Assessing performance 7:

Reviewing the doctor who practises complementary, alternative or unconventional medicine (CAM)

Ian M St George MD FRACP FRNZCGP

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***Ian St George** is a Wellington general practitioner; he was an appointed, then elected member of the Medical Council of New Zealand from 1987–2001, latterly as vice-president. He is now medical adviser to the Council.*

The WHO says 'Complementary and alternative medicine (CAM) refers to a broad set of health care practices that are not part of a country's own tradition and not integrated into the dominant health care system. Other terms sometimes used to describe these health care practices include 'natural medicine', 'non-conventional medicine' and 'holistic medicine".[1]

In a recent decision the Medical Practitioners Disciplinary Tribunal (the MPDT) stated, 'There is an onus on the practitioner to inform the patient not only of the nature of the alternative treatment offered but also the extent to which that is consistent with conventional theories of medicine and has, or does not have, the support of the majority of practitioners...'[2]

The MPDT went on, 'The Tribunal recognises that persons who suffer from chronic complaints or conditions for which no simple cure is available are often willing to undergo any treatment which is proffered as a cure. As such, they are more readily exploited.'

A recent competence review, in response to concerns raised, of a doctor practising complementary and alternative medicine (CAM) highlighted the necessity for a specifically designed kit of tools for assessing the performance of such doctors. As most CAM doctors are also general practitioners, such a kit should be able to review conventional general practice capability as well as CAM practice.

A proper review of the efficacy of a specific CAM practice is however beyond the expertise of most conventional reviewers, and thus beyond the scope of a performance assessment: whether homeopathy or naturopathy is effective is for others to determine. But for the most idiosyncratic practices an assessment will be necessary – and of course some methods have already been discredited elsewhere, and some simply amount to medical fraud.[3]

Objectives of a performance assessment

- To assess the doctor's general competence in conventional medicine.
- To assess the doctor's adherence to the Medical Council's *Guidelines on complementary, alternative or unconventional medicine*;[4]
- To assess the doctor's competence in assessing evidence relating to such practice (critical appraisal skills);
- To determine whether a detailed retrospective audit of cases is necessary to ensure patients have not been harmed;
- To determine whether the doctor should be referred for assessment to the Council's Health Committee or for investigation by the Health & Disability Commissioner.

Patients who consult registered medical practitioners who use alternative methods have stated they do so to 'get the best of both worlds'.[5] As most CAM doctors are general practitioners, their competence in conventional general practice medicine is therefore as important as their alternative practice.

Some doctors restrict the scope of their practice exclusively to CAM, while others continue conventional practice while either using CAM for their own patients, or accepting outsiders, either from other doctors or without formal referral.

There should be a clear understanding and agreement about who is providing continuity of conventional care – the care of continuing problems, preventive medicine and health education. Where the CAM practitioner is exclusively practising CAM, or is accepting patients from outside his or her own practice, there should be clear and specific communication from the CAM doctor to the patient's usual general practitioner. When an individual patient demands otherwise the CAM doctor should be prepared to accept the risk of not keeping the usual doctor informed.

In other words the CAM doctor should be either a provider or a collaborator in continuity of conventional care: CAM should not be provided in isolation or secrecy, and should not require disengagement from conventional care or carer.

In reviewing doctors' use of CAM investigations or treatments, the Medical Council requires that:

1. In **assessing** patients doctors must:

(a) perform a pertinent history and physical examination of patients, sufficient to make or confirm a generally recognised diagnosis, and in this meet the standard of practice generally expected of the profession;[6]

(b) investigate, when necessary, using generally accepted modalities pertinent to the patient's complaint. Where any other methods of investigating are being used informed consent must be obtained;

(c) reach a diagnosis that reasonable doctors would reach, supported by the data;

(d) advise patients of the evidence based and conventional treatment options, their risks, benefits and efficacy, as reflected by current knowledge;

(e) document all of the above in accordance with sound practice.

2. In **treating** patients doctors must:

(a) ensure that the treatment is effective, safe and cost effective;

(b) have current knowledge and skills in their area of practice;

(c) be competent in the practices they employ;

(d) act honestly and in their patient's best interests according to the fundamental values of the profession;

(e) provide sufficient information to allow patients to make informed choices, and to refer to, or consult with, others when patients request it, when the doctor requires assistance or when the standard of practice requires it;

(f) not misrepresent information or opinion. Patients must be made aware of the likely effectiveness of a given therapy according to published and accepted information, notwithstanding the doctor's individual beliefs;

(g) obtain informed consent to any proposed treatment.

3. In **advancing knowledge**, and providing treatments in areas of uncertainty where no treatment has proven efficacy doctors must:

(a) ensure that their patients are told the degree to which tests, treatments or remedies have been evaluated, and the degree of certainty and predictability that exists about their efficacy and safety;

(b) be prepared to collaborate in the collection of information that can be appraised qualitatively or quantitatively, so that new knowledge is created, to be shared with, and critically appraised by, the profession.

One of the reviewers is always a CAM practitioner, otherwise the team, as usual, consists of two doctors and one lay person. The instruments used to assess the doctor's competence include structured interviews, case-based oral,[7] a standard records review, and review of communication skills,[8] and may include a peer rating.[9] They will be interested in finding out...

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What are the diagnostic methods? Does the doctor move from open to increasingly focussed questioning, make diagnoses on the probabilities, exclude serious disorders? Or does he or she leap to a favourite diagnosis without these steps?

To what degree does the CAM doctor question scientifically, or accept criticism? Are special medicines offered for sale? What are the professional values? Is there evangelism? A claim of exclusiveness of methods? Does the doctor appear to be a zealot? A cult figure? Is there the stance that other doctors are all wrong? Is there paranoia? Does the doctor have a proper grasp of reality?

The initial interview

This is perhaps the most important tool. The doctor is interviewed using an open, non-threatening way – entrapment or a leading style of interviewing is avoided. The interview is nonetheless carefully structured. The reviewers are advised:

- Ask the doctor to describe how he or she started in alternative practice; the situation in which he or she works in terms of type of patients, whether referred or not, what kinds of conditions are treated.
- Does the doctor see him/herself always as the patient's general practitioner? If not, how much of the doctor's practice is CAM? what is the communication arrangement with the patient's GP and how clear is that to the patient?
- Ask the doctor to explain the kinds of alternative therapies used, and the specific training for them. What are the limitations of this CAM? When would the doctor advise discontinuation of the CAM because of nonresponse? What would be the plan after that?

Is this CAM unsuitable, ineffective or contra-indicated for any conditions?

- What is the scientific basis for this method? Is it supported by a scientific rationale?
- What are the doctor's fees? What are the doctor's promotional claims? What are the benefits of this kind of CAM for the patient (compared with orthodox medicine)?
- Ask the doctor to describe the CME, audit and quality improvement activities he or she has been involved in during the previous year (both in orthodox and CA medicine). Explore the doctor's contribution to professional groups, teaching and research.
- Is there any particular stress that may have affected the doctor's practice (e.g. fatigue/burnout, mental illness, colleague relationships, professional isolation, domestic factors, overload, systems stressors, physical illness?

The next part of the interview contains some standard questions. The interview should be as explorative as possible: the concepts covered include provision of information to patients, patient consent, power sharing, patient rights. The issues can be explored in different ways – e.g. role plays, case scenarios.

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Provision of information to patients

What is the extent of the information you think it is appropriate to provide patients when informing them about an alternative investigation or treatment?

If you suspect a patient has cancer, at what stage would you tell them this?

In what circumstances do you think you might withhold health information from a patient?

If something goes wrong in a patient's treatment, how much should they be told?

Do you ever admit mistakes to your patients? When might you and when might you choose not to?

Patient consent

Please describe how you seek your patient's consent for:

- Examining them
- Alternative investigations
- Alternative procedures
- Prescribing of alternative therapies
- If you sell medicines from your practice, describe how you inform patients.

Power sharing

How much do you think patients should be involved in decisions about their care?

What is your response if a patient asks you for a second opinion or to be referred to another doctor?

If the patient does not wish to follow your advice, what would your response be?

Patient rights

In what way do you ensure patients you see are informed of their rights?

What are patients you see told about what to do if they have a concern about the way they have been treated?

Communications with colleagues

How would you describe the relationship between yourself and other doctors in the region?

Do you meet with other doctors regularly in a peer discussion group? With whom do you discuss problem cases?

The interview is followed by a standard records review, case-based oral, review of communication skills (observation of actual practice), and a closing interview. The possibility of a detailed follow-up audit of cases is available as a recommendation from the review team if they are concerned about patient safety.

Disclaimer

These are the author's views, and are not necessarily those of the Medical Council of New Zealand or its members or other staff.

References

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3. www.quackwatch.com.
4. Medical Council of New Zealand. Guidelines on complementary, alternative or unconventional medicine. Wellington, 2004. (www.mcnz.org.nz/standards/guidanceresources/#mostr). See also Federation of State Medical Boards of the United States. Policy statement: Model guidelines for the use of complementary and alternative therapies in medical practice, Washington, 2001. (www.fsmb.org).
5. St George IM. The 'homeopathic clause' and the Tizard case. N.Z. Fam.Phys. 1993; 20 (Autumn): 46-47.
6. In its decision, Director of Proceedings v Dr R W Gorringe, the MPDT found that Dr Gorringe conducted inadequate clinical examinations of two patients, took inadequate histories, placed undue reliance on one diagnostic technique (peak muscle resistance testing) and '...failed to carry out any other diagnostic tests to confirm or exclude his diagnosis when, plainly, he should have done so.'
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