The National Registration and Accreditation Scheme: what would inclusion mean for naturopathy and Western herbal medicine?

Part II: Practice implications

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Introduction

The previous article in this series discussed the legislation of the National Registration and Accreditation Scheme (NRAC) and the new statutory health practitioner regulatory arrangements that will replace state or territory based regulation (Wardle 2010). Registration exists solely for the protection of the public. For practitioners who act in the patient's best interests and practice within their ability it is highly unlikely that the implementation of regulation will change the way they practice. However there are some areas that will differ, specifically in relation to increased accountability. Additionally some standards that have previously been non enforced will become more enforced. This article will examine how the implementation will directly affect the practice of naturopathy and Western herbal medicine by practitioners.

Practice requirements

Continuing professional education (CPE) requirements

As is currently the case for naturopaths and Western herbalists, practitioners regulated by the NRAS will be required to undertake minimum levels of CPE as required by the relevant board. This may include first aid certification which has been extended to practitioner groups previously exempt from this requirement. What may differ from the current scenario is that practitioners must now keep a portfolio of CPE for the past three years.

The legislation allows for evaluation of CPE to be outsourced, most often to professional associations. This would allow professional associations to continue to monitor CPE in compliance with minimum standards set by the registration authority and therefore from a practical perspective reporting may not differ considerably for practitioners. This would also allow professional associations to continue to focus on extra CPE requirements above and beyond these proscribed minimum benchmarks that they consider important. For example the National Herbalists Association of Australia (NHAA) may continue to require its naturopath members to not only comply with naturopathic CPE requirements, but also ensure that an appropriate level of this is focused on herbal medicine.

The aim of this part of the legislation is not to be overly onerous on practitioners, but ensure that public safety is afforded by ensuring that clinicians keep their knowledge up to date. It also helps to standardise CPE requirements across professional associations which currently exhibit enormous variability in their requirements (Lin 2005).

Examples of what could constitute appropriate CPE could be drawn from the current arrangements for osteopaths under the National Registration and Accreditation Scheme (see Table 1 and available from http://www.osteopathyboard.gov.au).

Insurance arrangements

Section 129 of the Act states that 'registered health practitioner must not practise unless appropriate professional indemnity insurance arrangements are in force'. In practice this is similar to the current scenario. Insurance may continue to be arranged through professional associations who are in the best position to negotiate group rates for their members, as any registration board is not able to negotiate on behalf of the profession it regulates.

Complaints

The number of complaints

It is likely that with the establishment of a regulatory scheme for naturopaths and Western herbalists the number of complaints against these practitioners will rise significantly. This has been previously observed in other professions that are newly statutorily regulated, for example there was a nearly 10 fold increase in complaints against Chinese medicine practitioners in Victoria upon the introduction of the Chinese Medicine Registration Board in 2002 (Figure 1).

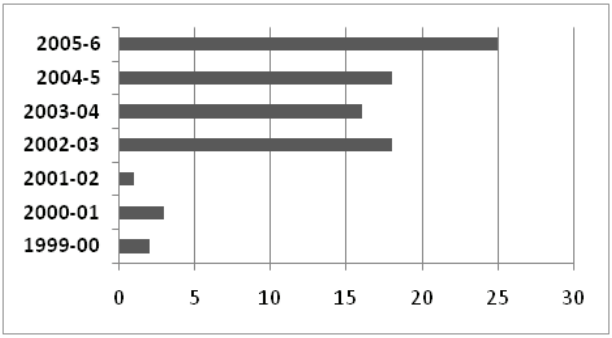
Where do these complaints come from?

Rather than being new complaints these are complaints that had previously been lost 'in the system'. For example numerous reports have highlighted the difficulty in collecting accurate data for complaints against complementary medicine practitioners such as

Table 1: Forms of accepted continuing professional education under the new Osteopathy Board of Australia

Type of activity	Evidence to be retained in the CPE portfolio
Attendance at seminars, conferences and workshops relevant to osteopathic practice	• Certificates or other proof of attendance from seminars, conferences and workshops attended • Study notes
Self-study and research using journals, distance education and online modules on topics relevant to osteopathic practice	• The dates and details of activity undertaken, resources used and topic(s) studied
Enrolment in and successful completion of units in applicable, health-related, tertiary courses	• Tertiary course assessment notices
Published articles in reputable journals relevant to the practice of osteopathy or textbook chapters where the osteopath is the main author or a substantial contributor	• Diary records of time spent on preparation of publications and copy of draft • Copies of published articles, books etc
Teaching, supervision, oral presentations (including recognition of preparation time), formal study groups and documented peer review relevant to osteopathic practice	• Course notes • Records of attendance and meeting notes

Figure 1: Number of formal complaints against Chinese medicine practitioners in Victoria 1999-2006 (Chinese Medicine Registration Board of Victoria www.cmrb.vic.gov.au)



naturopaths and Western herbalists as many patients are unaware of where to direct these, or unaware that they are even able to make complaints against these practitioners (Lin 2005, Wardle 2008).

Additionally although every professional association is required to have a national Code of Conduct and standards of entry, these are not always enforced. Some naturopathic and Western herbal medicine professional associations have been cited as not taking appropriate disciplinary action or following up on complaints even when egregious actions have been made by rogue practitioners, and notifications made to these associations may not have made it into official figures (New South Wales Legislative Assembly 2005). Such lapses, whether deliberate or accidental, may result in the numbers of 'official' complaints in the unregulated professions being passed on to health complaints authorities being artificially low.

Even when patients do make complaints to the various health complaints authorities in their state or territory most of these bodies have little legislative authority (with the exception of New South Wales and the Australian Capital Territory) and often can only refer the complaint for prosecution under different non health legislative authorities, for example under the Trade Practices Act for practitioners 'holding out' to be medical practitioners. All these factors combined have led to a general consensus that the number of complaints in unregistered professions is significantly underestimated.

What happens to complaints?

As the desired outcome from any notification is public protection only, it is not always necessary to interfere with the practitioner's registration. Practitioner education and counselling are usually seen as the most effective ways of improving public safety, as it enables practitioner improvement without unnecessary restriction of practice. Only the most serious cases are referred to a tribunal or are deemed appropriate to interfere with practitioner registration. For example in the profession of Chinese medicine approximately half of all notifications to the Chinese Medicine Registration Board of Victoria do not result in formal investigations or legal action. Rather practitioner counselling, mediation, undertakings being taken by the practitioner (a probationary period or official warning), or no requirement for investigation at all was seen as sufficient in these cases (Chinese Medicine Registration Board of Victoria 2008, 2010).

What forms a breach of practice?

The aim of the legislation is to protect the public not to unnecessarily punish practitioners. Accidents can and do happen. The legislation does not aim to punish practitioners for clinical mistakes as long as these mistakes are not caused by incompetence or malicious intent. For example an unpredictable allergic reaction to a herbal medication or an unlikely adverse reaction to treatment does not constitute a breach. However deliberate withholding of this information by not sufficiently reporting such reactions to authorities (where relevant) could constitute a breach. The Chinese Medicine Registration Board of Victoria lists notifications in its annual report each year. A summary from the 2010 report

Table 2: Types of notifications against practitioners received by the Chinese Medicine Registration Board of Victoria (Chinese Medicine Registration Board of Victoria www.cmrb.vic.gov.au)

Advertising	Testimonials or misleading advertising
Clinical Care	Inappropriate or poor clinical management Poor management of adverse reaction Incompetent or inappropriate treatment or consultation Refusal or failure to provide prescription details or treatment plan Use of expired products Inappropriate labelling of herbs Dispensing or use of illegal or contraindicated herbs Unsustainable use of endangered herbs
Conduct or behaviour	Character issues (for example, hidden previous history of violent or sexual crimes) Rudeness Lack of privacy protection or informed consent Professional association expulsion Fraudulent use of another person's professional association number
Ethics	Deception and pressure selling Disputed treatment cost and outcome Unsubstantiated or misleading claims 'Holding out' (for example, pretending to be a medical doctor) Exploitation of patients Dishonesty
Medical Reports, Records and Certificates	Fraudulent receipting or failure to provide receipts Inadequate patient records
Offences	Fraud Refusal to comply with sanctioned audits (for example, in investigation of health fund fraud) False statements
Practice Management	Infection control breaches Occupational Health & Safety breaches
Practitioner Registration	Failure to adequately insure Failure to comply with conditions placed in registration Obtaining registration by deception Practising while unregistered or assisting a practitioner to practise while unregistered Using false documents
Sexual misconduct	Sexual misconduct, sexual impropriety or rape Indecent assault
Other	Breach of undertakings or agreements with regulatory authority Engaging unqualified staff Failure to disclose offences Assisting students with exams

is listed in Table 2 showing the types of notifications received since its inception.

What does a breach look like in practice?

The intent and context of the specific circumstance determines whether a breach has occurred. Accidental clinical errors will occur in almost every clinician's lifetime, and some patients will experience paradoxical reactions to treatments. The key determining factor is whether the practitioner – either through deliberate intent, arrogance or incompetence – knowingly put the patient at undue risk, or in cases of arrogance or incompetence could have been reasonably expected to prevent harm from occurring. For context, a number of clinical examples are listed in Table 3. What practitioners should reasonably be expected to prevent is dependent upon the training of specific practitioners, for example, a naturopath would not be held to the same standards as an emergency physician in acute situations. However, it should be noted that if a practitioner advertises as a 'specialist', they may be held to the higher standards that this term – and the implied higher levels of training – would infer (Wardle 2011).

Is it a breach if my treatments don't work in a patient?

Treatments are allowed to be ineffective. Indeed not every treatment will work for everyone and ineffective

Table 3: Case studies of possible clinical situations resulting in a likely to breach or unlikely to breach

Likely breach	Not likely to be a breach
A patient with depression is currently taking anti-depressant medication (a selective serotonin reuptake inhibitor) and visits a practitioner to support her conventional treatment. The practitioner prescribes a mix including high doses of Hypericum perforatum. The patient eventually has onset of Serotonin syndrome, which is eventually resolved upon ceasing medication. *Note: This would be considered a breach whether or not the practitioner had asked for medication history. Not asking a patient with a high likelihood of prescription medication in such a circumstance is itself a breach, particularly as the prescribed herb interacts with a commonly used conventional treatment for this condition. Additionally, it could be reasonably expected that a trained herbalist or naturopath would be aware of the risk of Hypericum and SSRI medication resulting in serotonin syndrome.*	A patient with high blood pressure seeks the advice of a practitioner. The patient discusses their current blood pressure medication and their desire to wean off them. The patient's hypertension was confirmed by physical blood pressure is measured at 170/110. The practitioner discusses working in conjunction with the patient's GP to reduce medication, and offers their business card and a letter for the patient to take to the GP. The practitioner discusses dietary and lifestyle modifications with the patient. The practitioner also suggests that the patient take one clove of garlic, roasted, every day. The patient mistakenly takes one bulb of garlic every day and returns two weeks later with clinically low blood pressure and is yet to reduce conventional medication as they cannot make an appointment with their GP for another two weeks. The patient is counselled on the dangers of using high dose medicines that are clinically similar (both conventional and complementary) and has resolved to monitor their blood pressure and reduce medication accordingly until they can see their GP. *Note: Use of therapeutic products with potential CAM-drug interactions is OK as long as performed competently, does not endanger the patient, is appropriately monitored and the patient is appropriately informed.*
A returning patient, a woman 27 weeks pregnant, consults with her practitioner for recurrent urinary tract infections. The practitioner prescribes a nutritional and herbal treatment centred on Vaccinium macrocarpon. However, symptoms of urinary tract infection increase and the condition becomes more serious. The practitioner persists with the same treatment, stating that "it's best to avoid those hard antibiotics just yet" and the patient eventually succumbs to serious infection and develops pre-eclampsia at 31 weeks. Although the birth eventually goes smoothly the last trimester causes stress for the woman and her family and requires increased management. *Note: This would be considered a breach for two reasons. The practitioner persisted with an ineffective treatment even though the condition was becoming more serious. Additionally, the practitioner monopolised care in two ways, by not referring once they had reached the limit of their treatment but also by discouraging the patient from using conventional antibiotics in the treatment of acute UTI symptoms.*	A patient recently diagnosed with an aggressive form of cancer visits a practitioner claiming they want 'natural treatment'. The patient states they do not want to use chemotherapy. The practitioner recommends that the patient undertake conventional treatment in conjunction with naturopathic treatment to improve effectiveness. The patient still refuses to use chemotherapy. The practitioner treats patient with supportive treatments in accordance with their wishes. As the patient's condition worsens the practitioner again recommends the patient consider chemotherapy. The patient ultimately dies under the care of the practitioner. It is later determined in court that the success rate of chemotherapy in the patient's specific cancer is very high and that it likely would have resolved with chemotherapy. *Note: So long as the clinician documented the patients refusal of her advice to seek conventional care in conjunction with 'natural medicine' the practitioner has not breached their duty of care by respecting the patient's wishes, even if ultimately they were not in the patient's best interests. However, the practitioner is required to offer counsel to the patient on recommendations that are in the patient's best interests. Failure to do so could result in this scenario being a likely breach.*

treatments are in fact a valuable learning experience for clinicians of all types. Howeve if dogged adherence to an ineffective treatment despite evidence that it is placing the patient at risk, or denying them the opportunity to seek other treatments, constitutes a serious breach of professional conduct. Additionally practitioners will not be judged on the treatments they use, unless they knowingly place the patient at undue risk or are somehow exploitative in nature.

Failure to refer

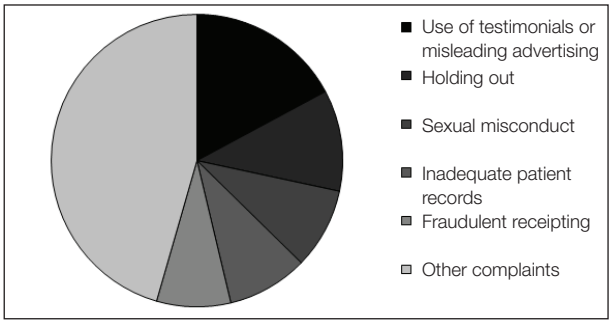
Often what practitioners don't do is of more consequence than what they do. A key risk associated with any health profession is the risk of omission caused by failure to appropriately refer, which has been discussed in previous articles in this journal (Wardle 2008). Inappropriate monopolisation of care can put the patient at risk and may constitute unprofessional conduct. In 2008 the *Australian Family Physician* published a case study highlighting what may constitute unprofessional conduct in naturopathic practice (Mackinnon 2008). A 72 year old North Queensland male had consulted a naturopath after sustaining injuries in a horse riding incident. The naturopath prescribed a turmeric supplement, packed the wound with comfrey leaves and continued this treatment without effect for a month. At the behest of his wife the patient sought medical attention during which time it was found that infection had spread to the meninges of his brain and urgent surgery was required. It is important to realise just why this would constitute a breach of professional conduct. The use of these, or any other treatments known not to cause considerable harm, was perfectly acceptable. However the fact that despite lack

of clinical effect and deteriorating condition of the patient the ineffective treatment protocols were continually supported and the naturopath failed to refer for a second opinion when the patient's condition became serious, do constitute a breach.

What are the most common breaches overseen by the Board?

The types of complaints to be expected under such a board can be garnered somewhat by viewing the major nature of complaints against Chinese medicine practitioners (Figure 2).

Figure 2: Types of notifications made to the Chinese Medicine Registration Board of Victoria between 2008 and 2010
(Source: Chinese Medicine Registration Board of Victoria, www.cmrb.vic.gov.au)



What practices will I no longer be able to do?

There are some restricted acts specifically in the legislation, namely sections 121-123 restricting dental acts, prescription of optical devices and cervical spine manipulation only to practitioner groups named by the Act. However the regulatory structure in Australia is one of registration, protection of title and ensuring professional conduct rather than licensure of specific acts. This means that generally there are very few acts or practices that are actually restricted or controlled. Theoretically this means that practitioners have almost unlimited scope. However in practice this means that practitioner 'scope' is limited by training.

Unprofessional conduct therefore only occurs when practitioners inappropriately go beyond their training thus exposing the patient to risk of harm.

Does regulation mean we can only practice evidence based medicine?

This is a common concern of many CAM practitioners in relation to impending regulation (Rogers 2007). However there are in fact no specific evidence based medicine sections of legislation. Most professional Codes of Conduct on the Australian Health Practitioner Regulation Agency website (www.ahpra.gov.au) do however contain a clause with wording and intention that suggests practitioner 'practise in accordance with the current and accepted evidence base of the health profession, including clinical outcomes'. But it should be noted that this evidence base is determined by the professions themselves. Each profession has a unique body of knowledge which forms the evidence base of the profession, and the setting of minimum education and training standards enacted by regulation ensures that students of these professions are exposed to a broad swathe of this knowledge. Naturopathy and Western herbal medicine are no different in this regard from any other regulated professions and contain a strong body of traditional knowledge, with a growing body of contemporary knowledge which forms its evidence base (for example Mills and Bone 2000, Pizzorno and Murray 2005; Sarris and Wardle 2010).

However evidence based medicine, or more appropriately evidence informed medicine or evidence based practice, is not analogous to protocol driven medicine (Lomas 2005). That evidence based practice implies a narrow view of treatment that only allows therapies with unequivocal positive randomised controlled trials is a false perception. For example a study relying on dogmatic adherence to these principles alone for clinical decision making would lead to the adoption of an ineffective treatment in 32% of cases and lead to the rejection of an effective treatment in 33% of cases (LeLorier 1997). Indeed only 11% of conventional medicine has definitive proof of effectiveness (although a further 23% are likely to be beneficial) (BMJ Clinical Evidence 2011). This is notwithstanding the fact that 'off label' prescriptions (prescriptions used for conditions in which they have not been studied) may account for up to one-fifth of total prescriptions in conventional medical practice (Radley 2006).

Even one of the founding fathers of the evidence based medicine, Professor David Sackett (1996), defined evidence based medicine as 'integrating individual clinical expertise with the best available external clinical evidence from systematic research' and suggested that 'good doctors use both individual clinical expertise and the best available external evidence and neither alone is enough. Without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best evidence, practice risks becoming rapidly out of date to the detriment of patients'.

What could constitute a breach however is deliberately ignoring the evidence when it does exist, for example by prescribing a remedy which has strong evidence of harm. In this less dogmatic light every practitioner should ideally be conducting evidence based practice to enhance patient outcomes. Again regulation does not place restrictions on practice, in fact restrictions are specifically discouraged by subsection (c) of the guiding principles of the legislation.

Communication and documentation

Communication takes an extra air of importance for regulated professions, and naturopaths and Western herbalists would be no exception (Wardle 2011). Clinical records serve as communication mediums between the practitioner and outside bodies. In any investigation of breaches, documentation (specifically clinical notes) will be used as evidence in any claims against the practitioner and are the official record of the encounter. The general adage is 'if it isn't written down it didn't happen'. For example if a patient who was advised against ceasing conventional cancer treatment but claims that the practitioner told them to avoid chemotherapy, clinical notes will be used to determine what happened in the clinical encounter. If it hasn't been noted that the patient refused the practitioner's advice, it will be more difficult for the practitioner to show that they acted professionally.

This is also relevant for informed consent, for example documenting that the patient has been informed of risks or 'unconventional' nature of treatments when appropriate. Documentation should also be inclusive of all examination procedures performed as this may also protect the practitioner from claims of financial exploitation or negligence should any legal or regulatory body action be initiated (for example by showing that appropriate clinical examinations indicated the patient required specific treatments rather than the application of protocol medicine).

Additionally it needs to be understood that practitioners do not own the clinical records, although they may own the physical material they are written on, and therefore have a duty of care to ensure their quality. This means that clinical notes may be read by persons other than the practitioner, and provisions of the Privacy Act mean that clients may also access these notes as well as other practitioners on client request. For these reasons clinical notes should be: legibly written in English; be brief, accurate and complete; contain only readily understood abbreviations; avoid value judgements and avoid comments which could be embarrassing for either client or practitioner (Wardle 2011).

In regulated professions unsatisfactory note taking is viewed as unprofessional conduct and can also be penalised in conjunction with breaches more directly related to the complaint. In areas where the evidentiary burden does not result in a complaint being prosecuted, action in relation to poor documentation can still occur.

Office product sales

The legislation contains no restriction on clinic product sales by regulated practitioners. Furthermore the practice is unlikely to be restricted not only because the current infrastructure required for splitting the point of prescription and sale simply does not exist (for example the development of a network of dispensaries for utilisation by practitioners), but also because the practice is often recognised as and accepted as an essential element to the individuation of medicine, a central tenet of many holistic health disciplines (Lin 2005, Kotsirilos 2007). However office product sales, like all areas of practice, must be conducted in a professional and ethical manner. The major issue associated with unprofessional conduct is one of economic harm to the patient caused by financial exploitation by nefarious practitioners, for example by over servicing or over prescribing. Although supplement sales are an accepted income stream for many practitioners, it must be remembered that duty of care to the patient means that practitioners are required to be health professionals first and business persons second. This does not mean that practice cannot be financially rewarding, it simply means that the patient's interests must always be paramount.

The issue of office product sales in specific relation to the sale of complementary medicines by Integrative Medical practitioners was explored by a recent article in the *Medical Journal of Australia* (Parker 2011) which would also be relevant for naturopaths and Western herbalists dispensing these medicines. This article suggested that if ethically conducted the practice would not pose problems for practitioners regulated under the National scheme provided full disclosure of information on pecuniary interests was provided to the patient and that the practitioner did not restrict the patient's right to obtain any products from other avenues.

Examples of unprofessional conduct related to clinic product sales

Generally office sales will not cause problems. However if undertaken in an unethical or unprofessional manner they can be reason for action taken against a practitioner under a regulatory authority. For example a Queensland medical practitioner had his medical registration suspended after prescribing Mannatech® products to patients with a variety of conditions (Medical Board of Queensland v Raddatz 2000). This case determined that the practitioner's enthusiasm for certain products can cloud clinical judgement concerning the evidence for what is in a patient's best interests; that patients can be easily deceived into believing that they are receiving tested or efficacious treatments when this may not be the case; and that practitioners should not make 'secret' profits from supplying medications and devices. This is particularly true for practitioners who may prescribe only one product line which may be unduly influenced by the aggressive marketing of supplement manufacturers. For example one company sponsored seminar aimed at natural medicine practitioners has stated that attendants may 'learn how to create a wellness clinic, which can create an ongoing flow of supplement sales, creating an income stream that requires little or none of your time to generate' (Carroll 2007).

However it should be noted that the primary reason for the suspension of the medical practitioner in question

in the previous case was not the use of the products themselves, but rather the indiscriminate prescribing of products valued at over $250 per month for a variety of conditions, without regard to clinical effectiveness in specific circumstances (for example the same products were offered to patients with hemochromatosis, cancer, infertility and epilepsy). He had also promoted the products as a business opportunity to a patient's daughter. Similarly action taken against a New Zealand GP for prescribing nutritional supplements valued at over NZD$200 per month succeeded not because of the treatment itself, but rather because the GP had failed to inform the patient that the products were part of a multilevel marketing scheme (Health and Disability Commissioner 1998).

This concept has also been observed in CAM practitioners. In Zhang vs Chinese Medicine Registration Board of Victoria (2008) it was determined that the failure of the Chinese medicine practitioner to disclose his financial interest in the sale of prescribed products at his Queensland clinic constituted unprofessional conduct. The complainant in the case stated that they felt that this interest was not communicated to them and that had this interest been disclosed it may have affected the willingness of the complainant to purchase the product.

Guidelines for professional and ethical conduct related to clinic product sales

In order to fully comply with professional and ethical obligations practitioners should provide full information about: a) the evidence that the prescribed product is appropriate for the condition being treated (which also includes traditional clinical rationale); b) the evidence, both traditional and scientific, for the risks and benefits of the prescribed product; c) the ongoing cost to the patient of using the product; d) any financial interest the practitioner has in relation to the product; and e) any mark up on costs (which may include dispensary costs as well as wholesale price) related to the product. The practitioner should also offer the patient purchasing options by providing information on alternative methods of sourcing the product or products in question (Parker 2011).

Additionally the practitioner should maintain accurate clinical records for products purchased by each patient including the type and amount of each substance, its delivery method and the period of treatment (Parker 2011). Clinical records should state the rationale for using specific products, as this will be the evidence used in any actions taken against the practitioner. If it can be reasonably determined by peers (in this case others in the naturopathic or Western herbal medicine practice communities) that the treatments prescribed and sold by the practitioner in question were clinically indicated or appropriate and given in the best interests of the patient then there will be no reason for further action to be taken. Although practitioners who financially exploit patients by over servicing or over prescribing will be affected by this element of registration, most practitioners will see little practical variation from current practices.

Advertising and marketing

The legislation does place restrictions on some forms of advertising and marketing, with section 133 of the Act focusing on this area. Section 133 states that:

> A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that: (a) is false, misleading or deceptive or is likely to be misleading or deceptive; or (b) offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer; or (c) uses testimonials or purported testimonials about the service or business; or (d) creates an unreasonable expectation of beneficial treatment; or (e) directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.

Creating an unreasonable expectation of cure or benefit is a practice generally condemned by most professional association Codes of Conduct, as well as being enforceable under the Trade Practices Act, and should therefore be obvious to most practitioners. However the other subsections may not be as clear at first glance and are discussed further below.

False, misleading or deceptive advertising

Elements that deal with false, misleading or deceptive advertising are usually obvious when investigated in detail. One example of this may be the protection of title which will be extended to medical specialists under the Act. Section 115 of the Act states that: 'a person must not take the title medical specialist unless the person is registered in a recognised specialty in the medical profession; or (c) a specialist title for a recognised specialty unless the person is registered under this Law in the specialty'. Any use of terms indicating specialist education may be considered misleading and also breach this advertising subsection if the practitioner has not had further training in this specific area.

However marketing and advertising of specialty scope of practice can continue in a number of ways. For example instead of 'female reproductive specialist' a practitioner may use the terms 'herbalist specialising in the treatment of female reproductive disorders' or use 'with a focus on women's health' in advertising and marketing material. Additionally all advertising and marketing material indicating specialised scope practitioners need to qualify and make very clear that they are not a medical specialist.

In Australia there is no restriction on the use of the term 'doctor' as long as its use is not misleading. Under the legislation (as is also explained in the Chiropractic and Osteopathic Board Codes of Conduct) the term doctor is allowable as long as its use makes it clear that such a title does not apply to medical practice (e.g. Dr Beat, Chiropractor or Dr Worm PhD, Naturopath).

To comply with the legislation's requirements that advertising not be misleading any use of a PhD to infer

this title should come from a recognised institution. In the Commissioner for Fair Trading v. Hunter (2008) a New South Wales naturopath was found to have engaged in deceptive behaviour by inappropriate use in advertising of the title doctor in relation to his PhD from the unrecognised Sri Lankan correspondence school Medicina Alternativa. This was deemed deceptive as, although viewed by the court as a diploma mill, it would have inferred the same equivalence in training standards as a terminal degree at an Australian university, even though the naturopath had not completed any recognised formal tertiary training. The method by which the naturopath had listed his qualifications in an advertisement (ND PHD MA) was also deemed deceptive, as MA (which the naturopath maintained related to source of his doctoral qualification-Medicina Alternativa) could be reasonably considered to suggest that the naturopath had an additional Master of Arts qualification. The use of the term ND was not called into question.

This principle can extend to other training. Considering that some CAM colleges are accredited by unrecognised institutions, or in some cases accrediting bodies considered unsuitable by various jurisdictions, any advertisement of qualifications should be limited to training formally recognised in Australia.

Gift, discounts and other inducements

Restrictions on the advertising which offers a gift, discount or other inducement (for example 'second consultation free') are not absolute. These forms of marketing are still allowable under the legislation. However any terms or conditions must also be clearly and explicitly stated in the advertisement. In practice this means that a blanket statement that terms and conditions apply or a referral to a website with full conditions is not enough. Although few restrictions are placed on the types of gifts, discounts or inducements practitioners may use, all terms and conditions must be stated in full on any advertising or marketing material that refers to these offers.

Testimonials

Restriction on the use of testimonials is one area that has been cause for much concern in the complementary medicine practitioner community. This restriction applies only to using patient testimonials directly on advertising or marketing material and does not in any way limit word of mouth advertising by patients themselves.

This restriction has been put in place due to its potential for abuse in marketing practice. For example many marketing strategy courses aimed at complementary medicine practitioners specifically offer suggestions on how to create believable patient testimonials for advertising and marketing material (Keighery 2005). This reduces the ability for patients to make objective informed choices on their healthcare options.

Advertising indiscriminate or unnecessary use of health services

Subsection (e) stating that a practitioner must not directly or indirectly encourage the indiscriminate or unnecessary use of regulated health services, is generally targeted at protocol driven medicine. Using standard protocols of tests, diagnostic procedures or products on all patients, regardless of clinical need, constitutes unprofessional conduct generally as it exposes the patient to unnecessary and inconvenient treatment and economic harm. However if it can be demonstrated that procedures are clinically relevant for each individual patient (and clinical notes document how this was determined), practitioners will rarely be penalised for the types of medicines or procedures they utilise. Although in many instances supported by the complementary medicine manufacturing industry, protocol medicine not only raises ethical concerns but also disrespects both the important clinical role of the trained practitioner in addition to the underlying principles of naturopathic and Western herbal medicine.

What will happen to my professional association?

Some associations, including the National Herbalists Association of Australia (NHAA), have indicated that the development of an independent regulatory authority for the professions of naturopathy and Western herbal medicine will allow them to free up resources previously devoted to accreditation and registration, which can be redirected into activities that promote their members. It needs to be remembered that professional associations perform many roles beyond accreditation and registration of practitioners, many of which cannot be performed by regulatory authorities. Although previous experience (for example Chinese medicine) has demonstrated that professional associations have small reductions in numbers upon the implementation of regulation, these are generally thought to be outweighed by the positive benefits to the profession, in addition to the broader public benefits, that the increased accountability and standards that regulation can generally bring (Australian Acupuncture and Chinese Medicine Association 2008).

Conclusion

As discussed in the previous article (Wardle 2010), the implementation of increased professional standards and accountability, and with them extra responsibilities and obligations for the professions of naturopathy and Western herbal medicine, is likely, whether or not a statutory regulation scheme is implemented. However the underlying aim of these developments is public protection, not too burdensome on the professions and most modern regulatory legislation offers protections against overly onerous impositions. For many practitioners little will change in practice, whilst for some a more professional attitude will be required. Only

practitioners who neglect their duty of care and place their patients at undue risk through deliberate actions need fear action from regulatory authorities, and are these the types of practitioners we want representing our profession anyway?

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