

Ontario Society of Physicians for Complementary Medicine



President: Dr. Robert Banner
drbanner@bellnet.ca

Secretary: Dr. C. Appleyard
drappleyard@bellnet.ca

August 30, 2011

Dr. Lynn Thurling
President
College of Physicians and Surgeons of Ontario
Chair
CPSO Working Group, Policy on Complementary Medicine

**Re: OSPCM Response to Draft Policy,
Non-Allopathic (Non-Conventional) Therapies in Medical Practice**

Dear Dr. Thurling;

I am writing on behalf of the executive of OSPCM, and the Section on Complementary and Integrative Medicine of the OMA to respond to the current draft proposal. As you may know, OSPCM is an organization founded in 1997 to support physicians committed to providing care to patients for whom conventional, or “allopathic” approaches are either not effective or desired. Sectional designation by the OMA followed two years later.

I must be forthright in expressing our profound disappointment with this draft document. We believe it is most important to address the broader issues that undergird this process, rather than critique the draft point by point.

In your Dialogue interview you state that there have been remarkably few complaints regarding complementary therapies. The notion that the current policy does not provide effective protection for patients is manifestly absurd. During the years 2005-2010, there were only 31 investigations arising from complementary medicine cases. No specific egregious physician conduct in relation to complementary therapies was reported to justify the Draft Policy and there are already strong provisions in legislation and regulations to deal with unacceptable physician behaviour across the profession.

Our first major concern is the attitude and ethic that is driving such a deep and trenchant hostility toward complementary and integrative medicine. This policy was not drafted in any kind of collegial atmosphere, with the extensive and reasonable input available from practitioners of complementary and integrative medicine. It is clear that this draft was crafted in the context of legislative changes that will compound the problem by enabling a heavy handed, biased and profoundly unfair treatment of any physician whose practice the College does not understand. A grave concern of ours is that the unreasonable demands of this policy will not necessarily prevent inappropriate behaviour, but will certainly curtail access to care for some very vulnerable patients.

The College has never, in any systematic way, approached OSPCM or the Section to allow us to enlighten the committee on the various facets of integrative or complementary medicine. The College is essentially trying to regulate something it knows nothing about, while people who are knowledgeable and willing to help are available but ignored.

The mandate of the College is first and foremost to serve and protect the public, but we would challenge your commitment to that responsibility. The Working Group has spent two years developing a policy that will hamstring practitioners who have chosen approaches to patient care that are made largely on the basis of the safety of these approaches (complementary and integrative). Where is the policy that regulates overprescribing and polypharmacy? The use of pharmaceuticals has long recognized to heavily contribute to morbidity and mortality, especially among the aged. Where is the policy that would regulate off-label uses of drugs? Even approved use of pharmaceuticals has a distressingly high rate of morbidity and mortality, documented as far back as the Lazarou study in 1998, and yet we rarely see in the Member's Dialogue any physician pulled up on the carpet for prescribing inappropriately. And where is the policy that prevents physicians from charging insurers large fees to routinely deny accident victims safe treatment that can potentially benefit them?

It is out of step with current evidence-based medicine thinking to make randomized controlled trials (RCT's) the only acceptable standard for efficacy. Furthermore, making it a standard solely for "non-allopathic" therapies is certainly a double standard when it is generally acknowledged that a considerable proportion of traditional medical practice does not have such evidence. Where are the RCT's that support new surgical techniques? Essentially there are none because innovation in surgical techniques does not lend itself to evaluation by that particular research modality. Therein lies the contradiction, and the double standard: what's acceptable for surgery is not acceptable for complementary and integrative medicine.

The name itself of the new policy carries undertones of disparagement and lack of respect, but more importantly, is ambiguous and confusing for the general public, the vast majority of whom would never have confronted the term “allopathic”. Semantically speaking, allopathy relates to treatments that oppose the cause of disease. The opposite is homeopathy, which relates to strengthening resistance to disease.

Non-allopathic implies that we are lumped with virtually everything else under the sun, and not necessarily restricted to health care practices. This is dismissive, and fails to recognize that the majority of physicians practicing complementary and integrative medicine are employing a relative handful of approaches for which there is increasing evidence. Some practices incorporating such modalities as acupuncture and environmental medicine, functional medicine and nutrition are already regarded as mainstream. Author James Whorton discusses the historical, pejorative use of the term “allopathy”:

One form of verbal warfare used in retaliation by irregulars was the word “allopathy”...”Allopathy” and “allopathic” were liberally employed as pejoratives by all irregular physicians of the nineteenth century, and the terms were considered highly offensive by those at whom they were directed. The generally uncomplaining acceptance of (the term) “allopathic medicine” by today’s physicians is an indication of both a lack of awareness of the term’s historical use and the recent thawing of relations between irregulars and allopaths.

Most of the Western world has adopted the terms “complementary and alternative and integrative” and one finds it used in major medical centres. The CPSO would be hard pressed to justify not following suit.

The 2010 National Physicians Survey has a question for GP/FP’s on their offering of CAM therapies. They reported that 7.4% offer alternative/complementary medicine, and 1.2% has alternative/complementary medicine as a specific area of focus. If Ontario has roughly 8,000 family doctors, then 592 offer these therapies and 96 are focused specifically on complementary therapies! These numbers are not reflected in the membership of OSPCM, nor in the Section of Complementary and Integrative Medicine of the OMA, I would suggest, partly out of a fear of reprisal from the CPSO.

These numbers do reflect the current public interest in having the medical profession to develop new, and more effective methods of health care. They also are in keeping with Section 5.1 of the Medicine Act, which of course states that a member may practice “a therapy that is non-traditional or that departs from the prevailing medical practice unless there is evidence that proves the therapy poses a greater risk to a patient's health than the traditional or prevailing practice”.

Non-traditional therapies like acupuncture and others are growing in popularity. More than half of the population relies on complementary therapies to support traditional care. Often, these nontraditional therapies are tried first, before the patient seeks conventional therapy. In other instances, they are explored as a last

resort. We argue that physicians who are trained in or use, or are familiar with these nontraditional therapies are best suited to advise/treat patients and to participate with colleagues in helping to advance understanding and improve usage of them. Courses in many of these modalities, accredited by the Royal College of Physicians and Surgeons of Canada, and/or the Accreditation Council on Continuing Medical Education in the United States, are already available in both countries.

Our second major concern is the legality of this draft, and the legality of the process by which it was drafted, and more broadly, the legality of the regulatory practices of the CPSO. Because of these concerns, we categorically reject this draft for many reasons, a few of which I will enumerate;

- 1) The Working Group did not invite anyone from the OSPCM or the OMA's Section on Complementary and Integrative Medicine to join the Working Group to provide relevant expertise.
- 2) The Working Group makes no reference to justifications flowing from its external consultation process nor did it consult these members in any systematic way. The public survey conducted by the Strategic Council had some significant methodological shortcomings, which the College showed no interest in addressing. The current online request for input also has biased questions.
- 3) The CPSO fails to explain the basis for "relevant considerations" justifying its policy process and the resulting Draft. For instance, was any kind of analysis done of the 31 investigations to address the types of problems that have arisen?
- 4) The Draft Policy makes no reference to the legal principles that currently support CAM, namely the *Brett* decision and Section 5.1 of the *Medicine Act*. As you know, the Brett decision legitimized alternative and complementary approaches to diagnosis and treatment when they are supported by a "minority opinion" that is both "competent and responsible".
- 5) The new test for CAM standard of practice – whether a therapy has "a favourable risk/benefit ratio" – may be exclusively determined by CPSO personnel, and so clearly conflicts with the *Brett* decision and section 5.1 of the *Medicine Act*.
- 6) The section on Professional Affiliations violates the *Charter* guarantee of freedom of association. This section was, for many of our members, particularly egregious.
- 7) Holding doctors who use complementary and integrative approaches "that pose a greater risk than a comparable allopathic treatment", as determined by College personnel, to the standard of RCT's is discriminatory because it holds them to a higher standard than conventional medicine. We hold that the new RCT requirement should be regarded as a violation of equality before the law as guaranteed by section 15(1) of the *Charter*.

- 8) The Working Group failed to consider patient outcomes in its analysis, even though it has adopted “the best possible patient outcome” as its foremost institutional goal, which clearly contradicts the rather famous assertion of a past Registrar of the CPSO, that “outcomes don’t matter”.
- 9) The Working Group failed to give proper weight to informed consent as an essential aspect of determining the standard of practice. It’s hard to explain why doctors using conventional modalities have the legal right to engage in high-risk activities once the standard of informed consent has been met. We refer to off-label prescribing as well as polypharmacy. Apparently, CAM doctors, or as far as we know any other physician knowledgeable and respected in CAM, using modalities with lower risks cannot rely on informed consent because the modalities do not meet the standard of a “favourable risk-benefit” ratio, according to CPSO staff, or the standard of RCT’s.
- 10) Physicians are not to discriminate against their patients. Asking about a patient’s socio-economic status could be considered intrusive, and not mentioning a potentially beneficial therapy because of its cost is unjust and creates a discriminatory double standard. The socio-economic status of patients is a completely irrelevant factor in this review process, unless one assumes, as the College seems to, that complementary and integrative practitioners are more likely to take advantage of patients; this assumption is another example of discrimination on the part of the Working Group.

For these reasons, we question whether the Working Group is acting in good faith. It should be clear, now, that we expect the Working Group, in the best interests of patients, to go back to the drawing board and to work collaboratively on an ongoing basis with members of the medical profession who are knowledgeable, experienced, and respected in the field of complementary approaches. We stand by our submissions of July 2010 re the “Complementary Policy”, and for that matter, our submission of June 1997, and, as always, we are willing to work with you on issues related to complementary/integrative medicine and patient care and safety. Our common goal should be to improve this policy so that it is workable for both the CPSO and physicians on the frontlines of health care, in the best interests of patients.

Sincerely,

Craig Appleyard MD, FCFP
Secretary-Treasurer,
Ontario Society of Physicians for Complementary Medicine
Section on Complementary and Integrative Medicine, Ontario Medical Association