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Physicians and Alternative Methods of Treatment: Do They Go Together?

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Introduction: The Silvia Millecam case

In August 2001, Sylvia Millecam died of breast cancer at the age of 45. Millecam was a famous Dutch comedienne and had been voted the most popular woman in the Netherlands many times. Her death came all the more as a shock when it was revealed that her chances of recovery were good in the early stages of her illness. At the start of her illness in 1999, more than 30(!) different physicians – the majority of whom were alternative practitioners – were involved in treating her. Many of the practitioners, including a Dutch faith healer known by her stage name 'Jomanda', repudiated the diagnosis of breast cancer. They referred to a 'bacterial infection', 'fibrositis' or a 'reaction to silicone breast implants'. These 'therapists' then provided her treatments such as salt therapy, electro-acupuncture and magnetic field therapies. These all failed to produce results, resulting in a medical event and death which an oncologist described as 'mediaeval'.

What made the case more complicated was that Millecam rejected conventional treatment comprising surgery and chemotherapy from the start of her illness. She had observed the side effects of chemotherapy among her circle of friends and she herself wanted to avoid this. A second salient detail is that a number of the alternative practitioners were also doctors. Their title of Doctor of Medicine instilled in Millecam trust in the alternative treatment. 'He is a doctor, so it should be fine,' was the way she looked at it.

The Netherlands Healthcare Inspectorate, an organisation associated with the Ministry of Health which supervises the quality of health care, conducted an extensive investigation into the course of events surrounding her treatment and published an exceptionally detailed report (IGZ 2004), which incidentally raises a number of interesting privacy concerns. Three doctors were called to account by the Disciplinary Committee for the Healthcare Sector, which assesses the professional competence of physicians. Following an appeal, two of the physicians permanently lost their title 'Doctor of Medicine'. A third physician was suspended for one year.

Apart from the Disciplinary Committee, the case was also handled by the Public Prosecution Service, which found that criminal errors had also been made as well as medical and professional errors by the practitioners treating Millecam. Following countless legal proceedings, in December 2010 two doctors were sentenced to three and six-week suspended prison sentences. The court found sentencing advisable 'in view of the seriousness of the facts and the consequences thereof, and in view of the importance of marking standards, not only by means of adjudication but also through punishment'. Faith healer Jomanda, however, was acquitted because the court deemed that it had not been proven that she had dissuaded Millecam from undergoing conventional care, nor had she left Millecam in a helpless state.

Freedom of choice

Sylvia Millecam's tragic death created a great deal of social unrest in the Netherlands and spurred social debate that continues to this day. Her death provoked a turning point in the debate about alternative and conventional medicine. Since that time, it has in fact become clear that the often-heard words 'it doesn't hurt to try' no longer holds true. Alternative methods of treatments can actually inflict harm, simply because of the fact that they may cause patients to miss out on meaningful conventional treatments, or they could delay the start of such treatment. Numerous people have therefore become more critical of alternative practitioners.

Following the disciplinary and criminal court judgements, an important standards and legal framework was developed for the acts of alternative practitioners. Yet these judgements have not curtailed a patient's right of self-determination in choosing his or her own healthcare provider: after all, patients will always retain leeway to approach an alternative practitioner. But the leeway for alternative practitioners, both physicians and non-physicians, has been more clearly defined: they must inform patients correctly about the effectiveness of their treatment and distinguish clearly between conventional and alternative treatments. Practitioners are also not permitted to blindly concur/agree if the patient refuses to face the facts. If the patient clings to an illusion, practitioners must endeavour to refute the illusion and point out to the patient the importance and necessity of undergoing conventional treatment. If need be, the practitioner should sever the treatment relationship. The refusal of patients to undergo

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conventional treatment does not grant alternative practitioners a licence to practise. The reason primarily being the vulnerability of patients suffering from a life-threatening disease. The position of such patients makes them grasp at straws all too easily. The court stated in its judgement that 'freedom of choice no longer applies in such a vulnerable situation'.

The Millecam case raises a number of important questions, i.e. how much leeway do physicians still have in diverging from the professional standard, and what should physicians do with patients who reject conventional medicine? Partly prompted by the Millecam case, the Royal Dutch Medical Association published guidelines in 2008 which were preceded by substantial debate in the medical profession.

What are alternative and complementary treatments?

The terms 'alternative treatments' and 'complementary treatments' are catch phrases, covering over three hundred different methods of treatments. A number of these methods of treatment claim to employ a 'holistic concept of mankind', which revolves around the patient as a whole rather than the specific illness. Other methods of treatment, such as chiropraxy, place less emphasis on this aspect. Some forms of treatment, such as bioresonance therapy, acupuncture and homeopathy, conflict with empiricism, the biological principles or the laws of physics. Homeopathy, for instance, assumes that water has a 'memory' which is capable of spurring the body to self-heal. Many alternative treatments are based on various, conflicting effectiveness principles. Homeopathy, for example, assumes extreme dilution, while orthomolecular medicine in fact uses high dosages of vitamins and dietary supplements. Some forms of treatment are harmless from a medical point of view, such as homeopathy, which is chemically identical to the solvent, generally water or alcohol. Other forms of treatment, such as chelation therapy or herbal therapy, may cause life-threatening complications, or interfere with regular treatments, such as anti-conception or chemotherapy. Many alternative forms of treatment lay claim to an aura of 'naturalness', even though a description of what this means is rarely given. All things considered, alternative or complementary forms of treatment do not have much in common – except that there is no scientific proof of their effectiveness, and for that reason they are not accepted by conventional medicine.

The main difference between conventional and alternative forms of treatment is that conventional medicine seeks to work in line with the requirements of evidence-based medicine (EBM). This implies that physicians are guided by the state of the art in medical science, combined with their clinical expertise, including taking account of the patient's expectations, wishes and experiences. Many alternative practitioners claim that their forms of treatment cannot be scientifically substantiated because they work in accordance with a 'different paradigm' or because each patient is different, and for that reason randomised trials cannot be conducted. In recent years this line of reasoning seems to be waning, and alternative practitioners are similarly claiming to employ evidence-based working methods, and referring to 'evidence-based complementary and alternative medicine' (EBM-CAM). Despite the purported scientific proof thereof, alternative practitioners generally attribute the fact that these forms of treatment do not belong to conventional medicine, to 'conservatism' or 'pharmaceutical industry interests'.

Conventional medicine has always heavily criticised the term 'alternative medicine'. After all, there is no such thing as 'alternative physics' or the 'alternative legal profession'. Who in their right mind would board an aircraft if the pilot were to use alternative methods to steer the aircraft? And, if the non-conventional practitioners were to actually offer alternatives, why are they not conventional? Moreover, numerous conventional practitioners hold the view that it is dangerous to suggest that alternative forms of treatment exist for serious illnesses. To avert these issues, nowadays alternative practitioners prefer to talk about 'complementary treatments' to suggest that these forms of treatment should be viewed as being *supplementary to* conventional medicine, and not as an *alternative* for the latter.

The term 'complementary' too, however, is subject to criticism. Astrology is also not 'complementary' to astronomy, is it? And, if such medicine can only be complementary, does the term 'medicine' still apply? For that reason the Royal Dutch Medical Association KNMG would prefer to refer to 'non-conventional forms of treatment', versus 'conventional forms of treatment' (KNMG 2008). Since it is uncertain whether these treatments also actually cure an illness, the term 'form of treatment' is more neutral than 'treatment'. According to the definition applied by KNMG, conventional forms of treatment are 'the forms of treatment based on the knowledge, proficiency and experience required for the purpose of obtaining and retaining the title of Doctor of Medicine, which is generally accepted by the medical profession and forms part of the professional standard' (KNMG 2008). In other words: conventional medicine is what physicians who practice conventional medicine do. This also includes experimental forms of treatment, the effectiveness of which still is subject to medical and scientific research, to the extent these have been tested within the statutory assessment framework. 'Non-conventional forms of treatment' are those forms of treatment that fall outside the scope of the above definition. The nature of the definition is purely procedural, and says nothing about any methods or concepts of mankind embraced by the various forms of treatment. The advantage of the above definition is that it is neutral, and does not lay down for once and for all what definition should be ap-

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plied to conventional medicine. This leaves open the possibility for incorporating in the professional standard certain treatments, which initially were non-conventional, if it emerges that there is sufficient scientific proof thereof. Another advantage of such a neutral definition, which avoids words such as 'alternative' or 'complementary', is that it does not make a statement on the value or position of alternative forms of treatment.

Legal situation

The Individual Healthcare Professions Act (*Wet op de beroepen in de individuele gezondheidszorg,* BIG) dating from 1999 regulates the competence of a wide range of healthcare providers in the Netherlands. In addition to safeguarding a patient's freedom of choice, the key objective of the Act is to ensure and monitor the quality of healthcare provision. A third objective is to protect the patient against incompetent and improper conduct by a healthcare provider. According to the BIG Act anyone is allowed to practice medicine. The performance of certain medical acts (such as obstetric and surgical treatments, punctures, injections and anaesthesia) is the preserve of specific professional practitioners. In the Netherlands, making a medical diagnosis is not an act reserved for a specific group of practitioners, and it therefore may be performed by anyone. Because alternative treatments are not the preserve of a specific professional practitioner, alternative treatments may be administered by physicians as well as non-physicians. Medical disciplinary rules only apply to professions protected by the BIG Act, such as doctors and nurses. Alternative practitioners who do not hold a protected title, such as that of a Doctor of Medicine, fall outside the scope of the medical disciplinary rules. They also do not need an official registration. Since the BIG Act is also geared towards the patient's freedom of choice, a situation has arisen in which extremely stringent requirements are imposed on physicians but where non-physicians virtually have free rein. They also do not carry a title protected by law, and consequently also cannot be discharged from their duties – unlike physicians. The Healthcare Inspectorate does not have any tools for intervening in the practices of alternative practitioners. Consequently, in day-to-day practice it has proven to be extraordinarily difficult to take legal action against alternative practitioners, partly because patients often find it difficult to file a complaint. Moreover, it often is difficult to prove that the treatment has inflicted harm on patients.

The legal situation in which everyone is permitted to practice medicine, barring medical acts reserved for specific practitioners, is not unique to the Netherlands but occurs in other Northern European countries as well. In many Southern European countries, only physicians are permitted to practice medicine.

Seven percent of the Dutch population is estimated to visit a non-conventional practitioner who is not a physician (Statistics Netherlands StatLine database 2007). Countless people do so for 'harmless' ailments, such as the common cold or for chronic complaints, such as rheumatism or arthrosis for instance. For more serious ailments, the conventional physician appears on the scene. There are few people who *solely* undergo alternative treatment. A declining number of Dutch physicians (currently estimated to be less than one thousand) apply non-conventional forms of treatment themselves, usually combined with a conventional practice.

The professional standard

Physicians are required to comply with the 'medical professional standard', which means: 'to act with due care in accordance with the knowledge of medical science and experience as a reasonably competent physician in the same medical category, in the same circumstances with medicines that are reasonably proportionate to the concrete treatment objective' (Netherlands Health Law Handbook 2000, 41-2, *Handboek gezondheidsrecht*). The definition that applies to the above has become increasingly clear from case law in recent years, as well as how much leeway physicians still have in applying alternative treatments.

The first key requirement imposed on physicians is that each medical treatment should be based on a conventional diagnosis, which must be conducted in the 'proper manner'. Physicians are therefore not permitted to begin a treatment 'out of the blue', nor are they permitted to use non-accepted diagnostic methods. 'Bioresonance tests' or 'vega testing' are therefore off limits for physicians.

Once a conventional diagnosis has been performed, physicians are only permitted to apply treatments for which a medical indication exists. There must also be a concrete treatment objective. For instance, a physician is therefore not permitted to prescribe chemotherapy if there is no indication for doing so, or if this does not, or no longer serves a purpose. The concrete treatment objective may obviously also be palliative care, or removing or relieving the existential pain suffered by the patient.

According to the rules of evidence-based medicine (EBM), the treatment indicated at a certain point in time, is determined by the state of the art in medical science, the clinical experiences of the medical profession and the patient's wishes and expectations. The professional standard may incorporate several treatments for a specific diagnosis. As a rule, the physician will focus on the treatment that will yield the best results, having the least burden on the patient. If a medical indication exists for several treatments, the choice is determined in a meeting between the physician and the patient.

As stated, evidence-based medicine is founded on three underlying pillars: proof,

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experience and the wishes and expectations of the patient. The patient's wish can thus never form an adequate reason for administering a treatment. The fact that a patient has asked for a particular treatment or the fact that a patient has consented to a particular treatment, does not discharge the physician from his duty to assess the indication and determine whether a particular treatment would be meaningful from a medical point of view. A physician who is confronted with a patient asking for chemotherapy while there is no medical indication for doing so, or in cases where concrete treatment results cannot be expected based on the state of the art in medical science, is not permitted to comply with the patient's wish. Even if a patient requests a futile medical treatment, such as injecting soda into tumours, the physician is not permitted to comply with the request.

The aspects incorporated in the professional standard at a certain point in time have not been set in stone, and there are always grey areas too where physicians do not agree with the prescribed treatment. The professional standard consequently is not a mandatory rule or 'cookery book medicine'. Each patient is different, and each situation requires another solution. Physicians therefore definitely have the necessary leeway to diverge from the professional standard. If they do so, they must be able to justify to their peers, the patient and society as to why they chose to diverge from the standard. Proper records and informed patient consent are vital in this context.

Physicians and alternative treatments

There are patients like Sylvia Millecam, who reject conventional treatment and wish to undergo alternative treatment – even if they are suffering from a serious disorder. What should physicians do in such cases? Physicians should be the first to earnestly point out the consequences to the patient if they wish to be treated by an alternative therapist. They are required to continuously highlight the need for conventional treatment. In the Millecam case the alternative healers stated that Millecam herself had refused conventional treatment and they felt that this served as a licence for them to administer their treatments. In the Millecam case, the Disciplinary Committee, however, stated the following in respect of the above: 'A physician can no longer provide a person alternative treatment with impunity if the patient proves to need help which clearly can only be provided in conventional medical circles.' If conventional treatment exists, physicians are not permitted to simply ignore it. And if the patient refuses conventional treatment, this should not serve as a licence permitting physicians to offer all kinds of non-conventional treatments. After all, by doing so they wrongfully raise the patient's hope and expectations. The Amsterdam Court of Justice formulates the above as follows:

"The law gives precedence to the well-informed patient's right of self-determination. This does not mean to say, however, that the physician or the party providing individual healthcare does not carry any further responsibility. If he is asked to provide insight into the motives underlying his choice for applying a certain method of diagnostics or therapy, it will not suffice for the physician or healthcare provider to refer solely to the wish expressed by the patient.'

Another aspect that has emerged from the Millecam case is that patients have faith in the title of Doctor of Medicine. 'He is a doctor, so that should be fine,' Sylvia Millecam's doctors were insufficiently aware of that fact. Physicians must at all times understand that their title of Doctor of Medicine carries a certain authority with it. This imposes heavy demands on what they advise and offer the patient. As the Disciplinary Committee stated in the Millecam case: 'A physician, who also practices in the domain of alternative medicine, is thus not discharged from acting in the capacity of a physician.' The KNMG formulates this as follows: 'Physicians are constantly aware that the diagnostics, methods of treatments and advice they offer revolve around the authority of the medical doctor/medical specialist education programme and the title of Doctor of Medicine or Medical Specialist.'

Are physicians allowed to offer alternative methods of treatment?

Coming to the key question: are physicians still permitted to apply alternative treatments, such as homeopathy or acupuncture? Clearly, such treatments may only be administered under very strict conditions. Doctors should always first ask themselves whether conventional treatment exists for the relevant diagnosis, and advise the patient thereof. After all, according to the KNMG rules of conduct 'the doctor is not permitted to apply treatments and disregard generally accepted diagnostic and treatment methods in the medical world'. The doctor must provide clear information to patients about the nature of their illness. The doctor must also make clear to the patient what the consequences are of not undergoing conventional treatment. But even if there is no conventional treatment, or this no longer exists, or if the patient rejects such treatment, the doctor cannot simply offer all kinds of treatments, the benefit of which has not been proven. Patients who are dying or whose treatments have finished are still required to be treated in accordance with the professional standard. After all, attention, comfort, pain control and palliative care fall within the scope of conventional medicine.

Furthermore, doctors must at all times avoid inflicting harm on the patient when providing non-conventional treatment. Harm is more than simply immediate

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medical damage caused by the treatment itself. When providing conventional treatment, the benefit of the treatment always counters harm. That benefit has not been proven in non-conventional treatments, which makes it more difficult to justify any harmful effects. Harm is also inflicted if the doctor offers false hope of improvement, or recovering from the complaints. And if, as a result of the non-conventional treatment, the patient does not start undergoing a meaningful conventional treatment or does so too late (doctor's delay), this is also viewed as inflicting harm. The doctor is likewise not permitted to provide misleading information about the effectiveness of the non-conventional treatment or substitute a conventional diagnosis for a non-conventional diagnosis. Doctors are also not permitted to attribute a therapeutic effect to a particular treatment if this has not been scientifically proven. The proof must be stronger than the evidence of a certain *method*. Stating that it has been proven that homeopathy works, therefore will not suffice. So, this rules out 'there is scientific evidence that homeopathy works'. A statement of this nature is as meaningless as the statement saying that 'there is scientific evidence that conventional medicine works'. Doctors will have to specify what scientific evidence exists for *a particular* treatment and *a particular* dosage for *a particular* indication.

All in all, the leeway doctors have in applying non-conventional treatments therefore is not that large. And that leeway will probably become even smaller with the continued protocols and professionalisation of the profession of medical doctor, and the continued advancement of EBM. EBM will undoubtedly prove that parts of conventional medicine will likewise not prove to be meaningful, and they will be deleted from the professional standard as a result. That is what progress is all about. The scientific underpinning of other parts of conventional medicine will see further improvement, and that will only serve to enlarge the gap between non-conventional and conventional methods of treatment. Continued scientific research may possibly also show that certain non-conventional treatments are effective, and they will be incorporated in the professional standard as a result. But many non-conventional methods of treatment will end up in the circular files of history – joining the countless others that have been laid to rest here. That too is progress.

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A Mission to Save Public Medicine

After a long and complex struggle, a groundbreaking agreement was reached, one that will greatly benefit public medicine.

Deterioration of the Israeli Health System

In November 2010, the Israeli Medical Association (IMA) officially began negotiations with the Israeli Treasury to discuss ways to improve the deteriorating health system. The IMA negotiated on behalf of 17,000 doctors employed in public hospitals and clinics. Unfortunately, after months of negotiations, little progress was made.

In early 2011, the Israeli Medical Association (IMA) publically announced the launch of "**a mission to save public medicine**," demanding additional manpower, more beds in hospitals, an increase

in physician salaries in the periphery and incentive pay for doctors working in specialties suffering from physician shortages.