Avant Mutual Group Limited
ABN 58 123 154 898

Office address
Level 6, Darling Park 3
201 Sussex Street, Sydney NSW 2000

Postal address
PO Box 746 Queen Victoria Building
Sydney NSW 1230

DX 11583 Sydney Downtown

avant.org.au

Telephone 02 9260 9000 **Fax** 02 9261 2921
Freecall 1800 128 268 **Freefax** 1800 228 268

28 June 2019

Medical Board of Australia
AHPRA
GPO Box 9958
Melbourne VIC 3001

By email: medboardconsultation@ahpra.gov.au

Public consultation on clearer regulation of medical practitioners who provide complementary and unconventional medicine and emerging treatments

Thank you for the opportunity to provide input into the Medical Board of Australia's draft guidelines.

Avant is Australia's largest medical defence organisation, providing professional indemnity insurance and legal advice and assistance to more than 78,000 healthcare practitioners and students around Australia.

On balance, we prefer Option 1. We support the Board issuing a statement drawing attention to doctors' existing obligations and providing case studies or examples for clarity. The obligations listed in the proposed guidelines (Option 2) already exist in *Good Medical Practice* and other documents listed in the discussion paper and can be applied to these types of practices.

However, if the Board decides to implement Option 2, we do have some concerns about the application of these guidelines because of the broad definition and the types of practice that fall within its scope. Our specific concerns are outlined below.

The definition

Given the breadth of the definition, and the fact that the types of practice being regulated pervade all medical specialties, we agree that it would be useful for the Board to provide examples of the types of treatment it is seeking to regulate, to assist practitioners understand how the guidelines are to be applied in practice.

Peer test

Using the phrase "usually considered conventional" within the definition implies a peer test for determining whether or not a practice is considered to be part of conventional medicine. Peer tests are applied retrospectively and therefore there is a risk that practitioners will be unable to determine with certainty whether these guidelines apply to their practice or not, before they begin treating a patient. Compare this with, for example, the Board's guidelines

for practitioners performing cosmetic procedures.[1] Practitioners performing cosmetic procedures can be certain of the guidelines that apply to their practice before they begin treating a patient.

There is no guidance about the point at which a practice or therapy becomes "usually considered" part of conventional practice. What sort of evidence base does the Board expect for a therapy to be considered conventional? How will a doctor be able to assess whether or not a treatment is usually considered conventional?

Further, if doctors can defend their position if their practice is considered 'conventional' within their group of peers, will these guidelines solve the problems that the Board is trying to address? On the other hand, could this put doctors at greater risk of disciplinary action if they consider a therapy to be conventional but on another doctor's view it was not?

Emerging treatments

We are concerned about grouping together three quite different types of practice into the one group: "complementary medicine, unconventional medicine and emerging treatments".

Some of our members have expressed concern about the impact of the proposed guidelines on the practice of integrative medicine. Others are uncertain about how the guidelines will apply to off-label use of medication which is quite different in nature from complementary and unconventional medicine.

We are also concerned about how the definition will be applied to emerging treatments. Therapies that are now mainstream were often once considered emerging or unconventional. As the Board is aware, medical practice occurs on a spectrum. We are not certain whether the proposed guidelines clearly distinguish legitimate, "cutting edge" approaches from what may be considered "fringe" or "maverick" treatments. Sometimes this is a matter of opinion, and one person's conventional medicine might be another's maverick practice.

Also, by specifically including 'emerging treatments' within the umbrella of treatments regulated by these guidelines, the Board may negatively impact innovation and improvements in medical practice. Emerging treatments can be incremental changes and innovations to current practice which eventually become accepted, conventional medicine. Determining the point at which something becomes conventional treatment can sometimes be difficult to ascertain, and often only with hindsight.

We appreciate that the Board does not wish to stifle innovation, but there is the risk that by including emerging treatments within the scope of the guidelines this will be the effect.

Evidence base

The three categories are quite different in nature but the common feature seems to be (and the issue that is sought to be regulated) practice that is not clearly evidence-based. It may be better to adopt a simple definition such as the one in the NSW Medical Council's

[1] Medical Board of Australia, *Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures*.

guidelines on non-evidence based care[2]. Alternatively, the Board could consider exchanging the words "not usually considered to be part of conventional medicine" from the proposed definition with "not evidence-based or has limited evidence supporting its efficacy". This test is more objective than the current test. It can also be independently applied by the practitioner before they begin treating a patient.

Part 1 Guidance for all registered medical practitioners

While we agree in principle that doctors should be in a position to inform patients about the risks of using complementary treatments together with conventional treatments (as required by part 1 of the guidelines), this can sometimes be challenging.

Clause 1.3 of the proposed guidelines notes that it is not expected that practitioners who do not practice in these areas would have knowledge of all of these areas, yet clause 1.4 requires doctors to inform patients where there is limited evidence for the use of some complementary and unconventional medicine and emerging treatments.

Some of our members have expressed concern that the wide range of complementary and unconventional treatments and therapies means it can be difficult for practitioners to have the knowledge to have a detailed discussion with a patient about potential interactions and side effects, as required by clause 1.4. This is particularly the case with less well known complementary and alternatives medicines.

We have had comments from some members that raising the lack of evidence base for certain treatments and therapies (as required by clause 1.4) with some patients can be detrimental to the ongoing doctor-patient relationship. This can be the case for many doctors who may only have a limited interaction with the patient. It can impact not only on the relationship between the patient and the doctor commenting on the lack of evidence, but also on the relationship between the patient and doctor who may have recommended the treatment, if the former questions the treatment of the latter.

Part 2 Guidance for registered medical practitioners who provide complementary and unconventional medicine and emerging treatments

As stated above, the obligations outlined in this part of the guidelines all apply to medical practitioners generally, whether the practitioner is practising conventional medicine or not. The obligations contained in this part of the guidelines are already contained in other documents, including in the Medical Board's *Good Medical Practice* and other materials referred to in the discussion paper. There is significant overlap with *Good Medical Practice*. Therefore, the guidelines do not provide "additional safeguards" but are an amalgamation of duties and expectations that already exist. We are concerned then that the introduction of these guidelines will not solve the issues that the Board has highlighted in the discussion paper.

[2] *"The provision of non-evidence based care, or aspects of care, to a patient".* Medical Council of New South Wales, *Complementary Health Care Policy.*

Please contact me on the details below if you require any further information or clarification of the matters raised in this submission.

Yours sincerely

[redacted]

Georgie Haysom
Head of Research, Education and Advocacy

Direct:
Email: [redacted]