

September 1, 2011

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

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

Dear Dr. Thurling:

Thank you for the opportunity to respond to the Working Group's Draft Policy on 'Non-Allopathic' Therapies. I am making this submission on behalf of the Acupuncture Foundation of Canada Institute, a not-for-profit organization that has been providing educational programs for physicians since 1974, one of the first of which introduced me to acupuncture. Over the ensuing 37 years I have accumulated extensive experience in the clinical use of acupuncture within my medical practice and have closely followed the emergence of basic science and clinical research in the field. I am an Adjunct Scientist at Toronto Rehabilitation Institute and the Principal Investigator on a university-affiliated multi-centre acupuncture study for spinal cord injury pain.

## TERMINOLOGY

Before addressing the details of the draft policy, I must register our strong objection to the use of the terminology 'Non-Allopathic' and 'Non-Conventional' rather than 'Complementary' and 'Integrative' to describe forms of treatment that this policy is designed to regulate.

In the draft document on page 2, line 52, it is stated that:

***Non-Allopathic Therapies (Non-Conventional Therapies):*** refers to a broad range of procedures or treatments that are not commonly used in allopathic medicine;<sup>3</sup> this includes those referred to as ***complementary or alternative***.

Reference 3 (your footnote) is as follows:

***3. Modified from Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice, Federation of State Medical Boards of the United States, Inc., 2002.***

A Google search led me to this document:

***Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice***  
Approved by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., as policy April 2002.

A search of that document revealed that there is no reference in it to the terms 'allopathic' or 'non-allopathic'. That document contains the following statement:

***CAM is a fluid concept that has been defined differently by various organizations and groups. For the purposes of these guidelines, the Committee has chosen to use the term CAM as defined by the National***

Institutes of Health (NIH) National Center for Complementary and Alternative Medicine (NCCAM) (see Definitions). The Committee acknowledges that some therapies deemed CAM today may eventually be recognized as conventional, based on evidence over time.

The NIH NCCAM site, to which the guidelines refer, continues to use 'CAM' (Complementary and Alternative), 'complementary' and 'integrative' medicine to describe the various approaches that the CPSO has chosen to call 'Non-Allopathic'. They do not use the terms that the CPSO has chosen to use. It should be noted here that 'complementary' implies that the particular approach is being used to complement western medicine; 'alternative' means that one is using it instead of western medicine. With respect to acupuncture, when I use it, it complements my western medicine; if an individual goes to his/her acupuncturist who is not a physician, the acupuncture done by that practitioner would be called alternative medicine.

Unfortunately, the prefix "non-", meaning "not or absence of" immediately casts a negative tone on the subject. It is doubly unfortunate when combined with "allopathic" since this term is not widely used. Both "complementary" and "alternative" carry high-recognition scores with physicians and the public alike; in our quest to ensure transparency and accountability, our vocabulary must be accurate, clear and straightforward. The term 'non-allopathic' will only serve to confuse and mislead the public and our profession. Worse still, it could lead individuals who do not understand the system to search for research on Non-Allopathic treatments and come up with virtually nothing, leading them to believe that there is no basis to anything so designated.

**Therefore, in this document I shall use the term 'Complementary and Integrative Medicine' and the acronym 'CIM' in place of 'non-allopathic'.**

### **RISKS OF COMPLEMENTARY AND INTEGRATIVE MEDICINE**

In the article in *Dialogue*, Vol. 7 Issue 2, you refer to the fact that there are not many complaints about physicians who provide CIM. You then go on to give a number from 2005-2010 of 31 investigations. Thirty-one is actually a fairly high number, given that, based on the 2010 National Physicians Survey, there may be 592 FP/GP physicians in the province using CIM.

Clarity is essential. I see that 31 refers to the number of *investigations*, not the number of *complaints*. As we well know, many of the physicians who have been investigated for CIM activity have not had complaints registered against them. Thus, the *true* number of complaints must be far lower than the 31 as published in *Dialogue*.

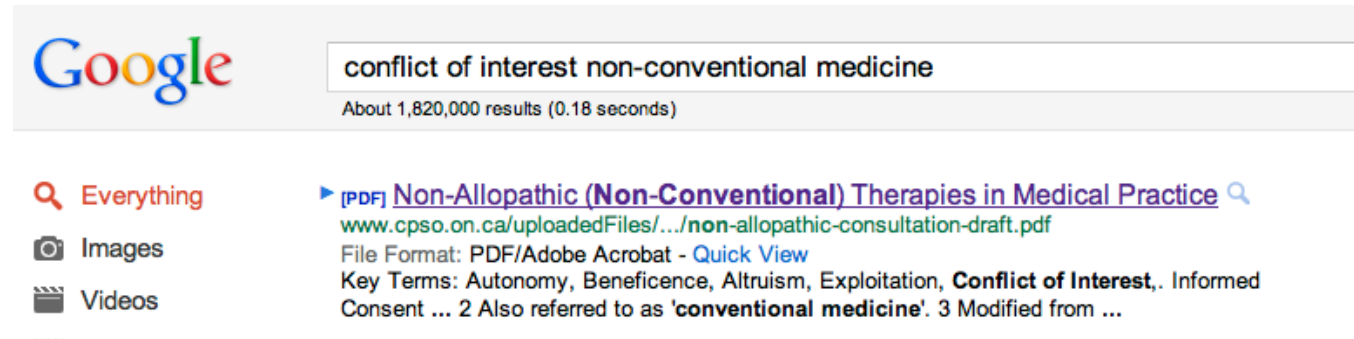
You are quoted as saying that many of the cases involved "egregious physician conduct, with patients often being harmed or exploited". Since 'egregious' connotes something horrific, I checked all the Dialogues from 2008 (the archives on the CPSO website only go back to 2008) to the current issue and I found only three cases where CIM was involved. One had to do with biofeedback and if there was patient harm involved, that was not emphasized in the summary; a second dealt with poor knowledge and management of allergy testing that put patients at risk and although 'alternative allergy treatment' was mentioned, it was unclear what that entailed; the third involved the issue of a physician signing forms for individuals who attended an alternative cancer facility without having seen them, a clearly unethical practice.

If there are egregious cases involving CIM amongst the few complaints received by the CPSO, we would appreciate knowing the details. We would also appreciate knowing what provoked the 31 investigations where CIM was involved and what the outcomes of those cases were, if they are completed.

## KEY TERMS AND BAD FAITH

Words such as Autonomy, Beneficence, Altruism and Hippocratic Oath are puzzling by their presence. Words such as Exploitation, Conflict of Interest and Trustworthiness imply wrongful actions on the part of practitioners. The term Informed Consent is the only descriptor that seems to have a place here. Where are terms such as Complementary, Integrative, Alternative, Acupuncture, Environmental Medicine, Homeopathy, Orthopedic Medicine, etc? Those terms are specific and appropriate.

How shocking it was to see the CPSO draft policy appear first amongst 1,820,000 hits upon searching 'conflict of interest non-conventional medicine'. See below:



Searching with all the other Key Terms brought up the draft policy and all were within the top seven hits. Hippocratic Oath was number two.

This policy is only a draft, but it is already denigrating our professional work and smearing our well-established reputations.

In summary, the tone of this document suggests that anyone who does anything that could be considered to be outside the box of conventional medicine is untrustworthy and any treatment that one might recommend that is neither drugs nor surgery is potentially dangerous and ineffective. The CPSO draft policy purports to protect the public from individuals such as those physicians who have trained in acupuncture through the AFCl program, among many others.

### **A. General Expectations for Physician Conduct**

To add to the negativity of this policy and raise concerns that all physicians who use CIM are not to be trusted, this section of the draft policy seems to be another attempt to make all of us sound like we often do not respect our patients' autonomy or act in their best interest, exploit them and have conflicts of interest such as "charging excessive fees and advocating for treatment options or products that will generate a personal benefit" for us. This is unnecessarily insulting, even with the disclaimer at the top saying that "these principles and obligations are broadly applicable for all medical practice"... but they "will have particular importance to this area of medicine".

It seems to me that the implication is that because the services we provide are generally not OHIP-covered, our patients are open to more exploitation than if they were covered.

## **Background Information re Acupuncture**

### **a) The Science Of Acupuncture**

Since the first paper published in the west reporting research from the University of Toronto on the connection of acupuncture with endorphins in 1976, a massive amount of research on acupuncture has been published in leading scientific journals around the world. There is strong evidence for its ability to ameliorate pain and normalize physiology. Anyone interested in details has only to search the internet or can look at the Acupuncture Foundation of Canada Institute's website at [www.afcinstitute.com](http://www.afcinstitute.com)

### **b) Typical Recipients of Acupuncture in a Medical Practice**

To enlighten the committee with respect to the value of medical acupuncture, it is appropriate to describe the type of cases that present themselves to a practitioner such as myself, who specializes in acupuncture. Virtually all of the patients who present themselves to me or other medical acupuncture practitioners for treatment are failures of mainstream medicine, many with complex histories and many suffering from severe chronic pain, much of it neuropathic. Most of these individuals have already seen many medical specialists without adequate relief of their symptoms.

Some others are individuals who ideologically and rationally have decided to forego western pharmaceuticals, either because of side effects or because they are seeking a 'natural' treatment that will encourage their body to heal and their painful condition to resolve. Many are individuals who have had good results with acupuncture in the past and wish to try it again for a new problem. The vast majority of our patients (about 80-85%) improve with acupuncture and nutritional supplementation, in spite of the complexity of their cases.

When deciding whether to do a trial of acupuncture to see if an individual will respond, one does not have to be concerned about risk/benefit when the acupuncture is performed by a skilled practitioner. Since the risk is so infinitesimally small, the potential for benefit will always be higher than the risk. Although approximately 85% of people respond to acupuncture, the degree to which they respond is on a Bell curve. Approximately 15% of people respond more dramatically than the average, but it is impossible to tell who is likely to respond that way. Thus, even if the condition is one that does not often respond to acupuncture treatment, it is still worth doing a trial of acupuncture, in case this person is such a strong reactor to treatment that it will work better than one could expect. . To do otherwise would be unethical, given the hopelessness of the person's situation. Signs of beginning benefit can often be observed unequivocally within one to two treatments

### **c) Safety of Acupuncture**

With respect to the pre-eminent issue of safety, there is no medical treatment safer than acupuncture. While there are case reports of serious complications from time to time<sup>1</sup>, large scale studies of safety show the incidence of serious complications to be near zero in well-trained hands.<sup>2</sup> To quote Ernst and White from their meta analysis, "Feelings of relaxation were reported by as many as 86% of patients. Pneumothorax was rare, occurring only twice in nearly a quarter of a million treatments". Thus, you can see that the main 'side effects' of acupuncture are beneficial, not harmful.

Given this safety profile and the fact that clinical research via randomized clinical trials is validating the efficacy of acupuncture for more conditions all the time, many would consider it to be professional

<sup>1</sup> Chang SA, Kim YJ, Sohn DW, Park YB, Choi YS. Aortoduodenal fistula complicated by acupuncture. Int J Cardiol. 2005 Sep 30;104(2):241-2.

<sup>2</sup> Ernst E, White A. Prospective studies of the safety of acupuncture: a systematic review The American Journal of Medicine Volume 110, Issue 6, 15 April 2001, Pages 481-485

misconduct for physicians to *not* recommend acupuncture to their patients for osteoarthritis<sup>3,4</sup>, low back pain<sup>5,6,7</sup>, headaches (both migraine<sup>8</sup> and myofascial<sup>9</sup>) and neck disorders<sup>10</sup>.

Allopathic medicine's widely-used NSAIDs and acetaminophen have the potential complications of renal and cardiac failure as well as liver damage. A study, published earlier this year online in the *BMJ*, concludes that NSAIDs significantly increase the risk of cardiovascular events in patients who take them regularly<sup>11</sup>.

Recent concerns by the CPSO about the prescribing or over-prescribing of opioid medications for chronic non-malignant pain have failed to address the issue of promoting non-pharmaceutical treatments such as acupuncture in order to avoid resorting to opioids for long term management of symptoms.

There are virtually no risks or complications with acupuncture in competent hands, hence we should encourage physicians to use and prescribe acupuncture, not discourage its use. Such a proactive policy would *really* protect the public.

#### **d) RCT Requirement for Performing Acupuncture**

There are some conditions for which there are RCTs to support acupuncture as well as meta-analyses, as referenced above. However, it is unrealistic to expect that every condition for which individuals seek treatment with acupuncture will have that kind of research behind it now or in the near future. Clinical research in acupuncture is difficult to do well, as is most research.

As mentioned above, I am the Principal Investigator on a multi-centre pilot study to test the validity of a protocol for neuropathic pain in spinal cord injury (SCI) that has been in continuous use at Lyndhurst Centre, one of five sites of Toronto Rehabilitation Institute (now part of UHN), since 1992. It has been used at GF Strong Rehabilitation Centre in Vancouver and Parkwood Hospital in London, ON since the mid 1990's and both centres are part of our study because they have observed that this treatment is effective in a high percentage of patients with burning pain post-SCI. It is a randomized clinical trial that is blinded (treatment blinded to assessor, outcomes blinded to treater) and utilizes a sham acupuncture protocol that involves needles with electrical stimulation on them.<sup>12</sup> I mention this to make the point that

<sup>3</sup> Berman BM, Lao L, Langenberg P, et al: Effectiveness of acupuncture as adjunctive therapy in osteoarthritis of the knee: a randomized, controlled trial. *Ann Intern Med* 2004; 141(12):901-10.

<sup>4</sup> Kwon YD, Pittler MH, Ernst E. Acupuncture for peripheral joint osteoarthritis: a systematic review and meta-analysis. *Rheumatology (Oxford)*. 2006 Nov;45(11):1331-7.

<sup>5</sup> Manheimer E, White A, Berman B, Forsy K, Ernst E. *Meta-Analysis: Acupuncture for Low Back Pain*. *Ann Intern Med*. 2005;142:651-663.

<sup>6</sup> Thomas KJ, MacPherson H, Thorpe L, et al. Randomized controlled trial of a short course of traditional acupuncture compared with usual care for persistent non-specific low back pain. *BMJ*. 2006 Sep 23;333(7569):623. (s)

<sup>7</sup> Haake M, Muller HH, Schade-Brittiner C, et al. German acupuncture trials (GERAC) for chronic low back pain: randomized, multicenter, blinded, parallel-group trial with 3 groups. *Arch Intern Med*. 2007 Sep 24;167(17):1892-98. (s)

<sup>8</sup> Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for migraine prophylaxis. *Cochrane Database Syst Rev*. 2009 Jan 21;(1):CD001218.

<sup>9</sup> Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for tension-type headache. *Cochrane Database Syst Rev*. 2009 Jan 21;(1):CD007587.

<sup>10</sup> Guzman J, Haldeman S, Carroll LJ, et al. Clinical practice implications of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders: from concepts and findings to recommendations. *Spine*. 2008 Feb 15;33(4 Suppl):S199-213.

<sup>11</sup> Trelle S, Reichenbach S, Wandel S. Cardiovascular safety of non-steroidal anti-inflammatory drugs: network meta-analysis *BMJ* 2011; 342:c7086

<sup>12</sup> <http://clinicaltrials.gov/ct2/show/NCT00523016?term=acupuncture+neuropathic+pain+spinal+cord+injury&rank=1>



I know of what I speak when discussing acupuncture research. It is very difficult to do and there are not unlimited funds available for such research, as there commonly are for pharmaceutical trials.

We think that restricting medical acupuncture doctors to treating only those conditions for which there is at least one positive RCT would deprive many patients of benefit that is otherwise not available to them. A good example is Chemotherapy-Induced Peripheral Neuropathy or CIPN. There is evidence of benefit from acupuncture for this horrible neuropathic condition that is caused by certain types of chemotherapeutic agents<sup>13</sup>. The co-authors of the referenced paper are radiation oncologists in Hamilton and on faculty at McMaster University.

A more recent study produced the following result:

“82% (n=14) of patients reported an improvement in symptoms following their course of acupuncture; one patient with advanced disease died during the 6 weeks. Some patients derived additional benefits from the treatment including a reduction in analgesic use and improved sleeping patterns.<sup>14</sup>”

**Conclusion** Although these results are encouraging, they are uncontrolled. They suggest that acupuncture could be an option for these patients and controlled trials using validated patient-reported outcome measures are justified.”

CIPN is an example of the type of cases we see in my clinic. We have had success in reducing CIPN in some of the few cases we have seen.

Another specific example of the harm that such a restriction would bring is two women, ages 64 and 55 with cerebral palsy who both have responded dramatically to scalp acupuncture. Their spasticity has been reduced to such a degree that the 64 year old can write with her right hand after having thought all her life that she was left-handed, because she could not use her more spastic right hand. Both can ambulate and balance better and following the second treatment, the 55 year old got her sense of smell back, 10 years after a brain injury had left her with worsened spasticity and anosmia (no sense of smell).

The same treatment has worked well in two cases of Parkinson’s Disease.

There are no controlled studies on this treatment for this purpose. It could be argued that these cases do not require an RCT, since the changes (apart from the ability to smell) are visible for all to see, as each person is her/his own control.

The Acupuncture Foundation of Canada Institute strongly objects to the rule in the draft policy that would require that there be an existing RCT to support treatment of whatever condition we wish to treat with acupuncture, on the above grounds. We will leave the strong objections to this part of the policy on more technical grounds to others to critique.

**Our critique of the policy itself will be from the perspective of medical practitioners of acupuncture.**

<sup>13</sup> Wong R, Sagar S. Acupuncture treatment for chemotherapy-induced peripheral neuropathy – a case series *Acupunct Med* 2006;24(2):87-91.

<sup>14</sup> Donald GK, Tobin I, Stringer J Evaluation of acupuncture in the management of chemotherapy-induced peripheral neuropathy *Acupunct Med* 2011;29:230-233 doi:10.1136/acupmed.2011.010025

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## 1) Providing Non-Allopathic Therapies

### i) *Clinical Competence: Knowledge, Skill and Judgment*

While we agree that “Physicians must always act within the limits of their knowledge, skill and judgment and never provide care that is beyond the scope of their clinical competence”, it is important to recognize that physicians can expand their knowledge beyond their basic training and develop expertise in a field that does not yet have a Royal College specialty designation. This can be accomplished through continuing education courses that are accredited through medical schools and other educational institutions and through years of clinical practice, using safe and effective approaches in a responsible and ethical way.

The key, and potentially contentious, issue is the question of who is to judge one’s clinical competence. Depending on RCPS specialists to judge the competence of someone who is well-trained in a new and emerging field, just because it seems to conflict with the accepted paradigm of a particular specialty, can create turf wars that are not productive and is inconsistent with the Brett decision, which legitimized alternative and complementary approaches to diagnosis and treatment when they are supported by a “minority opinion” that is both “competent and responsible”.<sup>15</sup>

An important determinant of acceptability of new approaches should be positive patient outcome, the value of which has been denigrated in the past by a CPSO Registrar. That attitude is not in keeping with the college’s current vision to “recognize and acknowledge our role and responsibility in attaining at a personal, professional, and at a system-level, the best possible patient outcomes”.

### ii) *Clinical Assessment and Diagnosis*

The policy regarding Clinical Assessments is in keeping with the way I conduct my practice and I expect the same of all medical practitioners who use acupuncture.

However, the section on diagnosis is a bit unrealistic in saying that one “must reach an allopathic diagnosis”, since some chronic pain patients and others with medical complaints cannot always be diagnosed by conventional means.

Having said that, I also know that there are techniques and tests available that can provide one with a useful diagnosis that is not a standard allopathic diagnosis but serves one well in improving the patient’s symptoms. In the case of acupuncture, that would include a traditional Chinese diagnosis based on the paradigm of Traditional Chinese Medicine (TCM), which is very useful when dealing with impossible-to-diagnose-by-western-medicine conditions. While knowing the anatomical/pathological diagnosis in western medical terms of a chronic pain problem is helpful when using acupuncture on an anatomical basis, that is not the case when dealing with internal medicine problems that require a more traditional acupuncture approach.

A standard lab test that is very useful in many cases of chronic pain, joint pains, weakness of muscles and depression is the 25OHD3 test for low vitamin D levels that can be the basis for the chronic problem. That is a test that is not done by most physicians but can provide a diagnosis where there was none.

The following section of the policy presents a difficult situation for acupuncture:

If physicians also form a non-allopathic diagnosis, such diagnosis must be objectively justifiable, based on the clinical assessment conducted and other relevant information available to the

physician.

Since this refers specifically to a ‘non-allopathic’ diagnosis, I think that, with respect to acupuncture, it would be impossible to comply with this directive. “Objectively justifiable”, with respect to traditional techniques that we may depend on to a greater or lesser extent, such as tongue diagnosis (a fascinating observation of the Chinese that there are correlations between the appearance of the tongue and the medical condition of the patient) and pulse diagnosis (dependent on taking the pulse in a particular way) are both transitory and subjective. I personally do not depend on them, but often look at the tongue because I am interested in the correlations with health (recalling that my family doctor always looked at my tongue when I was young, knowing that if it looked normal I might be feigning illness or I might be dehydrated if it had another appearance).

The second part of that section of the policy,

A demonstrable and reasonable connection, supported by sound clinical judgment must exist between the condition or symptoms for which the patient is seeking care, and the non-allopathic diagnosis reached,

will be possible to comply with, as long as it is accepted that ‘supported by sound clinical judgment’ includes the clinical judgment of TCM, something that a physician trained in acupuncture can gain through study and clinical practice.

NOTE: it is possible to use acupuncture to good effect without making a full TCM diagnosis, particularly with respect to the treatment of pain.

### **Therapeutic Options**

The requirement “to propose both allopathic and non-allopathic therapeutic options that are clinically indicated or appropriate” is often a moot point, since prior to seeking help with acupuncture, patients have usually tried most or all of the ‘allopathic’ options and often several other options as well, such as massage therapy, chiropractic, physiotherapy and even acupuncture.

If “propose” means that we must suggest allopathic options that we know to carry a much higher risk of harm than acupuncture, then our medical ethics would require us to break this rule. If the idea is that the patient must make the decision to choose which he/she prefers, in the case of a referral practice that is crystal clear, since that is why they come. In the case of primary care physicians trained in acupuncture, this expectation of them is not unreasonable, in my view, but the key word here is still “propose”. This clause is confusing, to say the least.

The last part of this section is one of the most contentious parts of this proposed policy:

Those options that pose greater risks than a comparable allopathic treatment or that will impose a financial burden, based on the patient’s socio-economic status, must be supported by evidence obtained through a randomized clinical trial that has been peer-reviewed.

The proposal that a CIM treatment “that will impose a financial burden, based on the patient’s socio-economic status, must be supported by evidence obtained through a randomized clinical trial that has been peer-reviewed” can be challenged in many ways, not the least of which is that if this applies only to those who cannot easily afford to pay for treatment or have insurance to pay for it, we are being asked to set a different standard for the rich and the poor. Are you suggesting that we apply a means test to everyone we see? This clause appears to eliminate the opportunity for getting help with acupuncture based on economic status and is discrimination that might be challenged under the Charter of Rights and Freedoms. To comply with this requirement would be a breach of ethics and I, for



one, would not comply.

The rule, **Physicians must never propose therapeutic options that have been proven to be ineffective**, begs the question “Proven by whom and by what means?” When it comes to acupuncture, there have been some meta-analyses that have been based on a low number of studies of low quality but have declared acupuncture to be useless for a particular condition anyway. The most egregious of these was a Cochrane review meta-analysis of acupuncture for rheumatoid arthritis (acupuncture alone is not a reasonable approach to treating RA; Chinese herbs must be part of the treatment) that was based on two RCTs; remarkably, it included a study in which one needle into a single point was purported to be a treatment for RA. No one who knows anything about acupuncture would accept that as a fair trial, yet it appeared in a Cochrane Review in 1999<sup>16</sup>.

Dr. Alejandro Jadad, of the universally-accepted *Jadad Scale* to evaluate the quality of studies told me himself that the scale that he devised was not adequate to judge acupuncture studies because many did not divulge what the treatment had been.

We have seen conclusions on the efficacy of acupuncture for various conditions move up the ladder from ‘not recommended’ to ‘safe and effective’ based on meta-analyses that changed over the years as more good evidence came on stream. This was true of acupuncture for low back pain and also for headaches, to name two. We have also seen two teams who did meta-analysis on virtually the same studies on low back pain come to different conclusions, which raises questions of bias, either for or against.

The next rule:

**If the effectiveness of a therapeutic option or associated risks is unknown, the College expects physicians to proceed in a cautious and ethical manner. Physicians are encouraged to consult with a teaching hospital or an academic facility to discuss the possibility of convening a research ethics board to oversee the clinical trials of the therapeutic option,**

is ludicrous in the case of acupuncture. To expect a person suffering with pain to wait five years to be sure it’s reasonable to try it while an RCT is done on acupuncture treatment that has virtually no risk is patently absurd. Furthermore, it is unethical.

I am sure that others will remind the committee that there are all kinds of evidence that the experts consider to be sound; RCTs are not perfect and they are difficult to do well. Since pharmaceutical agents can have lethal side effects, a system to rigorously test them had to be developed and the placebo-controlled RCT became the ‘gold standard’ for testing them. It could be argued that acupuncture, being as safe as it is, does not require scrutiny of the same order as drugs. That is not to suggest that research not be done on acupuncture, just to suggest that thought should be given to more suitable ways to test its efficacy.

### **Informed Consent & Communication**

The rule requiring consent is not contentious, apart from the clause that stipulates that the following must be conveyed to the patient:

- **whether the therapeutic option is supported by the allopathic medical community, along with the**

<sup>16</sup> Casimiro L, Barnsley L, Brosseau L, Milne S, Welch V, Tugwell P, Wells GA. Acupuncture and electroacupuncture for the treatment of rheumatoid arthritis. Cochrane Database of Systematic Reviews 2005, Issue 4. Art. No.: CD003788. DOI: 10.1002/14651858.CD003788.pub2.

level of support provided by the non-allopathic medical community;

This is not feasible, since one could not possibly have that information.

The second part:

- a description of how the therapeutic option compares to allopathic interventions that would be offered to treat the same symptoms or condition (comparison of risks, side effects, therapeutic efficacy, etc.).

would be feasible in instances where there are studies comparing acupuncture to 'usual treatment'. It is not unreasonable to expect physicians who use acupuncture to be cognizant of the current clinical literature and to be able to provide that information.

### Summary

With all due respect, this draft policy appears to have been crafted with the objective of limiting Ontario physicians' professional prerogative to introduce and utilize innovative approaches like acupuncture in their practices.

It would be a sad irony if patient-centred physicians were driven from Ontario to more forward-thinking provinces or the USA, should this draft become policy.

We believe that, aside from shunning bogus therapies and fraud, physicians must have the freedom to embrace a broader context of health care or we will become non-credible.

There is no valid excuse for the committee to have not included in the development of this policy members of the Section on Complementary and Integrative Medicine of the Ontario Medical Association and the Ontario Society of Physicians for Complementary Medicine (OSPCM). The executives of both bodies are respected physicians with, collectively, at least a century of experience in areas of medicine that help without harming and enable individuals whose chronic problems cannot be alleviated by mainstream medicine to safely get relief and comfort.

The Acupuncture Foundation of Canada Institute recommends that this policy be rethought and re-crafted in collaboration with physicians experienced in complementary and integrative medicine.

We would be pleased to offer you our help in developing a policy that will both protect the Ontario public and advance the practice of medicine locally and globally.

Yours truly,



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