Complementary and Alternative Medicine in Child and Adolescent Psychiatry: Legal Considerations

Michael H. Cohen, JD, MBA, MFA[a], Suzanne R. Natbony, JD[a], Ryan B. Abbott, MD, JD, MTOM[b,*]

KEYWORDS

• Complementary and alternative medicine • Health law • Informed consent • Liability • Medicolegal aspects

KEY POINTS

- All treatment decisions should be made in a child's best interests. If the child's parents make a decision, a psychiatrist may not simply override their judgment with his or her own preference, but can report the parents to state authorities or bring the case to court if the psychiatrist believes the child might be harmed by the decision.
- There is no case law regarding the use of complementary and alternative medicine (CAM) in child psychiatry, so the risk of malpractice liability in this setting is minimal. However, any deviation from customary medical practices creates an increased risk of legal liability.
- If CAM therapies are recommended, any known risks, benefits, and alternative treatments should be fully disclosed.
- As is the case with conventional medicine, physicians can reduce their personal liability by practicing good clinical medicine, obtaining informed consent, and comprehensively documenting.

COMPLEMENTARY AND ALTERNATIVE MEDICINE AND CHILD AND ADOLESCENT PSYCHIATRY

The term complementary and alternative medicine (CAM) describes a group of health care systems, practices, and products not currently considered to be part of conventional allopathic medicine.[1] Although systems of CAM (such as chiropractic, Ayurveda, homeopathy, and naturopathy) display considerable diversity, these systems share many of the same core values, such as a holistic approach to patient care and a strong emphasis on preventive medicine.[2] CAM systems and therapies may be grouped into broad categories such as natural products, mind-body medicine, and manipulative and body-based practices.[1]

The authors report no conflicts of interest.

[a] The Michael H. Cohen Law Group, 468 North Camden Drive, Beverly Hills, CA 90210, USA;
[b] Southwestern Law School, 3050 Wilshire Boulevard, Los Angeles, CA 90010, USA
* Corresponding author.
E-mail address: DrRyanAbbott@gmail.com

Child Adolesc Psychiatric Clin N Am 22 (2013) 493–507
http://dx.doi.org/10.1016/j.chc.2013.03.005 **childpsych.theclinics.com**
1056-4993/13/$ – see front matter

The use of CAM in child and adolescent psychiatry is growing in the face of increasing patient demand, a growing evidence base suggesting that certain CAM therapies may be effective, and CAM's typically lower costs in comparison with the rising costs of many biomedical therapies.[3] In the United States 10% to 15% of children use some form of CAM, and these numbers are increasing.[4] However, for psychiatrists and other conventional health care providers, prescribing CAM poses both ethical and legal concerns, including:

1. How to best manage parents who insist on using a CAM therapy against medical advice
2. Whether there is a legal duty to disclose a CAM therapy as a possible treatment alternative when recommending conventional treatments
3. Whether a CAM treatment recommendation or referral to a CAM provider will expose a psychiatrist to legal liability

This article explores these concerns and provides clinical advice for promoting patient health and safety while minimizing the psychiatrist's risk. The use of integrative medicine is discussed from a legal standpoint, so clinicians should bear in mind that certain actions may not be legally required but might nonetheless be clinically advisable or even essential.

BEST-INTEREST STANDARD

It is a well-settled principle that parents have an ethical and legal obligation to make medical decisions on behalf of their minor children.[5–8] There are 2 primary reasons why parents are entrusted with this authority to consent to, or refuse, medical treatment. First, it is generally believed that children lack the knowledge, experience, and maturity to make some of life's most difficult decisions.[9] Second, parents, with the assistance of health care providers, are expected to make decisions that are in their children's best interest. Courts presume that parents know the most about their children and care for their children's well-being more than anyone else, making them the most appropriate decision makers.[5,9] Nevertheless, the law has safeguards in place to protect children from poor parental decision making; for example, all treatment decisions must be made in the child's best interest.[5,7–9]

There is no precise test to determine which treatment option serves the child's best interest. Whether the treatment option is CAM or conventional care, many factors must be weighed to determine which treatment is most appropriate, including the risks and benefits of the treatment and its alternatives, congruence of the parents' views with the child's values and beliefs, the child's psychological and emotional welfare, the family situation, and whether less intrusive treatment would be as beneficial.[6–8,10] Some of these factors may be shaped by the parents' cultural and religious backgrounds, but ultimately the decision needs to be made in the child's best interest.[11]

DISAGREEMENTS WITH PARENTS

Disagreements about the best interests of the child may arise when the parents are pushing a psychiatrist to use a specific CAM intervention, especially if the psychiatrist is not familiar with the therapy and insufficiently knowledgable about its risks or benefits; this may lead to disagreement about the best course of action. The psychiatrist has the option to take time to learn about the suggested CAM treatment and then come back to discuss the treatment with the parents. Although there is generally no legal requirement for psychiatrists to inform themselves about the parents' preferred treatment, this would be a wise approach to take clinically. It may also be a helpful

negotiating stance for the psychiatrist to become familiar with the treatment, to demonstrate to parents that their preferences are being seriously considered. However, it is unlikely that a psychiatrist could be reasonably sued for rejecting a CAM treatment while refusing to become familiar with it.

If a psychiatrist and the parents cannot agree on the appropriate treatment plan for the child, the psychiatrist should fully explain his or her reasoning and answer any questions the parents may have. If the parents and the psychiatrist are still unable to come to a consensus, under normal circumstances the parents' decision should prevail, even if it is against the psychiatrist's medical preference or advice,[7,8] especially if there is medical uncertainty regarding the effects of the CAM treatment or when the risks associated with an alternative treatment are less serious,[8,12] and the clinician does not view the child as seriously endangered by the parents' decision. Of course, it may also be the case that a psychiatrist initiates the suggestion to use a CAM treatment in the face of parental objections. Here, it is even clearer that the parents' decision should prevail, given that the CAM treatment is not a widely accepted medical practice. Psychiatrists who want to use a CAM treatment should be cognizant of potential malpractice liability and professional disciplinary actions, discussed further herein.

LIMITATIONS ON PARENTS' AUTHORITY

Although parents are accorded considerable latitude in making decisions for their minor children, they are subject to limitations.[5,12] In every American jurisdiction, the state has the authority to intervene and provide necessary medical care when parental decisions seriously threaten a child's health, safety, or welfare.[5–8,13] Even religious beliefs cannot justify treatment decisions that seriously endanger a child's life or health.[12] As United States Supreme Court Justice Wiley Rutledge famously said in 1944 in *Prince v. Massachusetts,* "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children…[14]" Courts have interpreted the *Prince* decision to require a psychiatrist to notify child welfare authorities when a psychiatrist believes the parents' decision to refuse effective treatment will cause significant harm to the child.[7,8,12] In some states, such as Massachusetts, the psychiatrist is protected from lawsuit by the parents for taking the case to court. Thus, if the physician believes that a child might be harmed by a parent's decision or inaction, the physician can take the case to court or can refer the case to the state child welfare department, which will decide whether to take the case to court. In these cases, a court will consider expert evidence about medical practices, assess the benefits and burdens of a treatment and its alternatives (including nontreatment), and determine whether to respect the parents' decision or to allow child welfare authorities to consent to the treatment.[6,15–17]

Sometimes, parents will disagree with each other over a treatment plan and may have a generally adversarial relationship. In such instances, the child's treatment can become a weapon used against the other parent. Psychiatrists should deal with this situation in the same way they handle disputes regarding conventional treatment.[18] In most states if the parents are married, either parent may consent to medical care. If married parents disagree over care, it is legally unclear whether a psychiatrist can side with one parent; in this situation, the child's preferences may come into play. If the parents are divorced or were never married, the right to consent depends on state law: The parent with legal custody may have the sole right to consent. A psychiatrist should not deny a child necessary medical care because of uncertainty, but in the case of elective care or CAM, the safest course of action is to seek a court's decision in the case.

There is limited case law regarding disagreement about CAM use between a psychiatrist and the parents. The outcomes in these cases tend to turn on expert testimony and medical evidence presented at trial, during which the recommended treatment's risks and benefits are compared with the CAM treatment's risks and benefits. This process can result in seemingly discordant legal decisions. For example, within a month of one another, two courts came to very different conclusions about whether the use of an unconventional therapy had served the child's best interest.[19] These cases involved treatment of childhood cancer with laetrile, which is not approved as a safe and effective drug under the Federal Food, Drug, and Cosmetic Act. In the first case, a New York court considered whether the parents of a 7-year-old boy with Hodgkin disease were liable for child neglect when they refused conventional care (radiation and chemotherapy) in favor of nutritional and metabolic therapies.[16] Both the parents and the state presented expert testimony on the risks and benefits of conventional care in comparison with those of laetrile.[16] The New York court ultimately concluded that because there was medical evidence supporting the use of laetrile showing that metabolic therapy had fewer risks than radiation or chemotherapy, the parents' decision to forgo the conventional care was in the child's best interest.[16] A month later, a Massachusetts court considered whether laetrile was an appropriate supplement to chemotherapy for a 3-year-old child with leukemia.[17] Again, both sides presented evidence regarding laetrile's safety and efficacy, but none of the parents' expert witnesses claimed to be experts in blood disease or leukemia.[17] Based on the facts and evidence presented, the Massachusetts court found that using laetrile was not consistent with good medical practice because of the potential adverse interaction with the chemotherapy regimen.[17] The courts in both of these cases were faced with the question of whether a CAM therapy was an appropriate medical treatment under the particular circumstances. Although different types of cancer were at issue, the courts came to two completely different conclusions, based in part on the amount and type of evidence presented at trial about the risks and benefits of the CAM therapy when compared with the conventional treatment options. These decisions highlight the fact-sensitive nature of such inquiries, the importance of expert testimony and medical evidence, and the potential uncertainties of outcome when CAM cases are taken to court. There is, in fact, no case law involving a court's decision regarding the treatment of a psychiatric disorder in a child or adolescent using CAM.

INFORMED CONSENT

To respect an adult patient's personal autonomy and the right to decide what happens to his or her own body, health care professionals are legally and ethically obligated to obtain informed consent from patients before beginning any course of treatment.[9,20] As an example, evidence of informed consent can be shown through chart documentation of verbal consent discussions or through the use of consent forms provided to adult patients. Similar considerations apply to parents of a child with a psychiatric condition. Many clinicians receive verbal rather than written consent from parents for child psychopharmacologic treatments, and place documentation of the consent in the patient's chart; although this is a legally acceptable procedure, it is safer practice from a legal perspective to use an informed consent form signed by the parents, for both routine child psychopharmacologic treatment and CAM treatments.

If consent forms are used they should be tailored to the physician's practice, to the specific therapeutic procedure, and to the particular patient, and should not contain any guarantees. Patient consent forms for CAM treatments should address the following considerations for the patient: any possible benefits and potential

complications of the CAM treatment; the availability of any reasonable conventional treatment options; the degree to which the medical literature supports the CAM treatment; the absence of approval by the Food and Drug Administration of the CAM treatment; the patient's express awareness and understanding of known and unknown risks associated with the CAM treatment; and an explanation of why a CAM treatment is being used in lieu of conventional treatment.

Proper documentation of the informed consent process, whether through forms or chart notes, has the added benefit of ensuring that the patient or parent is involved in the decision-making process and has been provided with all the information needed to make an educated decision. Well-documented consent also helps protect the psychiatrist from liability if the patient is injured.[21]

Obtaining informed consent is sometimes more than a discrete event; rather, it may require an ongoing discussion between the psychiatrist, the patient, and the parents.[20] Psychiatrists are required to provide patients/parents with substantive information about the proposed treatment and its risks, benefits, and likely outcomes, as well as alternative courses of action, including nontreatment.[20,22–24] Furthermore, the medical treatment plan should include important medical evidence about the efficacy of each option, whether positive or negative.

In a situation where the psychiatrist recommends a CAM treatment over a viable, established intervention, complete disclosure and proper documentation are paramount. The informed consent disclosures are the same regardless of whether a CAM or conventional therapy is being recommended. The psychiatrist has a legal duty to be forthright about the known risks associated with the CAM therapy and must clearly explain any lack of data or information.[13,24] It is also important for the psychiatrist to make clear that the recommended treatment is outside the norm of conventional medicine. This perspective will require a full discussion of the differences between the alternative and allopathic treatments and why the CAM therapy is being recommended over the conventional treatment, most likely in terms of benefits and risks. As the gatekeeper of information for patients who may be unfamiliar with a CAM treatment, the psychiatrist needs to conduct open and honest dialogue about the treatment, allowing for questions to be asked and concerns to be expressed, before obtaining consent. Because of the heightened liability risks in the event the recommended CAM therapy injures the patient, it is critical for the psychiatrist to document in detail the types of information disclosed as a part of the patient's/parent's consent.

A written consent form is particularly advisable if the parent or child displays any trepidation of the procedure, if they are seemingly resistant to CAM, or if the recommended CAM therapy is risky or lacks published clinical trials supporting its safety and benefits.

Who Can Consent?

Although the law presumes that minors lack the capacity and maturity to make decisions affecting their health, there are certain situations in which minors are legally allowed to make their own treatment decisions, even over parents' preferences. For example, minors who need emergency medical treatment do not need to first obtain parental consent. Similarly, in most states, prior parental consent is not needed for minors who are legally emancipated or are seeking services related to sexual activity, substance abuse, or mental health.[25]

Courts and legislatures have also begun to recognize that some minors possess the competence and maturity to consent to medical treatment, especially as the minor nears adulthood,[26,27] allowing their decisions to supersede their parents' preferences. Studies show that around the age of 14, most adolescents are believed to have

developed the cognitive capacity and emotional stability to make their own health care decisions.[28,29] To have the necessary competence to provide informed consent under the law, a person must (1) be able to understand and appreciate the risks and benefits of the proposed treatment and its alternatives, and (2) make the decision voluntarily.[9,24,30] Unless a state's statute or common law provides otherwise, the Mature Minor Doctrine allows unemancipated minors to consent to or refuse general medical treatment if it is clear that they can understand and appreciate the consequences of their action.[30,31] This determination is both legal and factual.

Legally, psychiatrists should be aware of the minor consent laws in their jurisdiction,[30] because these laws differ from state to state. For example, in California there is no provision that allows minors to make health care decisions based on personal maturity,[32] whereas in Alabama, minors aged 14 years and older can consent to any kind of health service, irrespective of whether they have been deemed "mature."[33] The Arkansas legislature has passed a law explicitly incorporating the Mature Minor Doctrine into the consent statute.[34]

In fact, in most jurisdictions the psychiatrist must make the determination of whether the particular child has the maturity necessary to make his or her own treatment decisions. Competence to provide valid consent is situation specific. Psychiatric patients can provide legal consent as long as they possess sufficient decisional capacity for the situation at hand. Factors for the psychiatrist to consider include the minor's age, education, and experience, the risks and benefits of the proposed treatment, and the likely consequences of the decision.[26,30,31,35] The required level of understanding and appreciation will vary with the degree of potential risk involved and the minor's circumstances.[30,31] The psychiatrist should make a more demanding inquiry when the risks associated with the decision are high, such as when a minor is refusing life-preserving treatment. This kind of rigorous evaluation may also be advisable when a minor elects a CAM therapy over a more established, less risky conventional treatment, especially if the patient and parents disagree. However, a mature child or adolescent patient has the right to make an even inadvisable decision regarding a course of treatment as long as (1) the state's statutory or common law recognizes the Mature Minor Doctrine, and (2) the psychiatrist concludes that the patient has the cognitive capacity to make a treatment decision.[30,31] Psychiatrists initially determine whether the patient can consent, but these determinations can be legally challenged, and the court is the final arbiter.[36] Accordingly it is prudent for psychiatrists to create clear treatment and consent notes in the patient's record, especially if the minor is making a risky or controversial decision. It is worth noting that this is rarely an issue in clinical settings. In general, parents make decisions for their child and the youth agrees, even though a mature child or adolescent might legally have the capacity to make the decision.

Even when minors do not have the authority to provide legal consent, it is clinically important to include them in the informed consent discussion by explaining the information to them in a developmentally appropriate way that they can understand and process. The child can then express concerns and beliefs, ask questions, and eventually affirm a desire to accept the treatment plan; this is known as providing "assent."[37] There is no legal duty to obtain minor patients' assent outside of the research context, but from a clinical and ethical point of view the minor's involvement in the decision-making helps move the minor into a treatment alliance with the clinician, increases the patient's understanding and acceptance of the treatment, improves the patient's compliance with treatment, lets patients know that their opinions are valued and valuable, asserts their right to have a say in what happens to them, and ensures that the psychiatrist is responding to the child's thoughts and feelings.[37]

Psychiatrists should seek to obtain assent from minors aged 7 years and older. By age 7, children are generally able to know right from wrong and are able to discuss their motivations and desires. If a CAM treatment is being recommended, the psychiatrist should use clinical judgment to determine whether the youth should be informed about the CAM status of the treatment. For most adolescents, this information may be beneficial to relay, and may prompt the patient to ask important questions or voice concerns. Eliciting a youth's understanding, alliance, and assent may require some clinical approaches not required by the legal requirements of traditional informed consent.

What Satisfies "Informed" Consent?

Two primary standards are used to determine the amount and type of information that must be disclosed before consent is considered valid. The first is the patient-centered standard, which is followed by most US states and requires psychiatrists to disclose all the information a reasonable patient would want to know when deciding whether to consent.[20,23,24] Other states follow the second standard, a profession-centered approach, which only requires disclosing the information a reasonable health care professional would consider appropriate.[23,38] In practice, psychiatrists may have a difficult time determining what treatment alternatives to disclose to satisfy either one of these standards, especially when CAM treatments are taken into consideration. Most courts agree that alternatives that have not been shown to be therapeutically beneficial need to be addressed.[13,39,40] It would be unreasonable to require psychiatrists to be knowledgable about and discuss every possible alternative. Psychiatrists should first make themselves aware of the disclosure standard used in their jurisdictions and then determine whether a reasonable patient would want to know about that treatment alternative, or whether a reasonable health care provider would consider the information appropriate for disclosure. These standards attempt to strike a balance between overloading the patient or parents with too much information, much of which might be unnecessary and confusing, may be overwhelming, and draw out the decision-making process, and, alternatively, divulging too little information, such that the consent is not properly informed. Accordingly the patient-centered standard and profession-centered standard both attempt to arm the patient and parents with sufficient information to make the best decision for the child.

Obligation to Discuss CAM

Over the past few decades, developments in legislative and common law suggest that psychiatrists' disclosure obligations are continuing to evolve.[20,24] At the same time, more and more patients are inquiring about or are already using CAM therapies, either alone or in combination with conventional treatments.[13] This scenario presents both an ethical and legal dilemma: should mental health professionals be required to mention CAM therapies in their discussion of available treatment options during the informed consent process?[41,42]

To date, there have been no recorded legal cases that hold a psychiatrist or other conventional health care provider liable for failing to discuss CAM therapies as an alternative to the proposed treatment plan.[20,40] Accordingly a psychiatrist presumptively has no legal duty to discuss CAM options with patients. Instead, the case law on this subject concerns failure to discuss other conventional alternatives. Thus, when a clinician prescribes a CAM therapy, the clinician should thoroughly advise the patient about established conventional treatments.

Indeed, the general consensus in the legal literature is that there is no obligation to discuss a treatment modality, whether conventional or CAM, that neither has research

evidence supporting its efficacy and safety nor has been generally accepted in the medical community.[13,24,40–43] In *Moore v. Baker*, the court considered whether a physician was negligent for failing to mention a particular CAM therapy as an alternative to conventional surgery in treating coronary blockages.[44] The plaintiff presented evidence that some physicians approved its use to treat coronary blockages but, pursuant to Georgia's informed consent statute, the court held that the physician was not liable because chelation therapy was "not generally recognized and accepted in the medical community" as an alternative to coronary surgery.[44] Although some legislatures have articulated standards for disclosing treatment alternatives, it is predominantly up to the courts of each state to determine when a treatment alternative has enough evidence-based research and acceptance to trigger a disclosure obligation. As the body of case law on this matter grows, it will be interesting to look at how willing the courts are to include CAM options in the psychiatrists' disclosure obligations.

In contrast to the *Moore* court's approach, some legal scholars and clinicians argue for a proactive duty to disclose CAM treatments that have shown therapeutic benefits when the information would be material to the patient's decision to consent to or deny conventional treatment; in other words, when a reasonable patient would want to know about the CAM options before making a decision.[20,24,40,45] This scenario requires the psychiatrist to consider the available research data about a particular CAM treatment and make a judgment about whether this information would influence the patient's decision. There is no bright-line test to apply, but disclosure is more likely to affect the patient's decision when there are more data on efficacy and safety.[40,45] When research data are unavailable or inconclusive, the information would likely not be as influential, and there would be no duty to disclose.[20] When there is reliable evidence from research supporting the safety and efficacy of an intervention, even if unconventional, a psychiatrist may have an ethical, and possibly legal, obligation to disclose this option to the patient.[20,24,35] The psychiatrist's disclosure obligation will be expected to expand as the evidence amasses and the medical community starts to embrace the therapy. Until then, however, it is unlikely that a court would hold a psychiatrist liable for not disclosing the CAM therapy as a viable alternative to the recommended treatment.[39,41]

For some CAM treatments, there is strong evidence of safety and efficacy in adults but not in children. As with conventional treatments, it is challenging for clinicians to apply research from adult populations to a child's treatment.[37] From a legal perspective, there is no universally acceptable strategy for dealing with this issue. It is a medical judgment that must be decided on a case-by-case basis.

Even if the psychiatrist does not support the use of CAM, he or she should be aware of relevant research in this area to inform the decision-making process. Regardless of whether the psychiatrist recommends CAM or the patient's parents request CAM, it is good clinical practice for a psychiatrist to be candid about the known risks and benefits.[24,35,40,42] Psychiatrists should inform themselves regarding the evidence base for relevant CAM therapies, using resources such as the articles in this issue. Research suggests that perceived efficacy is the primary reason why most people decide to use CAM.[43] However, it is unlikely a court would find a legal duty for a physician to be knowledgable about a treatment modality that exists primarily outside of mainstream medical practice.

In addition, physicians should know about possible CAM-drug interactions.[44] For example, some studies indicate that certain dietary supplements may diminish or enhance the efficacy of conventional drugs.[45,46] Because most patients do not disclose information about their CAM usage spontaneously, psychiatrists should ask about CAM usage in the history-taking process.[24,47] It is important for the

psychiatrist to be aware of all types of treatments being used by the patient so that the psychiatrist is able to structure the treatment plan accordingly and warn the patient of any potential risks.

It has been suggested that the psychiatrist should balance the following 7 factors when deciding whether to support the use of a CAM therapy: (1) severity of the illness; (2) likelihood of response to conventional treatment; (3) adverse effects of conventional treatment; (4) evidence of safety and efficacy of the CAM therapy; (5) degree of understanding of the risks and benefits of the CAM treatment; (6) knowledge and voluntary acceptance of those risks by the patient; and (7) the patient's or parents' commitment to CAM use.[20,24,48] To avoid potential liability, a psychiatrist should not endorse using a CAM therapy that is known to be dangerous or that will interfere with or otherwise divert the child from imminently necessary, conventional care.[13,24,35] The more the evidence base supports the safety and benefits of a particular CAM therapy, the more the psychiatrist should be able to support the parents' decision to use that treatment.[13] Although the decision to use or incorporate a CAM treatment is ultimately up to the patient or patient's parents (provided the decision is not likely, in the view of the prescriber, to result in serious harm to the child),[12] the psychiatrist can have a meaningful role in the decision by educating the family and helping them through the decision-making process, thus ensuring that the parents are making a well-informed decision. In any event, the psychiatrist should continue to monitor the patient on the CAM treatment and, when appropriate, continue conventional treatment.

LIABILITY CONCERNS IN TREATING WITH CAM

Some psychiatrists and other health care professionals have shown trepidation in providing, referring, or recommending CAM out of fear of exposing themselves to liability.[49] By definition, CAM therapies are not the standard of care in conventional medicine, and by departing from the standard of care a psychiatrist may increase the risk of a medical malpractice suit. However, as the evidence base for CAM develops, certain practices gain greater acceptance, and as CAM becomes increasingly integrated into conventional practice, this risk is being minimized. Indeed, CAM is now integrated with conventional care in many medical practices across the country. For example, several University of California (UC) medical campuses have centers for integrative medicine, including UC San Francisco, UC Los Angeles, UC Irvine, and UC San Diego. There is also a growing professional movement for the use of CAM in psychiatry. For instance, there has been a Caucus on Integrative Psychiatry within the American Psychiatric Association since 2004, which has become formalized as the Committee on Alternative and Integrative Medicine. The American Academy of Child and Adolescent Psychiatry also has a Committee on Integrative Medicine.

As one example of how CAM is being integrated with conventional care, a study of older adults with major depression found that the complementary use of Tai Chi augments the use of escitalopram (Lexapro).[50] The study randomized 73 partial responders to escitalopram, who continued to use escitalopram daily, to a 10-week course of either Tai Chi or health education. Subjects in the Tai Chi group were more likely to report greater reduction in depressive symptoms and to achieve a depression remission ($F_{[5,\ 285]} = 2.26$; $P<.05$). Those subjects also showed greater improvements in health-related quality of life, physical functioning (group $\times$ time interaction: $F_{[1,\ 66]} = 5.73$; $P = .02$), memory (group $\times$ time interaction: $F_{[1,\ 65]} = 5.29$; $P<.05$), and a decline in an inflammatory marker, C-reactive protein (time effect: $F_{[2,\ 78]} = 3.14$, $P<.05$; group $\times$ time trend in posttreatment period: $F_{[1,\ 39]} = 2.91$;

$P = .10$). Similar findings are emerging in child and adolescent psychiatry, as articles elsewhere in this issue document.

The 2 main types of medical liability are battery and medical malpractice.

Today, battery claims are primarily applicable when a psychiatrist fails to obtain consent before treating a patient[51]; battery claims do not require proof of causation or injury, only that a touching occurred without the patient's consent.[51]

Malpractice claims are more common causes of action. In a medical malpractice claim, liability is imposed when a health care provider's conduct falls below the requisite standard of care and causes harm to the patient. At trial, expert testimony must be presented to establish the standard of care. The standard of care is what an ordinary, prudent professional in the same community would do under similar circumstances.[51,52] Thus, custom plays a central role in determining negligence.[53] However, in rare instances courts will look beyond custom; for example, where a cost-benefit analysis clearly suggests a particular course of action.[54] Such is particularly the case when there is no clear customary standard or when there are multiple schools of thought. Furthermore, for the patient to be successful in a malpractice case, the psychiatrist's negligence must be the cause of the patient's injuries.

Psychiatrists may face liability for practicing integrative medicine (ie, incorporating CAM treatments into their practices), even if the psychiatrist has informed the parents of conventional treatment and has discussed its advantages and disadvantages relative to the CAM treatment, and even if both the parents and physician agreed that the treatment was in the best interest of the child. This situation would require the parents to sue the psychiatrist, alleging that the doctor's negligent action injured their child. For their lawsuit to be successful, a plaintiff's expert witness (generally another child psychiatrist) must state that the treating psychiatrist deviated from the standard of care in providing the CAM treatment, and that providing the CAM treatment was what caused damage to the child. Essentially a physician would then be liable if a judge or jury accepted the testimony of the plaintiff's expert over any potential contradictory defense expert witnesses. A physician has a potential defense in that the parents knowingly and voluntarily assumed the risk of using CAM, but this is not guaranteed to prevent liability.

Disclosure of Risk

Psychiatrists who provide CAM should be aware they may face medical malpractice liability for failure to disclose all of the important known risks involved with a therapy before it is administered, as with conventional care.[13,24,55] Furthermore, a psychiatrist may be held liable for deciding to use CAM when it is contraindicated or when its use is not supported by reliable, scientific evidence, as long as expert testimony given during a trial could establish that an ordinary, prudent professional would not have provided these treatments under similar circumstances.[24,35] Psychiatrists should also be mindful of governing statutes, regulations, and policies that may restrict who can provide certain CAM therapies, because these laws vary depending on the jurisdiction. For example, some states require additional training or an examination for a medical doctor to provide acupuncture.

Referrals to CAM Providers

Another instance whereby psychiatrists may face liability is when making referrals to CAM providers.[56] In general, psychiatrists are not liable for merely referring a patient to another health care provider who then provides substandard care and harms the patient, regardless of whether the referral is to another conventional practitioner or

to a CAM specialist.[57,58] Psychiatrists usually are only held liable when they themselves provide the negligent care. However, there are several exceptions.

A psychiatrist may be held directly liable when the referral itself is negligent.[57,58] For example, a referral would be negligent if a psychiatrist failed to treat a patient with suicidal ideation and an active plan, and then referred the patient to a chiropractor. Psychiatrists are freely able to refer patients to other health care providers as long as the referral is reasonable and appropriate under the circumstances.[59,60] Also, a psychiatrist could be subject to liability for referring a patient to a provider whom the psychiatrist knew or should have known was unqualified or provided unsafe care,[57] such as might occur when the psychiatrist knows, or has reason to know, that a specialist may be incompetent.[61] Accordingly, as is the case with a referral to any external provider, it would be prudent for the psychiatrist to perform some due diligence to ascertain whether a CAM provider is properly credentialed, if applicable, and provides proper care. Some CAM providers, such as chiropractors, require state licensure. Others, such as Tai Chi instructors, may not require licensure or even certification. It may be more prudent to recommend an intervention generally rather than a specific provider if no external source of credentialing is available. Alternatively, if a direct referral is made, it should be documented in the patient's record that another physician (especially a CAM-specialized physician) recommended a particular provider.

Direct liability may also be attached if the psychiatrist provides negligent care after the referral is made.[58] For example, referring a patient to a CAM provider should not end the psychiatrist-patient relationship. The psychiatrist should continue to provide appropriate care and monitor the patient to ensure that the alternative therapies are not interfering with the conventional treatment plan or harming the patient. Similarly, if the referral causes a delay in the provision of necessary conventional treatment and the patient is injured as a result, the psychiatrist may face direct medical malpractice liability.[58]

Also, psychiatrists may be held vicariously liable for the negligent acts of others with whom the psychiatrist has a special relationship.[57,62] For example, a setting in which a psychiatrist is likely to be held vicariously liable occurs when the referring psychiatrist supervises or employs the CAM provider, or when the 2 providers engage in a joint undertaking to treat the patient in a collaborative way.[57,58] Although the boundaries of what constitutes a supervisory or collaborative relationship are not always clear, there needs to be some degree of control or intent to integrate treatment efforts on the part of the referring psychiatrist in order for the psychiatrist to be potentially liable for another clinician's actions.[57] For example, a collaborative relationship would likely be identified whereby a psychiatrist's medical practice employed a staff acupuncturist, and a supervisory relationship could be found whereby the psychiatrist dictated the acupuncture points and herbal medicines to be used by the acupuncturist. Simply continuing to treat and monitor patients as they receive CAM therapies from another provider would probably not implicate such a joint relationship. Therefore, vicarious liability is more difficult than direct liability to prove, because the necessary relationship must first be established before the referring psychiatrist can be held liable for the CAM provider's acts.

Disciplinary Action

Psychiatrists should also be aware that they may face professional disciplinary action for providing CAM. For example, the courts upheld a decision in 1985 by the North Carolina Board of Medical Examiners to revoke the license of the only medical doctor openly practicing homeopathy in the state on the sole basis that homeopathy does

not conform to the standards of acceptable and prevailing medical practice.[63] This ruling would be less likely today. In fact, after this decision, the North Carolina legislature amended the grounds for discipline to further require that the CAM treatment must have a safety risk greater than the conventional treatment, or that the CAM treatment must be generally ineffective.[64] Texas now has statutory guidelines covering the provision of integrative medicine, which stipulate that physicians shall not be found guilty of unprofessional conduct solely for using CAM, unless it can be demonstrated that such a method has a safety risk for the patient that is unreasonably greater than that of the conventional treatment of the patient's medical condition.[65]

Conventional Medicine Holds the Same Liability as CAM

Having reviewed the principal sources of liability for integrating CAM into a practice, a reader might think that staying as far away from CAM as possible would be prudent. However, conventional medicine raises the same concerns: After reading enough malpractice cases, a physician might decide that it makes no sense for anyone to practice medicine at all. Likewise, patients may think after watching drug advertisements on television, many of which casually mention that death can be a side effect, that no one should ever take medication. Of course, physicians do practice medicine, despite the potential for medical malpractice liability, and patients do take medications, many of which have the potential for serious side effects. The best that can be said of this is that no area of activity is completely free of risk, and that malpractice lawsuits are relatively rare in practice. Liability concerns should not dictate every decision made by a clinician. Ultimately, a physician should practice good medicine and be aware of risks.

SUMMARY

From a legal perspective, any time physicians depart from the customary standard of medical practice they run an increased risk of liability. As CAM by definition refers to practices that have not yet been accepted by the mainstream medical community, it is likely that incorporating CAM practices carries some degree of attendant risk. Despite this, physicians interested in integrating CAM into their practices should be comforted by the lack of malpractice cases regarding the CAM treatment of a psychiatric disorder in a child or adolescent. The reason for the absence of case law is unclear. It may be that CAM treatments are infrequently practiced in child psychiatry and even more rarely in high-risk situations, that this is a practice area with relatively few serious adverse outcomes, that CAM treatments tend to be relatively noninvasive, or that physicians who use CAM generally enjoy less adversarial physician-patient relationships. As long as physicians are knowledgable and mindful of the legal pitfalls relevant to CAM and take appropriate protective action, much as they do when practicing conventional medicine, they should not overestimate the risk of legal liability from judiciously using CAM treatments.

Introducing CAM treatments into a practice is somewhat similar to introducing any new treatment. Most child and adolescent psychiatrists are familiar with these procedures from the use of psychopharmacologic treatments in youth, which were only recently novel treatments, and which still today are often applied clinically before there is a solid database to support their widespread use.

As the delivery of health care continues to evolve into a more integrative approach, psychiatrists may need to make some changes to their daily practice to provide the best possible care to their patients and remain in compliance with the law. The

growing popularity of CAM essentially guarantees that all psychiatrists will have to deal with CAM in one way or another. Whether a psychiatrist wants to recommend an alternative therapy or the patient or parents request CAM, the following points will help the psychiatrist provide clinically and legally sound advice.

- CAM can be most safely recommended, from a legal point of view, when there is some published evidence of safety and efficacy. As with conventional treatments, there is no universal standard for when a treatment qualifies as evidence based.
- Any time a CAM treatment is discussed, fully disclose all of the known risks and benefits, so that the patient and the patient's parents can make informed decisions.
- Parents or legal guardians generally have the authority to make health care decisions on their children's behalf, although there are situations whereby the youth's decision may have precedence. All treatment decisions should be made in the child's best interest. If the parents' decision to use a CAM treatment is likely to subject the child to serious harm, the psychiatrist is legally obligated to notify welfare authorities.
- Only refer patients to CAM providers who are properly trained, and credentialed if applicable, and continue to monitor and treat the patient with conventional care as needed.
- Document any discussion of CAM in the medical record. If the parent insists on a therapy against medical advice, make clear documentation in the medical record of the parent's voluntary and knowing assumption of the risk.
- As evidence emerges that a CAM therapy may be safe and effective, or as a therapy gains widespread acceptance, there may be an obligation to disclose it as a viable treatment alternative to conventional treatment.

REFERENCES

1. Abbott RB. Treating the health care crisis: complementary and alternative medicine for PPACA. DePaul J Health Care Law 2012;14:35.
2. Abbott RB, Hui KK, Hays RD, et al. Medical student attitudes toward complementary, alternative, and integrative medicine. Evid Based Complement Alternat Med 2011;2011:985243.
3. Cohen M. Complementary & alternative medicine legal boundaries and regulatory perspectives. Baltimore (MD): Johns Hopkins University Press; 1998. p. 4–8, xii.
4. Davis M, Darden P. Use of complementary and alternative medicine by children in the United States. Arch Pediatr Adolesc Med 2003;157:393–6.
5. Parham v J.R., 442 U.S. 584, 602–06 (1979).
6. Boozang K. CAM for kids. Houst J Health Law Policy 2001;1:109–32.
7. Rosato JL. Using bioethics discourse to determine when parents should make health care decisions for their children. Temple Law Rev 2000;73:1–68.
8. Gilmour J, Harrison C, Cohen M, et al. Considering complementary and alternative medicine alternatives in cases of life-threatening illness: applying the best-interests test. Pediatrics 2011;128:S175–80.
9. Redding R. Children's competence to provide informed consent for mental health treatment. Wash Lee Law Rev 1993;50:695–751.
10. American Medical Association. Pediatric Decision-Making: Report of the Council on Ethical and Judicial Affairs. CEJA Report 8–1–07. Available at: http://www.ama-assn.org/doc/code-medical-ethics/10016a.pdf.

11. Eve v Mrs E, 31 DLR (4th) 1 (SCC 1986).
12. Black L. Limiting parents' rights in medical decision-making. Virtual Mentor 2006;8:676–80.
13. Cohen M, Kemper K. Complementary therapies in pediatrics: a legal perspective. Pediatrics 2005;115:774–80.
14. Prince v Massachusetts, 321 U.S. 158, 170 (1944).
15. Renfro v Fehrmann, 817 S.W.2d 592 (Mo. Ct. App. 1991).
16. In the Matter of Joseph Hofbauer, 393 N.E.2d 1009 (N.Y. 1979).
17. Custody of a Minor, 393 N.E.2d 836 (Mass. 1979).
18. Richards EP, Rathbun KC. Medical care law. Gaithersburg, VA: Aspen Publishing Company; 1999.
19. Cohen M. A fixed star in health care reform: the emerging paradigm of holistic healing. Ariz State Law J 1995;27:79–172.
20. Gilmour J, Harrison C, Cohen M, et al. Informed consent: advising patients and parents about complementary and alternative medicine therapies. Pediatrics 2011;128:S187–92.
21. Vincler L, Nicol M. When ignorance isn't bliss: what healthcare practitioners and facilities should know about complementary and alternative medicine. J Health Law 1997;30:160.
22. Truman v Thomas, 27 Cal.3d 285 (Cal. 1980).
23. Canterbury v Spence, 464 F.2d 772 (D.C. Cir. 1972).
24. Verhoef M, Boon H, Page S. Talking to cancer patients about complementary therapies: is it the physician's responsibility? Curr Oncol 2008;15: s88–93.
25. Boonstra H, Nash E. Minors and the right to consent to health care. Issues Brief (Alan Guttmacher Inst) 2000;2:1–6.
26. Belcher v Charleston Area Medical Ctr., 188 W.Va. 105 (W.Va. 1992).
27. Miss. Code Ann.§ 41-41-3(h).
28. Alderson P. Competent children? minor's consent to health care treatment and research. Soc Sci Med 2007;65:2272–83.
29. Weithorn L, Campbell S. The competency of children and adolescents to make informed decisions. Child Dev 1982;53:1589–98.
30. Gilmour J, Harrison C, Cohen M, et al. Treating teens: considerations when adolescents want to use complementary and alternative medicine. Pediatrics 2011;128:S161–6.
31. Derish M, Heuvel K. Mature minors should have the right to refuse life-sustaining medical treatment. J Law Med Ethics 2000;28:109–24.
32. English A, Kenney K. State minor consent laws: a summary. 2nd edition. Chappel Hill, NC: Center for Adolescent Health and the Law; 2003.
33. Ala. Code § 22-8-4.
34. Ark. Code § 20-9-602.
35. In re E.G., 549 N.E.2d 322 (Ill. 1989).
36. Gilmour J, Harrison C, Asadi L, et al. Childhood immunization: when physicians and parents disagree. Pediatrics 2011;128(Suppl 4):S167–74.
37. Popper CW. Medical unknowns and ethical consent: prescribing psychotropic medication for children in the face of uncertainty. In: Popper CW, editor. Psychiatric pharmacosciences of children and adolescents. Washington, DC: American Psychiatric Press; 1987. p. 127–61.
38. Robinson v Bleicher, 559 N.W.2d 473 (Neb. 1997) (disapproved of on other grounds in Hamilton v. Bares, 678 N.W.2d 74 (Neb. 2004)).
39. Morris v. Ferriss, 669 So.2d 1316 (La. App. 1996).

40. Weir M. Obligation to advise of options for treatment—medical doctors and complementary and alternative medicine practitioners. J Law Med 2003;10:296–307.
41. Vohra S, Cohen MH. Ethics of complementary and alternative medicine use in children. Pediatr Clin North Am 2007;54(6):875–84.
42. Cohen MH, Kemper KJ, Stevens L, et al. Pediatric use of complementary therapies: ethical and policy choices. Pediatrics 2005;116(4):e568–75.
43. Knoll A. The reawakening of complementary and alternative medicine at the turn of the twenty-first century: filling the void in conventional biomedicine. J Contemp Health Law Policy 2004;20:329–66.
44. Moore v Baker, US Dist LEXIS 14712 (S.D.Ga. 1991) (aff'd, 989 F.2d 1129, 1132 (11th Cir. 1993)).
45. Ernst E, Cohen M. Informed consent in complementary and alternative medicine. Arch Intern Med 2001;161:2288–92.
46. Plumber v State, 634 So.2d 1347 (La. Ct. App. 1994).
47. Caulfield T. Physicians, alternative medicine and the duty of informed consent. Health Ethics Today 2000;11:3.
48. Astin J. Why patients use alternative medicine. JAMA 1998;279:1548–53.
49. Gilmour J, Harrison C, Asadi L, et al. Natural health product-drug interactions: evolving responsibilities to take complementary and alternative medicine into account. Pediatrics 2011;128(Suppl 4):S155–60.
50. Goldman R, Rogovik A, Lai D, et al. Potential interactions of drug-natural health products and natural health products-natural health products among children. J Pediatr 2008;152:521–6.
51. Cvijovic K, Boon H, Barnes J, et al. A tool for rapid identification of potential herbal medicine drug interactions. Can Pharm J 2009;142:224–7.
52. Eisenberg D. Advising patients who seek alternative medical therapies. Ann Intern Med 1997;127:61–9.
53. Cramm T, Hartz A, Green M. Ascertaining customary care in malpractice cases: asking those who know. Wake Forest Law Rev 2002;37:699–700.
54. Helling v. Carey, 519 P.2d 981 (Wash. 1974).
55. Adams K, Cohen M, Eisenberg D, et al. Ethical considerations of complementary and alternative medical therapies in conventional medical settings. Ann Intern Med 2002;137:660–4.
56. Gilmour J, Harrison C, Cohen MH, et al. Pediatric use of complementary and alternative medicine: legal, ethical, and clinical issues in decision-making. Pediatrics 2011;128(Suppl 4):S149–54.
57. Lavretsky H, Alstein LL, Olmstead RE, et al. Complementary use of tai chi chih augments escitalopram treatment of geriatric depression: a randomized controlled trial. Am J Geriatr Psychiatry 2011;19:839–50.
58. Blanchard v Kellum, 975 S.W.2d 522 (Tenn. 1998).
59. Peters P. The quiet demise of deference to custom: malpractice law at the millennium. Wash Lee Law Rev 2000;57:163–205.
60. Clark v Dept. of Professional Regulation, 463 So.2d 328 (Fla. Dist. Ct. App. 1985).
61. Estate of Tranor v. Bloomsburg Hospital, 60 F.Supp.2d 412 (M.D. Penn. 1999).
62. Gilmour J, Harrison C, Asadi L, et al. Referrals and shared or collaborative care: managing relationships with complementary and alternative medicine practitioners. Pediatrics 2011;128(Suppl 4):S181–6.
63. In re Guess, 327 N.C. 46 (N.C. 1990).
64. N.C. Gen. Stat. § 90–14(a)(6).
65. 22 Tex. Admin. Code § 200.3 (2013).