Cases and recommendations of the Inquiry Committee [1]

Expected standards when providing complementary or alternative therapies

The *Health Professions Act* affords a measure of privilege and protection for physicians employing unconventional concepts in their medical practices, but there are limits. Section 25.4 of the Act states:

> *The College must not act against a registrant or an applicant for registration solely on the basis that the person practises a therapy that departs from prevailing medical practice unless it can be demonstrated that the therapy poses a greater risk to patient health or safety than does prevailing medical practice.*

The Inquiry Committee recently concluded two complaint investigations with criticism of physicians for failing to meet expected standards for their medical care of patients receiving therapy characterized as complementary or alternative. In one case a patient was treated with supra-physiological doses of thyroid and cortisol supplements. In the other, a patient who had not been adequately investigated or treated for symptomatic ischemic heart disease sought and received chelation therapy from a physician.

Many physicians are naturally frustrated by the persistence of unscientific treatments and have formed the mistaken belief that, given the statutory protection set out above, there are no rules by which the College can hold physicians employing these methods accountable when unsuspecting patients are placed at risk or harmed. While it is true that the Act values freedom of choice for patients, the expectations of the College are concisely set out in a

professional guideline titled *Complementary and Alternative Therapies* [2].

Key points include requirements that physicians must:

- carry out appropriate and conventional examinations and investigations in order to establish a diagnosis and basis for treatment
- employ a rigorous medical approach before offering any unorthodox therapy
- not expose the patient to any degree of risk from a complementary or alternative therapy of no proven benefit

The College is legally prohibited from investigating physicians solely for their use of unconventional therapies, but it can and does hold such physicians to expected standards in their medical management of the conditions they encounter. For every patient, standard medical assessments, diagnoses, differential diagnoses, and referrals are required. Patients have a right to refuse effective and proven therapies, but these must be explained and offered in accordance with practice standards.

The guideline concludes:

> *Physicians are advised to consult with the College about any questions that arise concerning complementary and alternative therapies because these considerations can be difficult and sometimes ambiguous*.

The Inquiry Committee found no ambiguity in these two cases.

Standards for obstetrical ultrasound

Every year the Inquiry Committee reviews several complaints alleging substandard performance, interpretation and/or reporting of second-trimester obstetrical ultrasound studies. The circumstances are often excruciating—missed major congenital anomalies.

The Society of Obstetricians and Gynaecologists of Canada recommends offering a routine second-trimester ultrasound between 18 and 22 weeks to screen for the number of fetuses, gestational age, placental location, and fetal anomalies. This is regarded as standard of care. Perinatal Services BC has published *Obstetric Ultrasound Assessment Standards* [3] that reflect a number of authoritative resources.

The Inquiry Committee is obliged to consider such standards when it determines whether care was acceptable in specific circumstances. Diagnostic radiologists and physicians providing care to expectant mothers are expected to be familiar with the Perinatal Services BC Standards. Imaging facilities should adhere to them, and physicians receiving reports should insist that they be appropriately formatted and complete and consider sending them back if they are not.

The Inquiry Committee recently investigated a case of delayed recognition of hypoplastic left heart syndrome, missed on two second-trimester studies. The committee was critical of one radiologist for accepting suboptimal views of the heart, contrary to the standards. The expectation is that a repeat ultrasound be performed if the specified cardiac anatomy is not confidently demonstrated (as detailed on page 8).

A second radiologist had reported on a limited study ordered specifically to assess only interval growth of the fetus. The standard states:

> *When performing ultrasound scans in the 2nd trimester at gestational ages other than 18wks 0d – 22wks 6d, every effort should be made to assess, document and report the structures listed in the 2nd Trimester Ultrasound Report.*

The facility where this radiologist was based had already amended its protocols to address this concern following an internal review prompted by this case.

The committee was assisted by an expert opinion stating that opportunities were missed to identify this lethal anomaly at 20 and 26 weeks. As it turned out, the complainant was not informed of the devastating diagnosis until 33 weeks. The complainant’s frustration was reportedly compounded by her recollection of the sonographers at both studies expressing concern about challenging anatomy but failing to make any note of it. The committee was not critical of the obstetrician, but concluded that a patient report of concerns verbalized by a sonographer may merit a call to the radiologist.

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