Integration of traditional Chinese medicine and Western medicine: some food of thought on clinical liability

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In Hong Kong, 50% to 60% of the population consulted traditional Chinese medicine (TCM) practitioners at least once in their lives notwithstanding the wide availability of services from Western medicine (WM).[1] A study has shown the concomitant use of TCM and WM by 25.9% of patients in Hong Kong.[2] There is a need for better integration clinically and legally, especially when both WM and TCM practitioners are uncertain of their liabilities if any medico-legal incidents arise during co-care. Application of various common-law elements of negligence (duty of care, standard of care, causation and foreseeability) would help to develop deeper insights into how liabilities would fall on different parties.

When a patient comes to consult a practitioner, WM or TCM, a doctor-patient relationship is arguably already established. If a patient is under the co-care with prescriptions of both TCM and WM, who owes the duty of care to the patient? A three-pronged test can be used to determine the duty of care[3]:

- the proximity (sufficient close) in the relationship between the claimant (patient) and the defendant (practitioner);
- damage being reasonably foreseeable; and
- whether the court considers it fair, just and reasonable to impose a duty of the given scope upon the defendant practitioner.

Who has the closest relationship with the patient claimant for a particular management? For instance, a patient consulted a WM doctor for back pain with no significant abnormalities detected, and the patient was advised bed rest, with sick leave certification and analgesia if needed. The patient then consulted a TCM practitioner and was prescribed some herbal medicine to take regularly. The patient also took analgesia, and s/he developed an allergic reaction. Who should owe a greater duty of care? Likewise, a patient consulted TCM for health maintenance with a prescription of TCM supplements. The patient then had a bad cough and was diagnosed with bronchitis by a WM doctor, who prescribed a course of antibiotics. The patient developed severe diarrhoea. Which practitioner owed a greater duty of care?

It is the submission of the authors that in the back pain case, the TCM practitioner may have had a closer relationship with the patient claimant upon initiation of regular treatments. The TCM practitioner should ask firstly whether the patient has been prescribed any medication. In the bronchitis case, the WM doctor may have had a closer relationship and should enquire about any concurrent medication including supplements. The patient claimant then bears the burden of proof with respect to whether the medication is likely to cause damage (*causation*). The defendant practitioner could defend against the claimant's allegations with scientific evidence. If the best available evidence has not revealed any significant adverse drug interaction, the court may not see it "fair, just and reasonable" to impose a duty on the defendant practitioner (*reasonable standard of care*).

In WM, the *Bolam* test is applied, where a doctor is "not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art".[4] Traditional Chinese medicine practitioners hold themselves as practitioners specialised in treatment of certain health conditions, and they might use methods not in perfect line with WM practices, and patients look for TCM because they prefer not to receive WM, should the *Bolam* test also apply, or should TCM follow its own specific standard of care?[5] Let us consider three cases to

provide some insights.

In the United Kingdom, Abdur Shakoor was treated by Situ, an herbalist (TCM practitioner) with 5 years' experience in China possessing both a traditional "medicine" and "modern" medical qualifications, but no British professional medical qualifications. Situ prescribed a course of Chinese herbal remedies for Shakoor's lipoma.[6] Shakoor got very ill and died of liver failure. Post-mortem examination found that his liver contained Bai Xian Pi (白藓皮), or Dictamnus dasycarpus, which could be hepatotoxic as published in western journals. The judge concluded that as long as the herbalist has complied with the United Kingdom's laws, not prescribing substances prohibited or regulated by statutes, and taking steps to keep abreast of pertinent information in TCM textbooks and periodicals, this would fulfil the standard of care of a reasonable herbalist.[6]

In Singapore, *Lim Poh Eng*,[7] a TCM practitioner, was charged criminally negligence in having caused grievous harm to a patient by prescribing colonic washouts without proper training in the procedure and use of equipment, and without any understanding of the risks and complications involved. Lim was convicted after trial and failed on appeal to argue that the standard of negligence in criminal cases should be higher than the civil standard. The High Court ruled that a TCM practitioner embanking on management without prior knowledge and training can be found negligent.

Practitioners providing TCM or complementary and alternative medicine for management should provide evidence to create a hypothetical standard of care, otherwise the same standard will apply as WM. A United States case, *Gonzalez*,[8] provides a legal reference. Dr Gonzalez (defendant doctor) initiated a cancer treatment including pancreatic enzymes, specific diets, vitamin and mineral supplements, animal organs extracts, and coffee enemas. Such departure from good and accepted medical practice was a proximate cause of the claimant's injuries. If the treatment risks and the alternatives had been appropriately given, a reasonably prudent person in the claimant's position would not have agreed.

The *Bolam*[4] test can still be applied to TCM/complementary and alternative medicine, in accordance with the standard of care provided by responsible TCM practitioners skilled in that particular field. This is particularly important for the '*but for*' test to prove causation: "but for the defendant's negligence, would the claimant suffer injuries?" In a claim, the claimant bears the burden of proof, and the defendant doctor can adduce expert opinions to rebut. In the United Kingdom case *Wilsher v Essex*,[9] a junior doctor mistakenly inserted a catheter into a vein instead of an artery in a preterm baby for oxygen monitoring and excess oxygen was given, which may be a possible cause of blindness but not a definite cause. So, the claim failed in causation. The damage must not be too remote or unforeseeable as in *Goodwill*,[10] where a doctor did not owe a duty of care for contraceptive advice to the person having sexual relationship in future after vasectomy.

Healthcare practitioners can refer to the basic doctrine of bio-medical ethics to avoid medical mishaps.[11] Identification of the 'material risk' in adopting 'patient-centred' care, particularly after the leading judgement of *Montgomery*[12] in the United Kingdom Supreme Court, would enable both WM and TCM practitioners to understand why patients seek alternative treatments in line with the principles of autonomy and also justice and fidelity,[13] acting for the best interests for patients. However, patients should understand the limitations that practitioners of TCM and WM might not fully comprehend the practices on other side. They can only advise on the benefits of treatment of their own specialities as well as the potential harmful effects (beneficence and non-malfeasance). It is the authors' submission that it is not fair, just and reasonable to ask WM doctors to be liable for any harmful effects of treatment under TCM and vice versa.

There is also concern of liability of referring patients from each side. The basic principle is whether the alternative therapeutic options are generally accepted within the medical community and a referral to a medical specialist usually does not attract malpractice liability, so referring doctors ought to know, through reasonable inquiry, the credentials of the practitioner to whom they refer.[14] Another concern is vicarious liability if the TCM practitioners are employed by or affiliated with an institution. A key factor is the degree of control that Chief Medical Executives, usually WM doctors, have over TCM practitioners. United Kingdom court cases provide good references. In *Barclays Bank*, the Supreme Court held that the bank was not vicariously liable by having referred its employees to doctors for pre-employment check if an employee was subsequently sexually harassed by a doctor referred.[15] In *Christian Brothers*, the Supreme Court discussed the test of control that "[m]any employees apply a skill or expertise that is not susceptible to direction by anyone else in the company that employs them. Thus, the significance of control today is that the employer can direct what the employee does, not how he does it." (para 36).[16] Chief Medical Executives can only control that their TCM practitioners comply with law and regulations, but not how those practitioners consult with patients. This is particularly important when a complaint is filed against a Chief Medical Executive regarding the performance of a TCM practitioner.

When patient is under co-care of a TCM practitioner and a WM doctor, there should be clear delineation of the duties and standard of care in those particular circumstances. Regulatory bodies should examine causation under co-care to determine issues of liability. If a WM/TCM practitioner embanks on management under other's domain, the standard of care required is that of an ordinary skilled person exercising and professing to have the special skill as in *Lim*[7] and *Wilsher*[9] (the House of Lords held that a junior doctor owes the same duty of care and standard of care as a qualified doctor). Structured inter-professional education and research can drive integration with better understanding of the clinical science of each other.[17,18] With the integrated Chinese-Western Medicine Programme executed by the Hospital Authority for cancer care, stroke, and low back pain since 2014, an integrated healthcare framework should be shared among the key stakeholders to ensure patient safety for definition of clear professional boundaries and roles.

Author contributions

All authors have contributed to the concept, review and analysis of literature and critical revision of the manuscript for important intellectual content. A Lee is responsible for the first draft. All authors had full access to the data, contributed to the study, approved the final version for publication, and take responsibility for its accuracy and integrity.

Conflicts of interest

All authors have disclosed no conflicts of interest.

Declaration

Content in this presentation is intended solely to provide general discussion concerning medico-legal perspective of Integrated Chinese and Western Medicine. It is not intended as legal or medical advice. Legal or medical advice should be obtained from qualified legal counsel or other professionals to address specific facts and circumstances and to ensure compliance with applicable laws and standards. This paper is written in personal capacity of the authors and the opinions expressed therein do not represent the organisations which they work for or affiliated with.

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