HEALTH PROFESSIONALS AND COMPLEMENTARY THERAPEUTIC SERVICES AND GOODS – What might consumers reasonably expect?

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Efficacy

Services and goods provided for therapeutic or health maintenance purposes can be seen as falling into one of five categories - those for which there is:

1. Good evidence of efficacy
2. Limited evidence of efficacy
3. No evidence of efficacy
4. Evidence of inefficacy
5. Evidence of risk to health

The principle of evidence-based services and goods is fundamental to the Australian health system. Thus, Australian consumers would generally understand that the accredited courses for health professionals (Note 1) deliver training to enable them to provide services and to provide or use goods which, at the time of the course, fall into the first category and possibly the second. In continuing professional development practitioners would be expected to learn of services and goods moving from one category to another as a result of new research.

Efficacy is the extent to which an intervention does more good than harm under ideal circumstances ("Can it work?"). There are other considerations to be taken into account in determining an appropriate therapeutic intervention. An intervention might meet the efficacy standard, but practical factors might mean it is not effective ("Does it work in practice?"). In addition, the efficiency of an intervention, that is its effectiveness in relation to the resources it consumes ("Is it worth it?"), must be taken into account.

Consumer expectations

Consumers would generally expect that any health professional would provide a service or use or provide a good that fell into the first category and possibly the second and that was effective and efficient. See Note 1

The Medical Board of Australia's code of conduct, *"Good medical practice: a code of conduct for doctors in Australia"*, includes guidance on providing good care, and obtaining consent. It states that doctors should provide *'treatment options based on the best available information'*. Section 8 of the code states obligations in relation to advertising including that good practice involves ensuring information *'is factual and verifiable', 'making only justifiable claims' and 'not exploiting patients' vulnerability'*.

The Medical Board is planning to develop guidelines for medical practitioners on *"Complementary and unconventional medicine and emerging treatments"* and defines these as including *"any assessment, diagnostic technique or procedure, diagnosis, practice, medicine, therapy or treatment that is not usually considered to be part of conventional medicine, whether used in addition to, or instead of, conventional medicine. This includes unconventional use of approved medical devices and therapies."*

Medical practitioners would be guided to make clear to a consumer the evidence or otherwise of efficacy of any complementary or unconventional medicine or emerging treatment a consumer might be considering using or obtaining, or which practitioners themselves might consider offering or recommending the consumer otherwise use or obtain.

The difficulty with alternate and unconventional and emerging treatments is the usual profile looks like:

- Can it work? – There is often little or no evidence and often no research has been undertaken because the patent system means any company can freeride on any investment in research.
- Does it work in practice? – In spite of a lack of evidence some practitioners believe so and have a group of patients or consumers who hold energetic and passionate beliefs in the usefulness of these kinds of care. These days this is supported by misinformation on the internet.
- Is it worth it? – Again, though there may be no evidence, many consumers believe their expenditure is worthwhile.

The definition of *unprofessional conduct* in the National Law that regulates registered health practitioners, which includes the following:

(d) providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person's wellbeing
(h) referring a person to, or recommending that a person use or consult, another health service provider, health service or health product if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of that interest to the person before or at the time of giving the referral or recommendation.

Arguably, it should be seen that the guidelines would, in effect, mean that it would be unprofessional conduct for a medical practitioner to offer or recommend or suggest or refer in relation to:
1 any of the 17 services the National Health and Medical Research Council (the NHMRC 17) found to have inadequate evidence of efficacy and which now may not be covered by health insurance, and
2 any service or good which falls outside category 1 or 2.

It seems appropriate that the principles applying to a medical practitioner in relation to "complementary and unconventional medicine and emerging treatments" should apply to all health professionals and certainly to all registered health practitioners.

Practitioners providing services or supplying goods separately from their registered practice - possible ethical issues

Health professionals including registered health practitioners often have businesses separate from their practice. (h) above seems to permit a registered practitioner to sell or be involved in selling a "*health service or health product*" separately from their registered practice provided they disclose their interest. But currently they are perhaps not constrained from "*d) providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person's wellbeing"* if they are not providing such services to a person as part of their registered practice even if the person is a client of their registered practice.

It seems unlikely that a consumer, whether or not a client of a particular health professional, perhaps especially a registered practitioner, would expect such a professional to set aside their professional principles when, separately from their practice, they offer goods and/or services. For example, a client of a dietitian could reasonably expect that if the dietitian had a business selling food products they would either not be offered a food product which nutritional science evidence indicated contributed to poor nutrition or, at the very, least be advised that the product had nutritional disadvantages. Likewise, a consumer could reasonably expect goods offered for sale for therapeutic purposes in a pharmacy to be only in categories 1 and 2 or at the very least to be advised if a good did not fall into those categories. The Pharmaceutical Society of Australia (PSA) has in fact said *"The supply of homeopathic products is in contravention of the PSA Code of Ethics for Pharmacists. The Code of Ethics, recognised by the Pharmacy Board of Australia, states that pharmacists should only "supply or promote any medicine, complementary medicine, herbal remedy or other healthcare product where there is credible evidence of efficacy and the benefit of use outweighs the risk."*

Psychologists must abide by a code that prevents them from engaging in multiple relationships with clients so they may only provide services and/or goods separate from their psychology practice to persons who are not their psychology clients. If a person who is a psychologist, or indeed is any kind of health professional, has a business, completely separate from their health practice, selling goods or services that are seen by at least some consumers as having therapeutic or health maintenance value when there is no evidence for such value (that is they are not in categories 1 or 2) is it enough that normal consumer law prohibits misleading and deceptive practices? Such goods or services may be sold, but claims of therapeutic or health maintenance value may not be made. Many would argue that an ordinary businessperson selling such goods and services is only legally and ethically obliged to ensure no incorrect information or impression is conveyed about the goods or services. Others would argue differently.

But there is perhaps a clearer ethical obligation if the seller is a person known to consumers to be a health professional. Because consumers invest a particular trust in them it might be argued that it is incumbent on health professionals to assist consumers to make adequately informed decisions about the therapeutic or health maintenance value of goods and services. Because of this trust consumers are likely not to take the steps they would normally take to inform themselves about

goods and services and the competitiveness of pricing. If the seller's status as a health professional is completely obscured it might be argued that no special obligations apply, but one might reasonably expect that the seller's personal ethics should result in their adhering to their professional ethics anyway. In many cases, especially in small communities or if the health professional had a high public profile, it would not be possible to completely obscure a professional status.

Placebo use

The placebo effect is no doubt often therapeutically useful. No doubt many people using one of the NHMRC 17 services have benefited from the placebo effect. And no doubt many people buying vitamins and supplements and herbal preparations which have no nutritional or pharmacological value to them are benefiting from the placebo effect. The problem is discriminating between a useful placebo effect and an inefficient use of national resources and a waste of consumers' money. Making money selling goods and services that are useless therapeutically and for health maintenance is clearly unethical and should be unlawful even if advertising and labelling is not misleading or deceptive. Surely it is unfair and surely it is unjust enrichment. Surely it offends the principle that "no one should be benefited at another's expense", a principle that is at least as old as Roman law "nemo locupletari potest aliena iactura".

Significance and Implications

This issue is significant in individual and community terms. Individuals are at risk of spending money they cannot afford on useless goods and services and perhaps delaying efficacious therapy or at worst not getting needed therapy at all. On some estimates at least 3 billion dollars are spent on vitamins, supplements, herbal preparations and the like with no therapeutic or health benefit and there is probably quite significant spending on the NHMRC 17. This amounts to significant allocative inefficiency and thus welfare loss. This is ironic given the amount the nation spends to produce health professionals of the highest standard. The productive capacity involved could be used on genuinely valuable therapeutic and health maintenance goods and services or in some other welfare improving manner. Uninfluenced by vested interests the Productivity Commission could be expected to make useful recommendations if given a reference. The ACCC should take more actions like the Nurofen action. The TGA should act, but it is perhaps politically unable to do what is necessary. The other
health practitioner boards, especially the Pharmacy Board, should provide guidance similar to that being provided by the Medical Board. State and territory health service/complaints commissioners should utilise the National Code of Conduct for Health Care Workers to the greatest effect possible.

Note 1
The term "professional" is used here to cover both health service providers who are registered practitioners in the National Registration and Accreditation Scheme and unregistered providers regulated by the National Code of Conduct for Health Care Workers. There would be many kinds of providers in the latter category whom many would not regard as professionals, but some, such as dieticians and counsellors, would be seen as professionals by most consumers.

Note 2
Consumer expectations was the basis for which Commission Hayne recommended a statutory best interests test for mortgage brokers. “Consumers expect mortgage brokers to act in their best interests – so the law should say this”. There are a number of regulatory concepts that apply to financial service providers that perhaps are appropriate for health professionals which are discussed in the appendix.

Note 3
Alexander technique, aromatherapy, Bowen therapy, Buteyko, Feldenkrais, Western herbalism, homeopathy, iridology, kinesiology, naturopathy, Pilates, reflexology, Rolfing, shiatsu, tai chi, and yoga.

Appendix

A health practitioner is not a mere seller but effectively akin to an agent acting on behalf of the consumer when they advise on health services or products. Existing general consumer law is not enough in this regard. The codes of conduct determined by the health practitioner boards have a broad regulatory effect but may not be adequate. It is not clear that these codes nor any other regulation applying to registered health practitioners require the provision of the good or service most suitable to a consumer’s needs. The National Code of Conduct for Health Care Workers does not seem to achieve this in respect of unregistered health service or goods providers.

The law has done two things to financial advisers to make their agency role clear:
a) A statutory best interests duty, i.e. a duty to act in the best interests of the consumer when advising on the appropriate product
b) A ban on conflicted remuneration, i.e. on remuneration that could reasonably be thought to affect the advice that the adviser provides to the consumer.

Arguably a) and b) should also apply to health professionals in substance.
- With a), even before the statutory best interests duty, the fiduciary duty under common law already applied to financial advisers. The fiduciary duty applies whenever there is a relationship of trust between two parties, requiring the fiduciary to act always for the sole benefit and interest of the one who trusts. A health professional would already be bound by such a duty – though a statutory obligation or duty in an enforceable code would serve to make that clearer.
- On b), arguably it is not enough to merely disclose a pecuniary interest as the consumer is not in a position to evaluate whether such interest is of reasonable value and how it compares to what the practitioner would stand to gain from other products or services. Perhaps a complete ban on such referrals where a pecuniary interest is involved is needed.

There is another interesting parallel to the proposed legislation implementing the best interests duty for mortgage brokers. The best interests duty will only apply to mortgage brokers, not to people who facilitate the provision of other credit products (e.g. personal loans). The consumer is not to expect that the duty will cease to apply when the broker advises on non-mortgage credit products. So, the bill in its current form will prevent a broker from setting up a separate business to provide advice on other credit products with the explicit intention of avoiding the application of the best interests duty. Something similar should apply to health practitioners.