Referrals and Shared or Collaborative Care: Managing Relationships With Complementary and Alternative Medicine Practitioners

AUTHORS: Joan Gilmour, LLB, JSD,[a] Christine Harrison, MA, PHD,[b] Leyla Asadi, MD,[c] Michael H. Cohen, JDA, MBA,[d] and Sunita Vohra, MD, MSc[e,f]

[a]Osgoode Hall Law School, York University, Toronto, Ontario, Canada; [b]Department of Bioethics, SickKids Hospital, Toronto, Ontario, Canada; Departments of [c]Medicine and [f]Pediatrics, Faculty of Medicine, University of Alberta, Edmonton, Alberta, Canada; [d]Fenton Nelson LLP, Los Angeles, California; and [e]CARE Program for Integrative Health & Healing, Stollery Children's Hospital, Edmonton, Alberta, Canada

KEY WORDS

complementary therapies, referral and consultation, pediatric, interprofessional relations

ABBREVIATION

CAM—complementary and alternative medicine

www.pediatrics.org/cgi/doi/10.1542/peds.2010-2720G

doi:10.1542/peds.2010-2720G

Accepted for publication Mar 30, 2011

Address correspondence to Sunita Vohra, MD, MSc, Edmonton General Hospital, 8B19-11111 Jasper Ave, Edmonton, Alberta, Canada T5K 0L4. E-mail: svohra@ualberta.ca

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

FINANCIAL DISCLOSURE: *The authors have indicated they have no financial relationships relevant to this article to disclose.*

abstract

In this article we discuss steps that clinicians should take after deciding to include a complementary and alternative medicine (CAM) treatment that is beyond the clinician's expertise in a patient's treatment plan. We use the example of an adolescent patient with chronic recurrent headaches that have not been relieved by medication or other therapies and whose physician refers her to an acupuncturist for treatment. We focus on (1) circumstances under which referral is appropriate, (2) the nature of the relationship between the referring clinician and the practitioner to whom the referral is made (considering conventional health care and CAM, regulated and unregulated practitioners), and (3) considerations when undertaking shared or collaborative care with other health care practitioners (conventional health care or CAM). We also suggest best practices in managing such relationships. *Pediatrics* 2011;128:S181–S186

Fourteen-year-old Lindy visits her physician complaining of chronic recurrent headaches that have not been relieved by any of the medications or therapies her physician has suggested. Having ruled out the possibility of other serious underlying medical conditions and exhausted other forms of treatment, Lindy's physician consults the medical literature and concludes that acupuncture may help.[1–3] *He refers her to an acupuncturist whose office is located in the same complex as his. Some of the physician's other patients have spoken highly of their results with acupuncture therapy, and when he met the acupuncturist in passing, the physician found him to be a kind and intelligent man. The physician writes Lindy a referral to ensure that the acupuncture will be covered by her mother's private health insurance. He continues to monitor Lindy, and she returns in 2 weeks, delighted that her headaches are no longer bothering her. Six months later, Lindy comes in because of new-onset fatigue. On examination, her physician notes jaundice. His tentative diagnosis of hepatitis is confirmed by a laboratory test as acute hepatitis B. After investigating the potential cause, the physician learns that the acupuncturist was using unsterilized needles and was not certified by any regulatory body or professional association. In addition to his concern for Lindy, the physician wonders whether he could be held liable for the referral.*

This scenario responds to 3 developments in health care delivery. First, more patients are asking physicians about and sometimes seeking referrals for complementary and alternative medicine (CAM) therapies. Second, governments have begun to recognize and regulate a growing number of CAM practitioners.[4–7] Third, governments increasingly encourage collaborative, or shared, care among health professions, in which responsibility for management of the patient's care or an aspect of it is assumed by 2 or more health care providers.[8–11] All of these developments necessitate greater attention to how interdisciplinary relationships should function regardless of whether the care is conventional, CAM, or a combination of the two.

Several recent studies have confirmed that many physicians are comfortable referring their patients to CAM providers.[12,13] Among CAM therapies, acupuncture has one of the highest levels of acceptance and referral by physicians, as do chiropracty, massage, and biofeedback.[14–17] A large 2007 American survey on CAM use revealed that acupuncture experienced some of the greatest growth in CAM services from 2002 to 2007.[18] It is regulated in >40 states and the District of Columbia in the United States,[19] where there are an estimated 18 000 licensed acupuncturists, and there are >8000 physicians trained to provide acupuncture.[20] In Canada, it has been made a self-regulated profession in a slowly growing number of provinces: British Columbia, Alberta, Quebec, and, when transitional arrangements are complete, Ontario.[4,21–24] Evidence establishes that acupuncture is generally safe when provided by qualified practitioners.[25–29] However, we use acupuncture as an example in this scenario because potential (although rare) risks associated with treatment highlight some of the issues that could arise when referring patients or sharing care.*

Other articles in this supplemental issue of *Pediatrics* address how to make clinical decisions about incorporating CAM into a patient's management plan.[30,31] In this article we discuss the steps to take after deciding to include a CAM treatment that is beyond the clinician's expertise, that is, how to refer or share care safely and appropriately to ensure good patient care and minimize potential liability. We focus on (1) referrals by physicians to other practitioners (both conventional health care and CAM), (2) considerations when referring to regulated and unregulated practitioners, and (3) shared or collaborative care.

ETHICS

When a clinician refers a patient to another practitioner, he or she is assuming some level of moral responsibility for the outcome of that referral. The implicit message being given to the patient is "I trust this person, so you can, too." A patient might presume the referring physician knows the other practitioner to be competent in his or her field and is someone who can be relied on to provide care safely. If a physician does not know the provider personally, he or she could check to determine if the practitioner is licensed by a trustworthy body, such as a professional college or regulatory body, when possible. The regulatory status of different types of complementary medicine practitioners varies among jurisdictions.[32–34]

Individual physicians may still feel that there is moral risk involved and may prefer to leave the decision to the patient, although this is a less helpful course of action. In such a case, physicians might provide information about a type of treatment or service and about a relevant professional association or regulatory body and let the patient/family identify a practitioner.

Lindy's physician seems to have decided to refer her to a specific acupuncturist on the basis of testimonials from other patients and his impres-

*See *Rose v Pettle* ([2004], OJ No. 739 [SC], [2006], OJ No. 1612 [SC]), a class action certified respecting patients allegedly infected or exposed to hepatitis B and HIV against a person who provided acupuncture and a physician who owned the clinic at which treatment was received.

sion that the acupuncturist is kind and intelligent, neither of which attests to his competence.

LAW

Deciding to Refer

The decision to refer a patient "is ultimately a matter for the clinical judgment of the referring physician."[35] A referral must be reasonable and appropriate under the circumstances,[35] and there should be a reasonable expectation that the therapy will benefit the patient.[36,37] Physicians should also be guided by applicable legislation and relevant policies adopted by their governing bodies,[38–41] which may, for instance, limit which practitioners can provide certain treatments or impose conditions on referrals. These principles apply regardless of whether referrals involve physician specialists, allied health care providers, or CAM providers.

Liability

In general, merely referring a patient to another physician or health care provider will not give rise to liability for negligence on the part of the referring physician in either the United States or Canada.[42,43] There are exceptions, however. Questions about liability have arisen in the context of conventional health care providers, but the cases did not specifically address referral to CAM practitioners. However, as integrated care is increasingly promoted and popular demand for various forms of CAM grows, the potential for litigation arising from CAM referrals will increase also.

A physician can be liable for negligence in referring if (1) the decision to refer or his or her ongoing care was negligent (ie, fell below the standard of care expected under the circumstances) (direct liability) or (2) the referring physician becomes legally responsible for the treating practitioner's negligence (vicarious liability).[35,43–45]

Direct liability (ie, the referral itself or the physician's concurrent or later care was negligent) could result if, for instance, the physician's referral to a CAM practitioner delayed or eliminated the patient's opportunity to receive needed conventional health care, provided that, as in any negligence action, the plaintiff could also establish that he or she suffered harm as a result and that the referral was unreasonable under the circumstances (ie, fell below the standard of care).[43] Studdert et al[43,46] have suggested that, as knowledge about the appropriateness of various forms of CAM increases, physicians may be held liable if they refer patients for therapies that they know or should know would not benefit the patient. Liability for referral could also be attached if the physician knew or ought to have known that the practitioner to whom he or she was making the referral provided unsafe care or was unqualified or that referral to a more appropriate or specialized practitioner was warranted.[44] In addition, the referring physician has a duty to ensure that significant information about the patient and her condition is communicated to the other practitioner to inform the latter's diagnosis and treatment plan.[35] The physician should ensure that appropriate patient consent for disclosure has been obtained when necessary. In some jurisdictions, sharing information with designated categories of CAM practitioners who are treating the patient may be included in exceptions to laws that protect patient confidentiality, whereas in others, specific consent for disclosure may be required.[47]

Vicarious liability is imposed when the referring physician, although not negligent himself or herself, is held legally responsible for the negligence of the practitioner to whom he or she made the referral. This liability is most likely to arise if the physician supervised the care, employed the caregiver, or jointly treated or managed the patient's care.[43]

Supervisory Relationship

Finding that a supervisory relationship exists depends in part on statutory requirements and factual evidence about the degree of actual or apparent control the physician exercised over the acupuncturist or that the patient reasonably expected would be exercised.[27,33] Employers are vicariously liable for the negligence of their employees. Beyond that, applicable statutory regimes that regulate acupuncture must be reviewed to determine if they impose formal supervisory responsibility or require other types of connection with physicians.†‡

Shared or Collaborative Care

Vicarious liability could also be imposed on the referring physician if he or she is found to have engaged in a "joint undertaking" with the acupuncturist. A jointly owned or operated clinic, or delivery of care with CAM practitioners in an "integrated" unit in a hospital, raises the possibility of a finding that the practitioners were engaged in a joint undertaking, because integration by definition implies a high degree of coordinated diagnosis and care.[43,44,48] Thus, some degree of consultation about integration of treatment efforts and plans, even if not

†For instance, Alberta requires consultation with a physician or dentist before an acupuncturist begins treatment and referral to a physician or dentist if the condition does not improve within a few months and imposes other limits on acupuncturists' practice (Acupuncture Regulation, Alta Reg 42/1998, made under the *Health Disciplines Act*, R.S.A. 2000, c.H-2, Sch.G).

‡British Columbia requires acupuncturists to refer the patient to a physician or dentist if the condition does not improve within a few months and limits their practice in other ways (Traditional Chinese Medicine Practitioners and Acupuncturists Regulation, BC Reg 290/2008, s.6, made under the *Health Professions Act*, R.S.B.C. 1996, c.183, ss.2, 5).

through a formal structure, may raise the potential of a finding that the patient's treatment was a joint undertaking. A joint undertaking does not always result in joint liability, however. For instance, conventional health care providers in a hospital setting have been held not liable for colleagues' negligence, because it is reasonable to expect that co-workers will provide nonnegligent care to patients unless circumstances should alert practitioners otherwise or the provider controlled the negligent practitioner's work.[49–51] Questions about legal responsibility in collaborative or shared-care situations can be complex and fact-specific. Nonetheless, simply continuing to provide conventional care and monitoring a patient's health status while he or she receives CAM therapy from another practitioner should not involve the physician so closely in the alternative treatment that he or she and the CAM provider would be considered to have entered into a joint undertaking sufficient for a finding of vicarious liability.

Referring to Regulated and Unregulated Practitioners

Whether the acupuncturist's lack of certification or registration with a regulatory authority or professional association is legally significant depends in part on where these events occurred. In some jurisdictions, acupuncture can only be performed by people who are authorized by law to do so; designated providers may include acupuncturists or other health professionals considered qualified, such as physicians, physiotherapists, naturopaths, or others.[43,44,51] In those instances, other people cannot legally provide this service. Health care providers should not facilitate unauthorized practice and should inquire to ensure that the practitioners have the requisite credentials.

Many types of CAM are not regulated, but that does not preclude making a referral unless prohibited by law or policy. However, it may require more extensive inquiry by the physician.[37(p778)] In jurisdictions where acupuncture is not a regulated profession, professional associations may exist that impose educational and other requirements for membership. Such associations are voluntary. Although membership may provide some indication that the practitioner is complying with generally accepted standards, practitioners do not have to join or be certified in any way. Physicians considering a referral to an unregulated practitioner should ascertain that the person is qualified to provide the service.

The physician should also learn about the proposed treatment plan to ensure that it is what was anticipated when referring and does not include practices known to be unsafe or ineffective. In addition, he or she should monitor the patient conventionally and treat as appropriate.[37(p778)]

Mandatory Reporting

Clinicians who learn that another practitioner, whether conventional or CAM, may be exposing patients to an unreasonable risk of harm should ascertain whether they have a duty to report that practitioner, pursuant to statutory, institutional, or professional obligations. Mandatory reporting obligations vary among jurisdictions.

CLINICAL RESPONSE

After deciding that a referral is appropriate, the physician who chooses a CAM practitioner must consider the needs of the patient in light of medical, legal, and ethical considerations. He or she should ensure that the practitioner has the required credentials to provide the treatment. If the CAM modality is not yet regulated, Frenkel and Borkan[52] have suggested considering the practitioner's education, training, and professional affiliations, although it is certainly more difficult for a physician to assess these than the more familiar credentials of conventional health care providers.[53] In these circumstances, another option is to refer the patient/parents to the relevant professional board or association directly and allow it to guide the patient to a qualified practitioner.

Because the ideal situation is one with open communication between the physician and CAM practitioner, the physician should attempt to find practitioners with whom he or she is comfortable. Frenkel and Borkan[52] even suggested that physicians should meet with these practitioners to determine if an effective working relationship could be established and could create a short list of practitioners for referral. This approach has been adopted successfully by several academic health centers in North America,[54,55] although it may not be realistic for physicians in different practice settings that are more isolated and have fewer administrative and other supports.[55] Ideally, physicians will become comfortable referring to CAM practitioners when the risks and benefits of the therapy (and the provider) are favorable for their patient's condition.[37] However, if a physician feels personally unable to appropriately advise a patient, that physician should clearly state his or her own view and reasons, refer the patient to another physician who may be more comfortable advising about the referral or to a regulatory authority or professional association, and also assure the patient that their relationship will not be affected by the patient's decision.[56]

RECOMMENDATIONS

When referring to other practitioners, physicians should do the following.

1. Determine if there is sufficient evidence that referral offers a reasonable prospect of therapeutic benefit, either after having tried and exhausted conventional treatments or, if the risk/benefit profile of conventional and CAM therapies favors the CAM therapy (eg, because of less frequent or severe adverse effects), consider referral for CAM treatment from the outset.[31,57]
2. Ascertain that the practitioner to whom the referral is being made has the requisite qualifications. Regulation of CAM providers varies among jurisdictions:
   a. Regulated professional: verify that the practitioner is licensed or a member in good standing. Membership in a regulated health profession authorized to provide this service confirms that the person has met education and training requirements and must comply with professional standards.
   b. Unregulated health practitioner: ask about education, qualifications, membership in professional associations, etc.
   c. Individual physicians may prefer to leave the decision to patients/parents, in which case they could provide information about a type of treatment or service and a relevant professional association and let the patient identify a practitioner.
3. Ensure that referral complies with applicable legislation and policies of regulatory authorities and/or health facilities about interdisciplinary interactions.
4. Learn about the practitioner's proposed treatment plan to make sure that it is consistent with what was expected on referral.
5. Monitor the patient conventionally and treat as appropriate.

When undertaking shared care, key for everyone involved, including patients/parents, is clear communication about (1) health care providers' individual roles and responsibilities, (2) decision-making processes, (3) policies regarding care provision, and (4) informed consent to the treatment plan, all backed by (5) appropriate record-keeping.[9]

ACKNOWLEDGMENTS

Funding for this project was partially provided by the SickKids Foundation (Toronto, Ontario, Canada). Dr Vohra received salary support from the Alberta Heritage Foundation for Medical Research and the Canadian Institutes of Health Research.

We gratefully acknowledge the contributions of Soleil Surette and Alison Henry for help in literature searching and manuscript preparation, Maya Goldenberg and Andrew Milroy for bioethics research assistance, and Osgoode Hall Law School students (now graduates) Nicola Simmons, David Vitale, Kristine Bitterman, and Janet Chong for assistance with legal research.

REFERENCES

1. Melchart D, Linde K, Berman B, et al. Acupuncture for idiopathic headache. *Cochrane Database Sys Rev*. 2001;(1):CD001218
2. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for migraine prophylaxis. *Cochrane Database Sys Rev*. 2009;(1):CD001218
3. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for tension-type headache. *Cochrane Database Sys Rev*. 2009;(1):CD007587
4. Traditional Chinese Medicine Act 2006, S.O. 2006, c. 27
5. Naturopathy Act, Sch. P to the Health System Improvements Act, S.O. 2007, c. 10
6. Homeopathy Act, Sch. Q to the Health System Improvements Act, S.O. 2007, c. 10
7. British Columbia: provincial health plan to cover acupuncture. *Toronto Star*. March 31, 2008:A17
8. Health Professions Procedural Code, being Sch. 2 to the Regulated Health Professions Act, S.O. 1991, c. 18, s. 3(1)9
9. Prada G, Swettenham J, Ries N, Martin J. *Liability Risks in Interdisciplinary Care: Thinking Outside the Box*. Toronto, Ontario, Canada: Conference Board of Canada; 2007
10. Health Professions Regulatory Advisory Council. *An Interim Report to the Minister of Health and Long-term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration Among Health Colleges and Regulated Health Professionals*. Toronto, Ontario, Canada: Queen's Printer; 2008. Available at: www.hprac.org/en/reports/resources/HPRAC-EnglishInterprofessionalCollaborationInterimReportMarch08.pdf. Accessed August 20, 2010
11. Health Professions Regulatory Advisory Council. *An Interim Report to the Minister of Health and Long-term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration Among Health Colleges and Regulated Health Professionals: Phase II, Part I*. Toronto, Ontario, Canada: Queen's Printer; 2008. Available at: www.hprac.org/en/reports/resources/InterprofessionalCollaborationReportPhaseIIPartIENGSept08.pdf. Accessed August 20, 2010
12. van Haselen RA, Reiber U, Nickel I, Jakob A, Fisher PA. Providing complementary and alternative medicine in primary care: the primary care workers' perspective. *Complement Ther Med*. 2004;12(1):6–16
13. Coulter ID, Singh BB, Riley D, Der-Martirosian C. Interprofessional referral patterns in an integrated medical system. *J Manipulative Physiol Ther*. 2005;28(3):170–174
14. Berman BM, Singh BB, Hartnoll SM, Singh BK, Reilly D. Primary care physicians and complementary-alternative medicine: training, attitudes, and practice patterns. *J Am Board Fam Pract*. 1998;11(4):272–281
15. Berman BM, Bausell RB, Lee WL. Use and referral patterns for 22 complementary and alternative medical therapies by members of the American College of Rheumatology: results of a national survey. *Arch Intern Med*. 2002;162(7):766–770
16. Sawni A, Thomas R. Pediatricians' attitudes, experience and referral patterns regarding complementary/alternative medicine: a national survey. *BMC Complement Altern Med*. 2007;7:18
17. Astin JA, Marie A, Pelletier KR, Hansen E, Haskell WL. A review of the incorporation of

complementary and alternative medicine by mainstream physicians. *Arch Intern Med*. 1998;158(21):2303–2310

18. Barnes PM, Bloom B, Nahin RL. Complementary and alternative medicine use among adults and children: United States, 2007. *Natl Health Stat Report*. 2008;(12):1–23. Available at: www.cdc.gov/nchs/data/nhsr/nhsr012.pdf. Accessed August 10, 2010
19. National Cancer Institute. Questions and answers about acupuncture. Available at: www.cancer.gov/cancertopics/pdq/cam/acupuncture/Patient/page2. Accessed November 9, 2010
20. American Cancer Society. Acupuncture. Available at: www.cancer.org/Treatment/TreatmentsandSideEffects/ComplementaryandAlternativeMedicine/ManualHealingandPhysicalTouch/acupuncture. Accessed November 9, 2010
21. Gilmour J, Kelner M, Wellman B. Opening the door to complementary and alternative medicine: self-regulation in Ontario. *Law Policy*. 2002;24:149–174
22. Health Professions Act, R.S.A. 2000, c.H-7
23. Acupuncture Regulation, Alta Reg 42/1998 (made under the Health Disciplines Act, R.S.A. 2000, c.H-2, Sch.g)
24. Professional Code, R.S.Q.C. C-26, Health Professions Act, R.S.B.C. 1996, c. 183, Traditional Chinese Medicine Practitioners and Acupuncturists Regulation, BC Reg 290/2008
25. Macpherson H, Thomas K. Short term reactions to acupuncture: a cross-sectional survey of patient reports. *Acupunct Med*. 2005;23(3):112–120
26. Lao L, Hamilton GR, Fu J, Berman B. Is acupuncture safe? A systematic review of case reports. *Altern Ther Health Med*. 2003;9(1):72–83
27. Ernst E, White AR. Prospective studies of the safety of acupuncture: a systematic review. *Am J Med*. 2001;110(6):481–485
28. White A. A cumulative review of the range and incidence of significant adverse events associated with acupuncture. *Acupunct Med*. 2004;22(3):122–133
29. Verhoef MJ, Boon H. Research that matters: linking researchers, practitioners, decision-makers and the public—abstracts from the Fifth Annual IN-CAM Research Symposium November 7 to 9, 2008, Toronto, Ontario, Canada. *J Complement Integr Med*. 2008;5(1):31
30. Gilmour J, Harrison C, Asadi L, Cohen MH, Vohra S. Informed consent: advising patients and parents about complementary and alternative medicine therapies. *Pediatrics*. 2011;128(5 pt 4):S187–S192
31. Gilmour J, Harrison C, Asadi L, Cohen MH, Vohra S. Treating teens: considerations when adolescents want to use complementary and alternative medicine. *Pediatrics*. 2011;128(5 pt 4):S161–S166
32. Caulfield T, Feasby C. Potions, promises and paradoxes: complementary medicine and alternative medicine and malpractice law in Canada. *Health Law J*. 2001;9:183–203
33. Cohen MH. CAM regulation in the United States. *Complement Ther Med*. 2002;10(1):3–7
34. Van Hemel PJ. A way out of the maze: federal agency preemption of state licensing and regulation of complementary and alternative medicine practitioners. *Am J Law Med*. 2001;27(2–3):329–344
35. Picard E, Robertson G. Negligence: specific duties and attendant standards of care. In: *Legal Liability of Doctors and Hospitals in Canada*. 4th ed. Toronto, Ontario, Canada: Carswell; 2007:316
36. Kemper K, Cohen M. Ethics meet complementary and alternative medicine: new light on old principles. *Contemp Pediatr*. 2004;21(3):61–72
37. Cohen M, Kemper K. Complementary therapies in pediatrics: a legal perspective. *Pediatrics*. 2005;115(3):774–780
38. Ontario, Medicine Act, S.O. 1991, c. 30, s. 5.1, Regulated Health Professions Act, S.O. 1991, c. 18, s. 27
39. College of Physicians and Surgeons of Ontario. Complementary medicine: policy 1-00. Available at: www.cpso.on.ca/policies/policies/default.aspx?ID=1532. Accessed August 20, 2010
40. College of Physicians & Surgeons of British Columbia. Complementary and alternative therapies. Available at: www.cpsbc.ca/files/u6/Complementary-and-Alternative-Therapies.pdf. Accessed August 13, 2010
41. Federation of State Medical Boards, Special Committee for the Study of Unconventional Health Care Practices. *Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice*. Dallas, TX: Federation of State Medical Boards; 2002. Available at: www.fsmb.org/pdf/2002_grpol_Complementary_Alternative_Therapies.pdf. Accessed August 13, 2010
42. Cohen M. Alternative and complementary care ethics. In: Singer P, Viens A, eds. *The Cambridge Textbook of Bioethics*. Cambridge, United Kingdom: Cambridge University Press; 2008:513–520
43. Studdert DM, Eisenberg DM, Miller FH, Curto DA, Kaptchuk TJ, Brennan TA. Medical malpractice implications of alternative medicine. *JAMA*. 1998;280(18):1610–1615
44. Cohen M, Eisenberg D. Potential physician malpractice liability associated with complementary and integrative medical therapies. *Ann Intern Med*. 2002;136(8):596–603
45. *Williams (Litigation Guardian of) v Bowler* (2005), OJ No. 3323 (Sup Ct)
46. Kung C. Defining a standard of care in the practice of acupuncture. *Am J Law Med*. 2005;31(1):117–130
47. Personal Health Information Protection Act, S.O. 2004, c. 3, Sch. A
48. Cohen M. Referrals to complementary and alternative medicine providers. In: *Beyond Complementary Medicine: Legal and Ethical Perspectives on Health Care and Human Evolution*. Ann Arbor, MI: University of Michigan Press; 2000:49–55
49. *Granger (Litigation Guardian of) v Ottawa General Hospital* (1996), OJ No. 2129 (Gen Div), para. 32
50. *Kielley v General Hospital Corp* (1995), 410 APR 338 (NLTD), aff'd (1997), 470 APR 163 (NLCA)
51. Cohen M. State law regulation of the practice of medicine: implications for the practice of complementary and alternative medicine. In: Faas N, eds. *Integrating Complementary Medicine in Health Systems*. Gaithersburg, MD: Aspen; 2001:218–225
52. Frenkel MA, Borkan JM. An approach for integrating complementary-alternative medicine into primary care. *Fam Pract*. 2003;20(3):324–332
53. Adams K, Cohen M, Eisenberg D, Jonsen A. Ethical considerations of complementary and alternative medical therapies in conventional medical settings. *Ann Intern Med*. 2002;137(8):660–664
54. Consortium of Academic Health Centers for Integrative Medicine. Members. Available at: www.ahc.umn.edu/cahcim/members/home.html. Accessed August 20, 2010
55. Vohra S, Feldman K, Johnston B, Waters K, Boon H. Integrating complementary and alternative medicine into academic medical centers: experience and perceptions of nine leading centers in North America. *BMC Health Serv Res*. 2005;5:78
56. British Medical Association. Referrals to complementary therapists. Available at: www.bma.org.uk/employmentandcontracts/independent_contractors/providing_gp_services/refcomtherap0406.jsp. Accessed August 19, 2010
57. Gilmour J, Harrison C, Asadi L, Cohen MH, Aung S, Vohra S. Considering complementary and alternative medicine alternatives in cases of life-threatening illness: applying the best-interests test. *Pediatrics*. 2011;128(5 pt 4):S175–S180

Referrals and Shared or Collaborative Care: Managing Relationships With Complementary and Alternative Medicine Practitioners

Joan Gilmour, Christine Harrison, Leyla Asadi, Michael H. Cohen and Sunita Vohra

Pediatrics 2011;128;S181
DOI: 10.1542/peds.2010-2720G

PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Referrals and Shared or Collaborative Care: Managing Relationships With Complementary and Alternative Medicine Practitioners

Joan Gilmour, Christine Harrison, Leyla Asadi, Michael H. Cohen and Sunita Vohra

Pediatrics 2011;128;S181
DOI: 10.1542/peds.2010-2720G