

Chapter 9

Complementary and Alternative Medicine

Joseph A. Barrette, JD

Introduction: Recognition of Complementary and Alternative Medicine (CAM) by the Biomedical Community Disciplinary Procedures

Particular CAM Practices Unprofessional Conduct Standard Medical Freedom Acts Medical Malpractice Malpractice Liability Management

Strategy Malpractice Liability for CAM Referral Conclusion

INTRODUCTION: RECOGNITION OF COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) BY THE BIOMEDICAL COMMUNITY

The attention of the entire health care industry was captured by two surveys published in the *New England Journal of Medicine* and the *Journal of the American Medical Association*.¹ The American Medical Association (AMA) recognized the need for medical schools to respond to the demand for alternative health care.² Approximately 60% of U.S. medical schools offer courses in CAM. 80% of medical students and 70% of family physicians want training in CAM therapies. Nearly 60% of conventional physicians have either made referrals or are willing to refer their patients to CAM practitioners. CAM special interest groups have been formed by the Group on Educational Affairs of the Association of American Medical Colleges, the Society of Teachers of Family Medicine, and the American Public Health Association.³

Physicians have integrated CAM therapies into their practices by either performing the therapy themselves or referring their patients to CAM practitioners. Physicians who have or may be interested in integrating CAM therapies into their conventional medical practices are concerned about malpractice liability and exposure to disciplinary action for unprofessional conduct.

DISCIPLINARY PROCEDURES

The Fourteenth Amendment of the U.S. Constitution provides that no state shall “deprive any person of life, liberty, or property, without due process of law.” A license to practice medicine is a valuable property right. It is subject to regulation under states’ police power, but may only be denied or withdrawn under procedures consistent with constitutional due process.⁴ Physicians who integrate CAM therapies into their practices are peculiarly subject to potentially unfair disciplinary medical procedures.

Typically, state medical boards are required to investigate every complaint they receive.⁵ However, medical boards may not be limited to investigating a single complaint but have the discretion to comprehensively investigate all aspects of a physician’s practice.⁶

After receipt of a complaint, medical boards will request patient and related records. The physician must comply with this request or may be charged with failure to cooperate.⁷ This charge may result in the suspension of the physician’s license. In order to obtain the physician’s records, medical boards may also resort to either statutory authority, which permits a comprehensive medical review (CMR),⁸ or serve upon the targeted physician a subpoena duces tecum. A subpoena duces tecum is a command to a witness to produce at the hearing documents that he has in his possession. Because “no agency of government may conduct an unlimited and general inquisition into the affairs of persons within its jurisdiction solely on the prospect of possible violations of law being discovered,”⁹ some courts have required that medical boards demonstrate a justifiable basis for a good faith investigation of professional misconduct.¹⁰ A targeted physician may challenge the reasonableness of either a CMR or a subpoena duces tecum.¹¹

A physician who is the subject of a medical misconduct charge is entitled to a peer review disciplinary process.¹² The issue presented for CAM physicians is whether the review will be by physicians who are their peers. That is, will physicians who are familiar with CAM clinical practices constructively participate at any stage during the disciplinary process? There are several stages in the disciplinary process when other CAM physicians could constructively participate: during the investigation, as members of the hearing committee, or as members of an administrative review board that reviews the hearing committee’s decision.

Some courts have held that CAM physicians are not entitled to have members of the hearing committee or administrative review board to “be practitioners of the same specialty as the physician under review, much less that they be adherents to the same philosophy of medicine.”¹³ If the effectiveness of a CAM therapy is either the basis of a complaint of misconduct or of general concern

68 Complementary and Alternative Medicine

to medical boards, it seems appropriate to encourage the constructive participation of CAM physicians in the peer review process.

PARTICULAR CAM PRACTICES

In most of the reported cases, the physicians were subjected to having their licenses being revoked or suspended even though the patients were not harmed and did not file a complaint to the medical board. The cases can broadly be divided into several types of CAM therapies: homeopathy, nutrition, ozone and nutrition, and chelation.

Homeopathy

Metzler v. N.Y. State Board of Professional Medical Conduct involved a New York physician's request to a court to review a determination by the Administrative Review Board for Professional Conduct (ARB) which revoked the physician's medical license.¹⁴ The ARB sustained the Hearing Committee's findings that the physician did "not practice orthodox or allopathic medicine but practices homeopathy."¹⁵ The physician argued that the standard of care was only applicable to allopathic medicine and not homeopathy.

Dr. Guess was a licensed physician practicing family medicine in North Carolina. Dr. Guess integrated homeopathy into his practice only as a treatment of last resort. The State Board of Medical Examiners (Board) revoked his license based exclusively upon the fact that he integrated homeopathy into his medical practice. The Board and the court concluded that the practice of homeopathy "departs from and does not conform to the standards of acceptable and prevailing medical practice in this State."¹⁶

Both the *Metzler* and the *Guess* courts failed to define what may be "acceptable and prevailing medical practice."

Nutritional Therapy

In *Gonzalez v. N.Y. State Department of Health*, the physician treated mostly patients with advanced and incurable cancer.¹⁷ Each patient had either exhausted or rejected conventional medical care. The Office of Professional Medical Conduct (OPMC) charged the physician with incompetence and negligence. The court held that despite patient consent, the physician was required to comply with the "usual standard of care."

Ozone and Nutrition

The physician in *Atkins v. Guest* treated cancer patients with a combination of ozone therapy and nutritional supplements.¹⁸ A complaint was filed by an emergency room physician after Dr. Atkins sent his patient to the hospital following an ozone treatment. The patient was released with no apparent side effects or injuries. Dr. Atkins moved to quash a subpoena duces tecum by the OPMC and asserted that he could not be legally found negligent or incompetent. The court denied the motion and left the

determination of negligence or incompetence to the New York State Board for Professional Conduct.¹⁹

Chelation

In *State Board of Medical Examiners of Florida v. Rogers*, the physician was ordered by the County Medical Association to discontinue the treatment of chelation for arteriosclerosis.²⁰ An administrative complaint was lodged against the physician for unprofessional conduct. The Florida courts held that the State Board of Medical Examiners unreasonably interfered with Dr. Rogers' right to practice medicine. The Florida Supreme Court concluded that the Medical Board's decision was not reasonably related to the protection of the public health and welfare because of a lack of evidence that chelation therapy was harmful. The court also noted that Dr. Rogers fully informed his patients about the experimental nature of chelation, including the possibility of no improvement.

UNPROFESSIONAL CONDUCT STANDARD

Professional medical cases frequently turn on standard of care issues.²¹ The courts and most medical boards apply the standard that a physician's conduct must conform to acceptable medical practices.²² This standard of care is essentially equivalent to the standard applied by the courts in medical malpractice cases. However, an important difference "is that it is generally not required that the state medical board establish that the questioned medical care caused injury."²³ Nor is there a requirement that the medical care created a risk of patient injury.²⁴ However, state statutory medical disciplinary schemes are directed toward protecting the health and safety of patients and the state's citizens. "The common thread running through each of these reasons [the delineated acts of professional misconduct] for revocation of a license is the threat or potential for harm to patients and the public."²⁵

When the applicable standard of care is the prevailing and accepted medical practices, CAM physicians are particularly vulnerable to misconduct charges based upon negligence and/or incompetence. This is due to the fact that when physicians offer CAM therapies, they are by definition deviating from conventionally accepted medical standards.²⁶

If physicians who offer CAM are charged with misconduct in a jurisdiction that applies the prevailing and accepted medical practice standard, they should consider a defense based upon "two schools of thought"²⁷ or a reasonableness standard.²⁸ This will be discussed later in this chapter.

In some jurisdictions, a patient's consent to CAM therapy does not relieve the physician from the conventional medical standard within the context of medical disciplinary proceedings. In other jurisdictions the consideration will be whether there has been patient harm or the risk thereof. Because of the heightened risk of license revocation

by physicians who practice CAM, some states have enacted legislation specifically intended to protect the right of physicians to offer CAM and the right of patients to choose their own medical care.

MEDICAL FREEDOM ACTS

In twelve states, physicians who integrate CAM into their practices are safeguarded by health freedom laws that are designed to protect them from discriminatory discipline while facilitating patient access to CAM therapies.²⁹ Several states specifically permit physicians to offer EDTA chelation³⁰ and some states license homeopathic physicians.³¹

These state laws require patient injury or risk thereof and/or require the medical board to demonstrate that the CAM therapy being integrated is unsafe or inefficacious. For example, in response to the *In re Guess* case, North Carolina amended its disciplinary medical provisions to provide that “the Board shall not revoke the license of ... a person solely because of that person’s practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by competent evidence, the Board can establish that the treatment has a safety risk greater than the prevailing treatment or that the treatment is generally not effective.”³² Alaska requires that the medical board “may not base a finding of professional incompetence solely on the basis that a licensee’s practice is unconventional or experimental in the absence of demonstrable physical harm to a patient.”³³

However, despite the intent of these health freedom laws, physicians are cautioned to continue to comply with conventional medical practices such as testing, patient monitoring, and record-keeping. In addition, physicians are advised to continue with conventional medical practices in cases that the philosophy of the CAM therapy may be inconsistent with the biomedical paradigm, such as homeopathy or acupuncture. In some of the jurisdictions that have Medical Freedom Acts, physicians’ unprofessional conduct is not based upon practicing CAM but failing to maintain “minimum standards of acceptable medical practice.”³⁴ For example, the minimum standard from which Dr. Gonzalez deviated included the failure to perform an adequate physical examination, perform sufficient follow-up monitoring, and maintain adequate records.³⁵ CAM physicians are held “to the same standard of care to which all physicians... are held... [t]here are no different standards for licensed physicians based on their philosophy, religion or personal approach to their calling.”³⁶

Some of the Medical Freedom Acts specifically inform CAM physicians of the required minimum standards of acceptable medical practice. For example, Louisiana and Texas require, *inter alia*, a detailed patient evaluation prior to offering a CAM therapy, a medical diagnosis, a treatment plan, periodic patient reviews, complete and accurate record-keeping, and informed consent.³⁷

Physicians should inform themselves of (1) whether the state within which they practice has a Medical Freedom

Act, and (2) whether there are required minimum standards of acceptable medical practice. In states that do not delineate the minimum standards or do not have a Medical Freedom Act, it would be prudent for physicians to comply with the accepted and prevailing medical practice.

MEDICAL MALPRACTICE Standard of Care

Generally, the legal standard for medical malpractice liability is whether a particular therapy deviated from accepted medical practice in the community and if that therapy resulted in patient injury. The standard duty of care is the same for all physicians regardless of whether they practice conventional or nonconventional therapies.³⁸ “[I]t would seem that no practitioner of alternative medicine could prevail on such a [standard] as the reference to the term ‘non-conventional’ may well necessitate a finding that the doctor who practices such medicine deviates from ‘accepted’ medical standards.”³⁹ However, there are several defenses that may result in either a total or partial bar to recovery in a medical malpractice claim: assumption of risk based upon a patient’s informed consent; the respectable minority or two schools of thought doctrine; and covenant not to sue.

Defenses

Assumption of Risk

Patients have the right to determine what shall be done to their own bodies.⁴⁰ This includes the right of patients “to make [an] informed decision to go outside currently approved medical methods in search of an unconventional treatment.”⁴¹ Physicians’ failure to obtain informed consent for the use of a CAM therapy may give rise to an independent malpractice claim.⁴² Either the reasonable medical practitioner or the prudent patient standard determines what constitutes adequate information.⁴³ Informed consent may be written or orally obtained. The question is whether the patient knowingly accepted all of the risks inherent in the offered therapy. In *Schneider v. Revici*, the physician treated cancer patients with nontoxic, noninvasive methods that were not recognized by the medical community. The patient signed a detailed consent form. After 14 months of treatment, the cancer spread and the patient sued. The court held that a patient may expressly “assume the risk of medical malpractice and thereby dissolve the physician’s duty to treat a patient according to the medical community standards.”⁴⁴ An expressed assumption of risk would be a total bar to recovery in a malpractice claim.

In *Boyle v. Revici*, the patient did not sign a consent form. However, at the trial upon a malpractice claim the physician submitted evidence that the patient consciously and with knowledge of the risk decided to forgo conventional cancer treatment and instead sought the physician’s nonconventional medical care. The Court held that “[a]bsent a statutory requirement that express assumption

70 Complementary and Alternative Medicine

of risk requires a writing... a jury should decide whether a plaintiff has knowingly accepted all of the risks of a defendant's negligence."⁴⁵ Therefore, a defense may be based upon an implied assumption of risk.

The physician in *Charell v. Gonzalez* used hair analysis and nonconventional therapies to diagnose and treat cancer patients. A patient's cancer metastasized and eventually caused blindness and severe back problems. The patient brought a malpractice action based upon the physician's departure from good and accepted medical practice, as well as a cause of action for the physician's failure to obtain informed consent. The jury found that the patient impliedly assumed the risk of injury and apportioned 51% of the responsibility to the physician and 49% of the responsibility to the patient. The court held that "even though [the physician] had not given appropriate information regarding the risks of his procedure... it was within the province of the jury, based upon the evidence,... that [the patient] independently obtained sufficient information... to conclude that there was an implied assumption of risk."⁴⁶ The evidence showed that the patient was well educated, and that she, her husband, and her daughter did a significant amount of investigation regarding the physician's nonconventional treatment.

Respectable Minority or Two Schools of Thought Doctrine

The respectable minority is also referred to as the two schools of thought doctrine. The test to determine whether a physician's treatment falls under the respectable minority doctrine is unclear. The two tests applied by most jurisdictions that have adopted the respectable minority doctrine are either (1) the treatment is advocated by a considerable number of physicians, or (2) the treatment is what a reasonable and prudent doctor would have done under the same or similar circumstances.

In the Aricon case of *Leech V. Bralliar*, the federal district court considered the appropriateness of prolotherapy treatment for a whiplash injury to the neck.⁴⁷ The court found that prolotherapy "was recognized as an appropriate method of therapy by a small minority of physicians in the United States."⁴⁸ The Court stated that "[t]his minority of physicians has not been shown to be other than respectable physicians."⁴⁹ The respectable minority consisted of only 65 physicians throughout the United States. The court also noted that the therapy had not been generally accepted by the medical profession.

The plaintiff in *Hood v. Phillips* claimed that the physician was negligent in the choice of a surgical technique.⁵⁰ The Texas Supreme Court reviewed the various respectable minority tests and rejected the notion that the tests are to be based solely upon numbers because it conveyed to the jury that "the standard for malpractice is to be determined by a poll of the medical profession."⁵¹ The Court held that "[a] physician who undertakes a mode or form of treatment which a reasonable and prudent member of the medical profession would undertake under the same or similar circumstances shall not be subject to liability for harm caused thereby to the patient." The Court added that "this

standard should be applied whether the mode or form of treatment is experimental, outmoded, or rejected."⁵²

Finally, in *Jones v. Chidester* the Pennsylvania Supreme Court held that the applicable standard to avoid malpractice liability is whether a physician "followed a course of treatment advocated by a considerable number of recognized and respected professionals...."⁵³ The court reasoned that this hybrid test integrates both the quantitative and qualitative standards applied by the other jurisdictions. Because the contours of the respectable minority or two schools of thought doctrine are "too fluid and imprecise," some have opined that it does not provide a workable test for an alternative standard of care in CAM malpractice cases.⁵⁴ However, as CAM therapies become more recognized and accepted by the general medical community, the standard of care will shift to include those CAM therapies.⁵⁵

Covenant Not to Sue

In *Colton v. New York Hospital*, plaintiffs sued for medical malpractice related to an experimental kidney transplant from one brother to another.⁵⁶ The operation was successful but the recipient brother soon died as a result of a pre-existing liver ailment. The donor brother experienced life-threatening complications resulting in physical disabilities. The brothers signed an explicit and detailed form labeled "...Consent to Kidney Transplant, And Covenant Not To Sue Upon, And Release of All Claims." The defendants argued that the document was a complete bar to recovery. The plaintiffs claimed that to the extent the instrument sought to relieve defendants from their own negligence it was void as against public policy. The court held that "an experimental procedure which... may ordinarily be in and of itself a departure from customary and accepted practice (and thus possibly actionable as malpractice) even if performed in a non-negligent manner, may be rendered unactionable by a covenant not to sue."⁵⁷ While a covenant not to sue may permissibly embrace negligence that is based upon a deviation from accepted medical practice, it must be strictly construed against the party asserting it and must be clear and unequivocal. In *Colton*, the covenant not to sue did not specifically enumerate negligence or malpractice.

In *Schneider v. Revici*, the court reviewed the application of a covenant not to sue to CAM.⁵⁸ The court recognized the efficacy of a covenant not to sue in the context of medical treatment. However, the court contrasted the form in the *Schneider* case with that in the *Colton* case and found that it was not labeled a covenant not to sue and that it was not clear and unequivocal. Therefore, the facts did not support the defense being submitted to the jury.

Many courts have held that it is against public policy for medical negligence to be the subject of a preinjury release.⁵⁹ However, with proper informed consent, patients may consent to experimental medical care that might otherwise not be generally accepted by the medical community.⁶⁰ The distinction made by the *Vodopest* court as contrasted with the *Colton* court is that the parties may covenant to exempt the physician from liability for patient

injuries that are the consequences of the nonnegligent, proper performance of the experimental procedure.

MALPRACTICE LIABILITY MANAGEMENT STRATEGY

Cohen and Eisenberg suggest the following steps to minimize potential malpractice liability:⁶¹

1. Determine the clinical risk level by reviewing existing medical literature to assess the evidence for safety and efficacy of a given CAM therapy.
2. Document the literature supporting the therapeutic choice.
3. Provide adequate informed consent by engaging in a clear discussion of the risks and benefits of using the CAM therapy.
4. If feasible, obtain the patient's express, written agreement to use the CAM treatment.
5. Continue to monitor the patient conventionally.

MALPRACTICE LIABILITY FOR CAM REFERRAL

There are no reported cases that consider physicians' malpractice liability for the failure to refer a patient to a CAM practitioner. However, as CAM therapies are proven to be efficacious, physicians may have a duty to refer patients to CAM practitioners.⁶² Physicians may be exposed to malpractice liability for either the negligent or vicarious referral of patients to a CAM practitioner. Although there are no reported cases for either situation, courts may extend the legal theories applied to conventional medicine cases.

A cause of action for negligent referral may be based upon the theory that the patient suffered a loss of chance of recovery.⁶³ If a CAM referral "delays, decreases, or eliminates the opportunity for the patient to receive"⁶⁴ more appropriate and necessary health care from another provider, the referring physician may be liable.⁶⁵ Negligent referral may also arise in situations where the physician knows or has reason to know that either the provider is incompetent or the CAM therapy is ineffective or dangerous.⁶⁶

Vicarious liability has been recognized when there has been joint employment, a concert of action, some control of the course of one by the other, or agency.⁶⁷ The general rule is "that the mere referral of a patient by one physician to another, without more, does not render the referring doctor vicariously liable for the negligence of the treating physician."⁶⁸ However, courts have held physicians liable when they have exercised supervisory responsibility or control over other health care providers including other physicians.⁶⁹ The referring physician must act in good faith, with reasonable care in the selection of the CAM provider and without knowledge of the CAM provider's incompetence or lack of skill.⁷⁰ The CAM provider should also be properly credentialed and in good standing. Physicians who work closely with CAM practitioners, such

as in an integrative health clinic, may be considered to have engaged in a joint undertaking or to have acted in concert.⁷¹ Therefore, any harm to the patient as a result of the CAM therapy could be vicariously imputed to the physician.

Cohen and Eisenberg recommend the following referral liability management strategies:⁷²

1. Closely monitor the clinical risk level.
2. Document the literature supporting the decision to refer.
3. Provide adequate informed consent of the risk and benefits of the CAM therapy.
4. Document the discussion of the patient's decision to visit a CAM provider.
5. Continue to monitor the patient conventionally.
6. Inquire about the CAM provider's competence.

Physicians who integrate CAM therapies into their medical practice may take consolation in the fact that there are substantially fewer malpractice claims against CAM practitioners.⁷³ In addition, claims of patient injury were considerably less severe with CAM practitioners as compared to claims against conventional physicians.⁷⁴ Also, patients who are likely to use CAM therapies are more educated, knowledgeable, and tend to use the therapies for less serious illnesses.⁷⁵

CONCLUSION

Integrating the use of CAM therapies into a medical practice increases a physician's risk for license suspension or revocation. Currently, medical boards require physicians to practice consistent with accepted and prevailing medical standards. Although misconduct charges may be based upon the physician's practice of CAM, the charges typically tend to allege a failure to perform adequate patient evaluation, testing, monitoring, and record-keeping. Therefore, it is recommended that physicians who use CAM therapies continue to comply with all of the conventional medical practices. Many states have enacted legislation that provides some protection for physicians who practice CAM. The Medical Freedom Acts of most states delineate the minimum standards of acceptable medical practice that physicians must maintain prior to and contemporaneous with the use of CAM.

Patients file fewer complaints against CAM practitioners than they do against conventional physicians. Therefore, physicians who practice CAM are at low risk for malpractice claims against them. However, malpractice claims have been brought by terminally ill patients who have exhausted conventional medicine and underwent CAM treatments that proved to be unsuccessful. To adequately defend against a malpractice claim, physicians should obtain from the patient a detailed written consent that thoroughly explains the risks and benefits of the CAM therapy. It is recommended that physicians continue to provide conventional medical care or advise their patients to continue to consult their primary care physician.

There is low risk of physicians' liability for medical malpractice or referral to CAM practitioners. However,

72 Complementary and Alternative Medicine

physicians would be wise to consider the malpractice liability and the referral liability management strategies outlined above.

Endnotes

1. David M. Eisenberg et al., *Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use*, 328 *New Eng. J. Med.* 246 (1993) (the survey was conducted in 1990); David M. Eisenberg et al., *Trends in Alternative Medicine in the United States, 1990–1997*, 280 *J.A.M.A.* 1569 (1998).
2. Miriam S. Wetzel et al., *Courses Involving CAM at U.S. Medical Schools*, 280 *J.A.M.A.* 784 (1998).
3. *Id.*
4. *Doe v. Axelrod*, 123 A.D. 2d 21, 26 (1st Dept. 1986). *See also Keney v. Derbyshire*, 718 F. 2d 352, 354–355 (C.A.N.M. 1983).
5. *See, e.g.*, N.Y. Pub. Health Law §230(10)(a)(i) (1991).
6. *Alter v. New York Dept. of Health, State Bd. for Prof'l Conduct*, 145 Misc. 2d 393, 395–396 (N.Y. Sup. Ct. 1989).
7. N.Y. Pub. Health Law §230(10)(a)(iv) (1991).
8. *Id.*
9. *A'Hearn v. Comm. on Unlawful Practice of Law of N.Y. Lawyers' Ass'n*, 23 N.Y. 2d 916, 918 (1969). *See also Levin v. Murawski*, 59 N.Y. 2d 35, 41 (1983).
10. *Murawski*, 59 N.Y. 2d at 41. *See also Matter of BU 91-04-1356A*, 186 A.D. 2d 1054 (4th Dept. 1992).
11. *Murawski*, 59 N.Y. 2d at 35. *See also, e.g.*, N.Y. Pub. Health Law §230(10)(o) (1991) for challenges to a CMR.
12. *See Cal. Bus. & Prof. Code* §805 (1991); N.Y. Pub. Health Law §230 (1994).
13. *Metzler v. N.Y. Bd. for Prof'l Med. Conduct*, 203 A.D. 2d 617, 619 (3d Dept. 1994).
14. *Id.* at 617.
15. *Id.*
16. *In re Guess*, 393 S.E. 2d 833, 835 (N.C. 1990).
17. *Gonzalez v. N.Y. Dept. of Health*, 232 A.D. 2d 886 (3d Dept. 1996).
18. *Atkins v. Guest*, 158 Misc. 2d 426 (N.Y. Sup. Ct. 1993).
19. *Id.* at 431.
20. *State Bd. of Med. Examiners of Fla. v. Rogers*, 387 So. 2d 937, 937 (Fla. 1980).
21. Glenn E. Bradford & David G. Meyers, *The Legal and Regulatory Climate in the State of Missouri for Complementary and Alternative Medicine: Honest Disagreement Among Competent Physicians or Medical McCarthyism?*, 70 *U.M.K.C. Law Rev.* 55, 58 (2001).
22. The standard may be statutorily defined as in *In re Guess*, 393 S.E. 2d 833. Or it may be judicially defined as in *Metzler*, 203 A.D. 2d 617.
23. Bradford & Meyers, *supra* note 21, at 102 n.26.
24. *In re Guess*, 393 S.E. 2d at 838. *See also Metzler*, 203 A.D. 2d 617, and *Gonzalez*, 232 A.D. 2d 886.
25. *Guess*, 393 S.E. 2d at 840–841.
26. Michael H. Cohen, *Holistic Health Care: Including Alternative and Complementary Medicine In Insurance and Regulatory Schemes*, 38 *Ariz. L. Rev.* 83, 109 (1996).
27. Mary S. Newbold, *Medical Malpractice Law—Pennsylvania's "Two Schools of Thought" Doctrine Revisited: Definition and Application Clarified—Underlying Goal Thwarted—Jones v. Chidester*, 610 A. 2d 964 (Pa. 1992), 66 *Temp. L. Rev.* 613, 613 (1993).
28. Barbara D. Goldberg, *As Alternative Treatments Increase, So May Malpractice Claims*, 16(7) *Med. Malpractice Law & Strategy* 1 (1999).
29. *See, e.g.*, Alaska Stat. §08.64.326(a)(8)(A) (1990); Colo. Rev. Stat. §12-36-117 (1997); Fla. Stat. ch. 456.41 (2001); Ga. Code Ann. §43-34-42.1 (1997); Mass. Gen. Laws Ann. ch. 112, §7 (1901); N.Y. Educ. Law §6527(4) (1994) and N.Y. Pub. Health Law §230(1), 230(10)(a) (1994); N.C. Gen. Stat. §90-14(a)(6) (1993); Ohio Rev. Code Ann. §4731.227 (2000); Okla. Stat. tit. 59, §§492(F), 493.1(M), and 509.10(2) (1994); Or. Rev. Stat. §677.190(1) (1995); 22 *Tex. Admin. Code* §200.1–200.3 (1998); Wash. Rev. Code Ann. §18.130.180(4) (1991).
30. *See South Dakota Professions and Occupations Statute*, S.D. Codified Laws §36-4-29 (1993); Louisiana 1999 La. Acts R.S. 37:1285.3, 40:678 and La. Rev. Stat. tit. 40(4)(II-B) (1999).
31. Arizona, Connecticut, and Nevada license homeopathic practice for physicians already licensed in any state.
32. N.C. Gen. Stat. §90-14(a)(6) (1993).
33. Alaska Stat. §08.64.326(a)(8)(A) (1990).
34. *Metzler*, 203 A.D. 2d at 618.
35. *Gonzalez*, 232 A.D. 2d at 887.
36. *Metzler*, at 618–619.
37. La. Reg. tit. 46, §7103–7107 (2001) (Professional and Occupational Standards, Chapter 41, Integrative and Complementary Medicine); 22 *Tex. Admin. Code* §200.1–200.3 (1998).
38. *Gray v. Gonzalez*, 290 A.D. 2d 292, 292 (1st Dept. 2002).
39. *Charell v. Gonzalez*, 173 Misc. 2d 227, 227 (N.Y. Sup. Ct. 1997).
40. *Schloendorff v. Soc'y of the N.Y. Hosp.*, 211 N.Y. 125, 126 (1914).
41. *Schneider v. Revici*, 817 F. 2d 987 (2d Cir. 1987).
42. Edward Ernst & Michael H. Cohen, *Informed Consent in Complementary and Alternative Medicine*, 161 *Arch. Intern. Med.* 2288 (2001).
43. Hunter L. Prillaman, *A Physician's Duty to Inform of Newly Developed Therapy*, *J. Contemp. Health Law and Policy* 43, 45 (1990).
44. *Schneider*, 817 F. 2d at 995.
45. *Boyle v. Revici*, 961 F. 2d 1060, 1063 (2d Cir. 1992).
46. *Charell*, 173 Misc. 2d at 233.
47. *Leech v. Bralliar*, 275 F. Supp. 897 (D.C. Ariz. 1967).
48. *Id.* at 899.
49. *Id.*
50. *Hood v. Phillips*, 554 S.W. 2d 160 (Tex. Sup. Ct. 1977).
51. *Id.* at 165.
52. *Id.*
53. *Jones v. Chidester*, 610 A. 2d 964, 969 (Pa. Sup. Ct. 1992).
54. Michael H. Cohen, *Complementary and Alternative Medicine: Legal Boundaries and Regulatory Perspectives*, 58 (1998).
55. *Id.*
56. *Colton v. New York Hospital*, 98 Misc. 2d 957 (1979).
57. *Id.* at 970.
58. *Schneider v. Revici*, 817 F. 2d 987, 993 (2d Cir. 1987).
59. *Vodopost v. MacGregor*, 913 P. 2d 779, 789 (Wash. 1996).
60. *Id.*
61. Michael H. Cohen & David M. Eisenberg, *Potential Physician Malpractice Liability Associated with Complementary and Integrative Medical Therapies*, 136 *Ann. Intern. Med.* 596, 599 (2002).
62. *Id.* at 597. *See also Cohen, supra* note 54, at 59.
63. *Delaney v. Cade*, 873 P. 2d 175 (Kan. 1994).
64. David M. Studdert et al., *Medical Malpractice Implications of Alternative Medicine*, 280 *J.A.M.A.* 1610, 1612 (1998).
65. *Delaney*, 873 P. 2d at 182.

66. Cohen & Eisenberg, *supra* note 61, at 600.
67. *Reed v. Bascon*, 530 N.E. 2d 417 (Ill. 1988).
68. *Datiz v. Shoob*, 71 N.Y. 2d 867 (1988).
69. *Harris v. Miller*, 438 S.E. 2d 731 (N.C. 1994) (nurse); *Reed*, 530 N.E. 2d 417 (Ill. 1998) (physician).
70. *Jennings v. Burgess*, 917 S.W. 2d 790 (Tex. 1996).
71. Cohen & Eisenberg, *supra* note 61, at 600.
72. *Id.* at 601.
73. Studdert et al., *supra* note 64, at 1610.
74. *Id.*
75. David M. Eisenberg et al., *Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use*, 328 *New Eng. J. Med.* 246, 251 (1993).

