



Non-Allopathic (Non-Conventional) Therapies in Medical Practice (formerly, Complementary Medicine)

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Legislative References: *Health Care Consent Act*, 1996, S.O. 1996, c.2, Sched. A.; *Medicine Act*, 1991, S.O. 1991, c.30; O. Reg. 114/94 *General*, O.Reg. 856/93 *Professional Misconduct*, O.Reg. 865/93, *Registration*, enacted under the *Medicine Act*, 1991, S.O. 1991, c.30.

Reference Materials: CPSO, *Practice Guide: Medical Professionalism and College Policies*; CPSO, *Consent to Medical Treatment* policy; CPSO *Medical Records* policy; CPSO, *Changing Scope of Practice* policy; *Oath of Hippocrates*. In: Harvard Classics, Volume 38. Boston: P.F. Collier and Son, 1910.

Introduction

In increasing numbers, patients are looking beyond allopathic medicine to non-allopathic therapies for answers to complex medical problems, strategies for improved wellness, or relief from acute medical symptoms. Patients may seek advice or treatment from a range of health care providers, including Ontario physicians.

The College supports patient choice in setting treatment goals and in making health care decisions, and has no intention or interest in depriving patients of non-allopathic therapies that are safe and effective. As a medical regulator, the College does however, have a duty to protect the public from harm. Thus, the object of this policy is to prevent unsafe or ineffective non-allopathic therapies from being provided by physicians, and to prohibit unprofessional or unethical physician conduct in relation to these therapies.

This object is achieved through clear statements of expectation for physician conduct, which are grounded in the profession's commitment to ethical and professional conduct and the pursuit of clinical excellence. This is a commitment the College expects all physicians to embody in their practice, everyday.

45 This policy addresses issues that are relevant in the context of non-allopathic therapies. However, physicians are expected to comply with all of their legal, professional and ethical obligations and are advised to consult additional College policies, the *Practice Guide*¹, and other resources as necessary.

Terminology

50 ***Allopathic Medicine***²: refers to the type of treatment, diagnostic analysis and conceptualization of disease or ailment that is the primary focus of medical school curricula and which is generally provided in hospitals and specialty or primary care practice.

55 ***Non-Allopathic Therapies (Non-Conventional Therapies)***: refers to a broad range of procedures or treatments that are not commonly used in allopathic medicine;³ this includes those referred to as **complementary** or **alternative**. Non-allopathic therapies tend to differ from allopathic medicine in terms of diagnostic techniques, theories of illness and disease, and treatment paradigms. The categorization of specific therapies as non-allopathic is fluid: as clinical evidence regarding efficacy is accumulated, certain non-allopathic therapies may gain broad acceptance and thus be accepted in allopathic medicine.

60 Principles

In accordance with the *Practice Guide*, the professional expectations in this policy are based on the following principles:

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1. Act in patients' best interests, in accordance with fiduciary duties;
 2. Respect patient autonomy with respect to health care goals, and treatment decisions;
 3. Communicate effectively and openly with patients and others involved in the provision of health care;
 4. Maintain patient trust through a commitment to altruism, compassion and service.

70 Scope

This policy applies to physicians who provide non-allopathic therapies, physicians whose patients pursue non-allopathic therapies, and physicians who form professional affiliations with non-allopathic clinics, therapies, or devices.

¹ *The Practice Guide: Medical Professionalism and College Policies*, CPSO:
<http://www.cpsso.on.ca/policies/guide/default.aspx?id=1696>

² Also referred to as 'conventional medicine'.

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.

75 **Policy**

The College expects that when acting in a professional capacity, physicians do so competently, in accordance with their legal, ethical and professional obligations.

80 This policy sets out general expectations for physician conduct, based on broad principles of ethics and professionalism. It also sets out specific expectations, tailored to three unique contexts of physician involvement in non-allopathic therapies contemplated in this document.

A. General Expectations for Physician Conduct

85 The general expectations for physician conduct expressed in this section mirror existing obligations contained in the CPSO's *Practice Guide*, and the Hippocratic Oath⁴.

Grounded in principles of ethics and professionalism, these expectations translate into specific obligations for physician conduct: obligations to respect patient autonomy, to act in patients' best interests, to refrain from exploiting patients, and to avoid conflicts of interest.

90 These principles and obligations are broadly applicable to all medical practice. They are highlighted here to underscore their relevance and application to non-allopathic care since they will have particular importance to this area of medicine.⁵

i) Respect Patient Autonomy

95 Patients are entitled to make treatment decisions and to set health care goals that accord with their own wishes, values and beliefs. This includes decisions to pursue or to refuse allopathic or non-allopathic therapies.

100 The College expects physicians to respect patients' treatment goals and decisions, even those which physicians deem to be unfounded or unwise. In doing so, physicians should state their best professional opinion about the goal or decision, but must refrain from expressing *non-clinical* judgements.

ii) Act in Patients' Best Interests

105 When acting in a professional capacity, physicians must always be motivated by a regard for what is best for the patient. This expectation applies equally to situations in which physicians are treating patients, and situations where physicians may not have an identifiable patient, but are affiliated with a clinic, therapy or device.

⁴ *Oath of Hippocrates*. In: Harvard Classics, Volume 38. Boston: P.F. Collier and Son, 1910.

⁵ Characteristics of non-allopathic care, including the experimental nature of some therapies, the fact that many therapies are privately funded, and that patients may pursue treatment as a matter of last resort, suggest that these principles and obligations will be relevant.

iii) *Refrain from Exploitation*

Exploitation occurs when a physician, in his or her professional capacity, dominates and influences patients to further the physician's own personal interests.⁶

110 Exploitation is an abuse of power, and is directly contrary to the profession's commitment to altruism and beneficence. It undermines the trust and confidence individuals and the public at large have in the medical profession and is never acceptable.

iv) *Avoid Conflicts of Interest*

115 Conflicts of interest may occur when physicians obtain a personal benefit from interactions with patients. Physicians are expected to avoid situations in which their own personal interests may conflict with their duties to their patients.⁷

This includes refraining from charging excessive fees for services or products⁸, and refraining from advocating for the preferential use of treatment options or products that will generate a personal benefit for themselves-financial or otherwise.

120 **B. Specific Expectations for Physician Conduct**

125 In addition to the general expectations above, the College has specific expectations for physician conduct which relate to the three physician roles contemplated in this policy: providing non-allopathic therapies; treating patients who use non-allopathic therapies, and forming professional affiliations.

1) Providing Non-Allopathic Therapies

130 When providing non-allopathic therapies, physicians are expected to demonstrate the same commitment to clinical excellence and ethical practice, as they would when providing allopathic care.

i) *Clinical Competence: Knowledge, Skill and Judgement*

Physicians must always act within the limits of their knowledge, skill and judgement⁹ and never provide care that is beyond the scope of their clinical competence.¹⁰

⁶ *Norberg v. Wynrib*, [1992] 2 S.C.R. 226.

⁷ See O.Reg. 114/94 *General*, Part IV, Conflicts of Interest, and O.Reg. 856/93 *Professional Misconduct*, enacted under the *Medicine Act*, 1991, S.O. 1991, c.30.

⁸ Section 1(1), paragraph 21, O.Reg. 856/93 *Professional Misconduct*, enacted under the *Medicine Act*, 1991 S.O. 1991, c.30.

⁹ Section 2(5), O.Reg. 865/93, *Registration*, enacted under the *Medicine Act*, 1991, S.O. 1991, c.30; *Changing Scope of Practice* policy: <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1622>; *Practice Guide*, see note 1.

¹⁰ This expectation applies to all non-emergent situations. In emergency situations, physicians may be permitted to act outside their scope of expertise in some circumstances. See the *Physicians and*

135 This expectation applies equally to treatments or therapies that the physician proposes and those that may be requested directly by patients. Where patients seek care that is beyond the physician's clinical competence, physicians must clearly indicate that they are unable to provide the care. Physicians should consider whether a referral can be made to another physician or health care provider for care the physician is unable to provide directly.

140 ii) *Clinical Assessment and Diagnosis*

When assessing patients and forming a diagnosis, physicians are expected to act in accordance with the standards of allopathic medicine.

Clinical Assessments

145 To act in accordance with the standards of allopathic medicine, physicians providing non-allopathic care must ensure that clinical assessments they conduct involve taking a complete patient history, and performing any necessary medical or laboratory examinations or investigations that are required to obtain relevant and comprehensive information about the patient's ailment or condition.

150 There may be some instances in which the patient has seen other health care practitioners for the same ailment, and has had a clinical assessment completed. Physicians may not have to conduct their own independent assessment in these circumstances, provided they have reviewed the previous assessment and have determined that it meets the standards of allopathic medicine. Should physicians have any doubts in this regard, the College expects them to err on the side of caution
155 and complete their own clinical assessment.

Diagnosis

To act in accordance with the standards of allopathic medicine, physicians providing non-allopathic care must reach an allopathic diagnosis.

160 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.

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

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iii) *Treating the Patient: Therapeutic Options and Informed Consent*

170 Although consent is an important and necessary requirement to authorize therapeutic intervention, consent alone will not discharge the sum total of physician obligations that are applicable at this phase of the health care encounter. Physicians must also comply with the expectations relating to therapeutic options set out below.

Therapeutic Options

Physicians are expected to propose both allopathic and non-allopathic therapeutic options that are clinically indicated or appropriate.

175 Any non-allopathic therapeutic options that physicians propose to patients must:

- have a demonstrable and reasonable connection, supported by sound clinical judgement, to the diagnosis reached;
- possess a favourable risk/benefit ratio, based on the merits of the option, the potential interactions with other treatments the patient is receiving, and other considerations the physician deems relevant;
- take into account the patient's socio-economic status when the cost will be borne by the patient directly; and
- have a reasonable expectation of remedying or alleviating the patient's health condition or symptoms.

185 Reasonable expectations of efficacy must be supported by sound evidence. The type of evidence required will depend on the nature of the therapeutic option in question, including, the risks posed to patients, and the cost of the therapy. 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.

Physicians must never propose therapeutic options that have been proven to be ineffective.

195 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.

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Informed Consent & Communication

205 Before providing non-allopathic therapies to patients, physicians must obtain consent, in accordance with the legal and policy requirements set out in the *Health Care Consent Act, 1996*¹¹ and the *Consent to Medical Treatment* policy¹².

In addition, the College expects that through the consent process, physicians will convey the following to patients:

- the physician's rationale for recommending the therapeutic option in question;
- reasonable expectations about the clinical efficacy of the therapeutic option;
- 210 • whether the therapeutic option is supported by the allopathic medical community, along with the level of support provided by the non-allopathic medical community; and
- a description of how the therapeutic option compares to allopathic interventions that would be offered to treat the same symptoms or condition
- 215 (comparison of risks, side effects, therapeutic efficacy, etc.).

The details of the consent process, including the above information should be documented in the patient's medical record.

220 When communicating with patients about therapeutic options, physicians must always provide patients with accurate and objective information. They must never inflate or exaggerate the potential therapeutic outcome that can be achieved, misrepresent the proven benefits of allopathic care or make claims regarding therapeutic efficacy that are not substantiated by evidence.

225 Clinical concerns must always be highlighted, however physicians must refrain from expressing personal non-clinical judgements or comments about the therapeutic options, or the patient's health care goals or preferences unless that input is specifically requested by the patient.

2) Treating Patients who pursue Non-Allopathic Therapies

230 Physicians in allopathic practice should be alert to the reality that their patients may be pursuing non-allopathic therapies from other practitioners, or may seek their advice about these therapies.

¹¹ *Health Care Consent Act, 1996*, S.O. 1996, c.2, Sched. A.

¹² Available online at: <http://www.cpsso.on.ca/policies/policies/default.aspx?ID=1544>. Physicians are reminded that this policy articulates consent requirements pertaining to medical treatment. Separate obligations will apply when patients are consenting to medical research. The College recommends that physicians seek the guidance of their legal counsel or the CMPA for further detail.

i) Patient Use of Non-Allopathic Therapies & Documentation

235 In order to provide safe, high quality allopathic care, physicians must have complete, accurate information about their patients. This includes information about any non-allopathic therapies patients may be pursuing.

240 The College advises physicians to inquire about patient use of non-allopathic therapies on a regular basis. This might involve incorporating questions about non-allopathic therapies into annual health exams, and/or patient assessments for specific health conditions or ailments.

Where patients are pursuing non-allopathic therapies, physicians should note this fact in the patient's medical record, along with any details of the therapy the patient is able to provide.

ii) Discussing Non-Allopathic Therapies

245 When asked for information about non-allopathic therapies, physicians must respond in a professional manner, within the limits of their knowledge, skill and judgement.

250 Where physicians are unfamiliar with the non-allopathic therapy in question, they must indicate as much to the patient, and explain that they are consequently unable to comment on the matter. Physicians may wish to consider whether they can assist patients in obtaining information. This may involve suggesting potential resources¹³, or referring patients to other practitioners.

iii) Implications for Allopathic Therapeutic Options

255 The College does not expect allopathic physicians to be knowledgeable about every non-allopathic therapy their patients may be pursuing or about which they may inquire.

260 If physicians are aware that a patient is receiving non-allopathic therapies, they must weigh this fact when determining which allopathic therapeutic options may be suitable. In particular, physicians must consider whether any potential negative interactions may arise between the allopathic treatment and non-allopathic therapy and take reasonable steps¹⁴ to ensure that by recommending allopathic treatment, the patient's health or clinical outcome will not be compromised due to a negative or otherwise adverse reaction between allopathic and non-allopathic care.

Where physicians have been unable to determine conclusively whether the potential exists for negative or adverse interactions between allopathic and non-allopathic

¹³ This may include directing patients to journal articles, scientific studies and/or websites or providing them with more general resources, such as the contact information of regulatory colleges which govern practitioners of the desired therapy.

¹⁴ Reasonable steps may include conducting basic research into the matter, or consulting with the non-allopathic practitioner, with the patient's consent.

265 care, they must communicate this to the patient, and include a corresponding notation in the patient's medical record.

3) Professional Affiliations

There may be circumstances where physicians are asked to form a professional affiliation with a non-allopathic clinic, therapy or device.

270 Physicians should be aware that patients might equate the affiliation with a professional endorsement of efficacy or safety.

As such, before physicians form a professional affiliation, they must critically assess the clinical basis for the care offered by the clinic, or the therapeutic benefit to be obtained from the therapy or device. Professional affiliations must only be formed if:

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- physicians are satisfied on the basis of evidence, and sound clinical judgement that the proposed care or health benefit is safe or at minimum, is not more risky than comparable allopathic interventions; and
 - there is a reasonable expectation that the care provided will be clinically effective.

280 If physicians have met these requirements, and proceed to form a professional affiliation, they must ensure that any advertising materials accord with the requirements in regulation.¹⁵

¹⁵ See section 6 of O.Reg. 114/94 *General*, enacted under the *Medicine Act, 1991*, S.O. 1991, c.30.