as where an unproven or novel treatment is used a doctor will not, on that account alone, be in breach of a duty of care although the doctor should provide information about the risks so that they may be compared to those of other treatments.[97]

Of course information about CAM options can only be provided if a doctor has the information or the facility to refer appropriately to enable the patient to access the information. What about doctors who have no knowledge or competence to advise patients about or to refer patients for CAM treatments? The level of medical knowledge prevailing at the time of an adverse event is a relevant factor in determining whether a doctor has met the required standard of care.[98] A doctor is also required to keep abreast of developments in medical practice;[99] however, failure

to use the latest treatment or to be aware of every new publication will not necessarily constitute negligence.[100] On the other hand failure to use an orthodox approach or use of an untried technique may amount to negligence.[101]

In any proceeding for breach of the duty to provide information and advice it could be anticipated that medical evidence as to the treatment options reasonably available for the patient's condition at the time would be relevant and in this respect at least have a bearing on materiality.[102] Evidence as to the safety and efficacy of a CAM treatment *'scientific legitimacy'*[103] doctors' clinical practice *'clinical legitimacy'*,[104] whether the CAM treatment is contemplated as an adjunct or an alternative treatment and how safe and efficacious the conventional treatments are for the patient's condition would also be relevant.[105] Such evidence will not be conclusive in determining if a doctor has acted reasonably in discharging the obligation to provide information, although it may be decisive in some cases in establishing what alternative options, including CAM options, should have been considered by a doctor when applying the test of materiality.

Ultimately the question to be answered is *'[h]as the doctor in the disclosure or lack of disclosure which has occurred acted reasonably in the exercise of his professional skill and judgement'*[106] and this is the courts *'...after giving weight to the paramount consideration that a person is entitled to make his own decisions about his life'*.[107]

Conclusion

It remains to be seen if a court would find that a doctor had acted unreasonably in failing to disclose information and advice about CAM treatment options. Consumers tend to seek out CAM for health promotion, when conventional treatments have failed and to address the psychosocial aspects of illness,[108] uses that are perhaps less likely to be a part of the circumstances of litigation for breach of the duty to provide information. The obligations of doctors will become clearer as the role and place of complementary medicine in mainstream practice evolves.

The AMA has indicated that it intends to provide guidance to practitioners on a number of aspects of CAM in the future. In the meantime it would be advisable for doctors to elicit information from patients about use of CAM treatments, answer patients' direct questions about CAM treatments, take steps to become informed about reasonably available CAM treatments that have been shown to be safe and effective and become familiar with qualified and competent CAM practitioners (medical and non-medical) to whom referrals[109] can be made when necessary.

While the risk of litigation in this area is probably low at this time the obligation to disclose information is about facilitating patient choice. Opening a dialogue with a patient about CAM will enable a doctor to address any safety concerns, help to create an environment of shared decision making, and facilitate the patient's access to the best of conventional and complementary treatments to ensure better health outcomes for the patient.

(Footnotes)

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1 If a patient wishes to bring an action for failure to disclose information there are a number of matters that the patient must prove. The discussion in this paper is limited to circumstances in which information about CAM options may be considered material.

2 *Rogers v Whitaker* (1992) 175 CLR 479.

3 Wayne B Jonas and Jeffrey S Levin, 'Introduction: Models of Medicine and Healing' in Wayne B Jonas and Jeffrey S Levin (eds) *Essentials of Complementary and Alternative Medicine,* (1999) Lippincott Williams and Wilkins, Maryland, 3.

4 Michael Cohen, *Beyond Complementary Medicine* (2000) The University of Michigan Press, 37.

5 Daniel P Eskinazi, 'Factors That Shape Alternative Medicine' (1998) 280(18) *JAMA* 1621, 1621. CAM is not just about products and treatments but medical systems that influence *'...the way physicians treat, manage and understand health and disease'*: Ronald A Chex, Wayne B Jonas and David Eisenberg, 'The Physician and Complementary and Alternative Medicine in Essentials of Complementary and Alternative Medicine' in Jonas and Levin (eds) above n 3, 31.

6 By 1997 more than 100 surveys on CAM use had been carried out, however, many of these have been criticised for poor research methodology leaving uncertainty about the true prevalence of CAM: E Ernst, 'Prevalence of use of complementary/ alternative medicine: a systematic review' (2000) 78(2) *Bulletin of the World Health Organisation* 252.

7 D M Eisenberg, R B Davis, S L Ettner, S Appel, S Wilkey, M Van Rompay, R C Kessler, 'Trends in alternative medicine use in the United States, 1990-1997:results of a follow-up national survey' (1998) 280(18) JAMA 1569-75.

8 Cited in Chex, Jonas and Eisenberg above n 5, 32.

9 Catherine Zollman and Andrew Vickers, 'Users and Practitioners of Complementary Medicine' (1999) 319 *BMJ* 836, 836.'

10 Catherine Zollman and Andrew Vickers, 'Complementary Medicine in Conventional Practice' (1999) 319 *BMJ* 901, 901-02.

11 Catherine Zollman and Andrew Vickers, 'What is Complementary Medicine' (1999) 319 *BMJ* 693, 693.

12 Catherine Zollman and Andrew Vickers, above n 10, 901-02.

13 A MacLennan, D Wilson, A Taylor, 'Prevalence and cost of alternative medicine in Australia' (1996) 347 *The Lancet* 569-73.

14 Cited in Dr K Phelps, 'AMA Discussion paper: Complementary Medicine' (2001) 17 JAIMA 12.

[15] S S Kristoffersen, P A Atkin and G M Shenfield, 'Uptake of Alternative Medicine' (1996) 347 *The Lancet* 972.

[16] Professor Avni Salli, 'Conference Highlights' (1999) 12 *Australian Integrative Medicine Association Newsletter,* 13.

[17] M Pirotta, M Cohen, V Kotsirilos, S Farish, 'Complementary therapies: have they become mainstream in General Practice' (2000) 172 *MJA* 105-9.

[18] Compared with 95% German GPs (1993), 16% United Kingdom (1986) and Canada (1995) and New Zealand 30%(1990 and 1998): K Hall and B Giles-Corti, 'Complementary therapies and the general practitioner: a survey of Perth GPs' (2000) 29(6) *Australian Family Physician* 602, 604.

[19] Hall and Giles-Corti, above n 18, 604.

[20] Hall and Giles-Corti, above n 18, 604; Pirotta, Cohen and Kotsirilos et al above n 17, 105-9.

[21] Hall and Giles-Corti, above n 18, 604.

[22] Heather L Eastwood, 'Complementary therapies: the appeal to general practitioners' (2000) 173 *MJA* 95-98.

[23] Phelps, above n 14, 12.

[24] Phelps, above n 14, 15.

[25] See http//www.health.gov.au/tga/docs/pdf/facts.pdf.

[26] See http://nccam.nih.gov/

[27] *Chinese Medicine Act 2000* (Vic); Dr Marc Cohen, 'From Complementary to Integrative and Holistic Medicine' in Dr Marc Cohen (ed) *Perspectives on Holistic Health* (2000) Monash University, 37.

[28] Dr Marc Cohen, above n 27, 37.

[29] Including the Complementary Health Care Council, the Australian Self-Medication Industry, the Australian Traditional Medicines Society, the Australian Acupuncture and Chinese Medicine Association and the Australian Herbalists Association of Australian. There are two notable peak bodies for medical practitioners - the Australian Medical Acupuncture College and the Australian Integrative Medicine Association: Phelps, above n14, 12.

[30] Phelps, above n 14, 12.

[31] Richard Haigh, 'Alternative Medicine and the Doctrine of Patient Disclosure' (2000) 8 *Journal of Law and Medicine* 197, 198, 201.

[32] *Rogers v Whitaker* (1992) 175 CLR 479, 483 (Mason CJ, Brennan, Dawson, Toohey and Mc Hugh JJ) citing *Sidaway v Governors of Bethlem Royal Hospital* [1985] AC 871, 893 (Lord Diplock).

[33] (1992) 175 CLR 479.

[34] For example, *Chappel v Hart* (1998) 195 CLR 232; *Rosenberg v Percival* (2001) 178 ALR 577; *Bustos v Hair Transplant Pty Ltd & Peter Wearne* (unreported, District Court, NSW, 20 Dec 1994); *Karpati v Spira* (unreported, Supreme Court NSW, Spender AJ, 6 June 1995); *Hribar v Wells* (1995) 64 SASR 129.

[35] Professor Skene states that the *Rogers v Whitaker* decision has broader implications than warnings about material risks: Loane Skene, *Law and Medical Practice - Rights, Duties, Claims and Defences* (1998) Butterworths 148.

[36] *Rogers v Whitaker* (1992) 175 CLR 479, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

[37] *Rogers v Whitaker* (1992) 175 CLR 479, 489.

[38] *Rogers v Whitaker* (1992) 175 CLR 479, 493. In a separate judgment that was mostly in agreement with the majority judgment.

[39] LBC, Laws of Australia, vol 27 (at 30/6/99) 27.2 Medical Practitioners 'Chapter 4 Negligence: Standard of Care' [31]

[40] Available at NHMRC website at http://www.health.gov.au/hfs/nhmrc/publications/fullhtml/cp60.htm The guidelines were published and widely circulated in 1993 after the High Court decision of *Rogers v Whitaker* (1992) 175 CLR 479.

[41] NHMRC Guidelines above n 40, 2, 4.

[42] In Victoria, for example, the *Health Services Act 1988* (Vic) and *Health Services (Conciliation and Review) Act 1987* (Vic). Section 9 of the former sets out the objectives of the Act and provides that *'users of health services are provided with sufficient information in appropriate forms and languages to make informed decisions about health care'* (s 9(e)) and that *'users of health services are able to choose the type of health care most appropriate to their needs'* (s 9(g)). The preamble to the *Health Services (Conciliation and Review) Act 1987* (Vic) sets out guiding principles for providers and users of the Victorian health system including the need for (d) *'the provision of adequate information on services provided or treatment available, in terms which are understandable;'* (e) *'participation in decision making affecting individual health care;'* and (f) *'an environment of informed choice in accepting or refusing treatment or participation in education or research programs.'*

[43] 464 F 2d 772 (US CA 1972).

[44] *Rogers v Whitaker* (1992) 175 CLR 479, 494. His Honour, Robinson J in *Canterbury v Spence* was referring to alternative forms of treatment generally.

[45] (1983) 33 SASR 189, 192.

[46] (1985) Aust Torts Reports 80-758, 69,545.

[47] (1987) 37 DLR (4th) 624, 644.

[48] Professor Loane Skene considers that the test would be the same: See Loane Skene, above n 35, 148.

[49] *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

[50] *Rogers v Whitaker* (1992) 175 CLR 479, 493 (Gaudron J).

[51] *Rogers v Whitaker* (1992) 175 CLR 479, 493.

[52] *Rogers v Whitaker* (1992) 175 CLR 479, 490, 493.

[53] *F v R* (1983) 33 SASR 189, 192-193.

[54] *F v R* (1983) 33 SASR 189, 190-91; *Rogers v Whitaker* (1992) 175 CLR 479, 488.

[55] *Rogers v Whitaker* (1992) 175 CLR 479, 490.

[56] *F v R* (1983) 33 SASR 189, 192.

[57] 37 DLR (4th) 624, 644 (Sask CA 1987) (Sherstobitoff JA).

[58] *F v R* (1983) 33 SASR 189, 192; NHMRC Guidelines, above n 40, 6.

[59] David M Eisenberg, 'Advising Patients Who seek Alternative Medical Therapies' (1997) 127 *Annals of Internal Medicine* 61-69.

[60] Loane Skene, above n 35, 146-47.

[61] *F v R* (1983) 33 SASR 189, 192 citing *Smith v Auckland Hospital Board* [1965] NZLR 191.

[62] *Rogers v Whitaker* (1992) 175 CLR 479, 493 (Guadron J).

[63] See NHMRC Guidelines, above n 40, 6.

[64] *Rogers v Whitaker* (1992) 175 CLR 479, 487.

[65] *F v R* (1983) 33 SASR 189, 192.

[66] Loane Skene, above n 35, 148.

[67] Catherine Zollman and Andrew Vickers, 'Complementary Medicine and the Patient' (1999) 319 *BMJ* 1486, 1488.

[68] *'Patient has chronic or relapsing disease, conventional approaches require maintenance treatment. Patient is experiencing or is concerned about adverse drug reactions. Patient is unhappy about progress. There is unexplained poor compliance with treatment or follow up':* Catherine Zollman and Andrew Vickers, 'Complementary medicine and the doctor' (1999) 319 *BMJ* 1558, 1558.

[69] Questions recommended for eliciting the relevant information about CAM include: *'Have you tried any other treatment approach for this problem? Have you ever seen a complementary or alternative practitioner for this problem? Have you used any herbal or natural remedies that you have bought from a chemist or health food shop?* Zollman and Vickers, above n 68, 1558.

[70] NHMRC Guidelines, above n 40, 5, 8.

[71] NHMRC Guidelines, above n 40, 8; *F v R* (1983) 33 SASR 189, 193.

[72] Haigh, above n 31, 203.

[73] Michael Cohen, above n 4, 38.

[74] (2001) 178 ALR 577, 592.

[75] *Rogers v Whitaker* (1992) 175 CLR 479, 494.

[76] *Rosenberg v Percival* (2001) 178 ALR 577, 590.

[77] *Rosenberg v Percival* (2001) 178 ALR 577, 593 (Gummow J).

[78] 464 F 2d 772 (US CA 1972).

[79] *Rogers v Whitaker* (1992) 175 CLR 479.

[80] Jonas and Levin, above n 3, 3.

[81] Acupuncture, for example, is a service that is reimbursed under the Medicare Benefits Schedule when provided by doctors.

[82] Jonas and Levin, above n 3, 3.

[83] Catherine Zollman and Andrew Vickers, above n 10, 901.

[84] Jonas and Levin, above n 3, 3.

[85] For example, The Lancet, The New England Journal of Medicine, British Medical Journal and the Journal of American Medical Association: Zollman and Vickers, above n 68, 1560.

[86] See http://www.cochrane.org/ and http://www.nlm.nih.gov/pubs/factsheets/pubmed.html

[87] Dr Marc Cohen, above n 27, 35. Moynihan claims that one of the most widespread misunderstandings today is *'...that all medicine is 'scientific' and that its treatment and technologies are largely proven'* while what is clear is that many of the treatments offered have never been the subject of scientific testing. Moynihan relies on a US estimate by the Office of Technology in 1994 which estimated that 10 to 20 per cent of procedures had been evaluated for efficacy and safety and a more optimistic estimate published in The Lancet in 1995 that claimed that 80 per cent of procedures and treatment in a British hospital were found to be based on good evidence: Ray Moynihan, *Too Much Medicine* (1998) ABC Books 5.

[88] Dr Marc Cohen, above n 27, 38.

[89] Profession Chris Silagy, 'Complementary Medicine; Science or Art: A Personal Perspective' in Dr Marc Cohen above n 27, 275.

[90] Professor Chris Silagy, Director, Institute Public Health Research, Monash University, personal communication 21/11/99.

[91] Wayne B Jonas, 'The evidence house: how to build an inclusive base for complementary medicine' (2000) 175(2) *The Western Journal of Medicine* 79

[92] [2000] 4 All ER 181, 189.

[93] Includes vitamins, minerals, herbal medicines, nutritional supplements, homeopathic remedies and some aromatherapy oils: See Schedule 4 Therapeutic Goods Regulations (Cth).

[94] Therapeutic Goods Administration, *Guidelines for Levels and Kinds of evidence to Support Indications and Claims*, (October 2001) available at Therapeutic Goods Administration website at http:/www.health.gov.au/tga/cm/cm.htm

[95] Dr Fiona Cumming, 'Regulating Complementary Medicines - The TGA Point of View' (2001) 4(1) *Natural Health Review* 34, 34.

[96] Eastwood, above n 22, 95-98.

[97] LBC, Laws of Australia, vol 27 (at 30/6/99) 27.2 Medical Practitioners 'Chapter 4 Negligence: Standard of Care' [28].

[98] *Roe v Minister of Health* [1954] 2 QB 66, 77; *Albrighton v Royal Prince Alfred Hospital* [1979] 2 NSWLR, 165, 175-74; *E v Australian Red Cross Society* (1991) 27 FCR 310, 326-27.

[99] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582; *Gover v State of South Australia* (1985) Aust Torts Reports 80-758, 69, 544.

[100] *Gover v State of South Australia* (1985) Aust Torts Reports 80-758, 69, 544; LBC, *Laws of Australia,* vol 27 (at 30/6/99) 27.2 Medical Practitioners 'Chapter 4 Negligence: Standard of Care' [28].

[101] *Clark v McLennan* [1983] 1 All ER 416 (performance of anterior colporrhaphy surgery two months earlier than usual for stress incontinence following the birth of a child, the surgery being unsuccessful).

[102] See *Rogers v Whitaker* (1999) 175 CLR 479, 488 citing *Reibl v Hughes* [1980] 2 SCR 880, 894 - 95.

[103] Eastwood, above n 22.

[104] Eastwood, above n 22.

[105] Zollman and Vickers, above n 66, 1558. In *Moore v Baker* a patient sued a doctor for failing to disclose the use of EDTA chelation therapy as an alternative to carotid endarterectomy. Georgia's informed consent law required that a physician inform a patient of *'practical alternatives to such proposed surgical or diagnostic procedures which are generally recognized and accepted by reasonably prudent physicians.'* In filing a motion for summary judgment the defendant tendered evidence to prove that the therapy was not generally accepted by reasonably prudent physicians - therapy was not taught in medical school when Dr Baker was a student, professional associations, such as the American Medical Association, who had voiced opposition to the therapy, therapy not approved by the Federal Drug Administration for treating conditions such as blocked carotid artery: 1991 US Dist Lexis 14712.

[106] *F v R* (1983) 33 SASR 189, 193.

[107] *Rogers v Whitaker* (1992) 175 CLR 479, 487 citing *F v R* (1983) 33 SASR 189, 193 (King CJ); *Geissman v O'Keefe* (unreported, Supreme Court, NSW, Simpson J, 25 November 1994, 11).

[108] Jonas and Levin, above n 3, 4-5.

[109] There are a number of legal considerations relating to doctors referring patients to CAM practitioners which are not considered here.