September 8th 2011

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College of Physicians and Surgeons of Ontario
Chair - CPSO Working Group,
Policy on Complementary Medicine

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

Dear Dr. Thurling:

The committee for the revision of Complementary and Alternative Medicine policy for the CPSO has asked for comments regarding the second draft of the new policy. Please find my comments below:

Background

I have practised complementary and alternative medicine since , after graduating from years in family medicine residency and moving into a practice which was then called "Holistic Medicine". During the ensuing years of practice I engaged in a number of training programs including acupuncture, various types of psychotherapy, and innumerable courses in clinical and nutritional biochemistry. In fact, I have over 2000 hours of training outside of my orthodox medical training, which amounts to approximately 10 days of training for every year that I have practised. In the 1980s I headed up and had a variety of opportunities to present and make comments to the CPSO on a number of topics and issues related to CAM. I am also a published author in the area of CAM.[1,2,3]

Introduction

I must say that when I read the draft policy for the new complementary and alternative medical policy I was shocked by its tenor which appears to be one of antagonism and presumption. The Committee needs to understand that the training undertaken by medical doctors who choose to practise complementary and alternative medicine is **in addition to** and indeed complementary to the orthodox/conventional medical training that we receive at medical school. We have not "thrown out the baby with the bathwater". We have not cast aside what we have learned in medical school; we have simply shifted paradigms and in doing so have broadened our concept of the healing process. There are significant flaws that need to be corrected in this policy if you seriously expect physicians to follow its recommendations. I will comment only on the ones that I think that are most important.

Body of Comments

1. In the first place, changing the name from complementary and alternative medicine policy to "non-allopathic" or "non-conventional" is entirely unacceptable. To be referred to as "not something" sets a tone in this policy that is confusing at best and at worst dismissive, perhaps even akin to racial profiling if you substitute the word 'race' with 'physician'[4]. As someone recently pointed out to me this is somewhat parallel with being called "non-Christian" - personally I don't want to be labelled as "non-" anything. The term "Complementary and Alternative Medicine" (CAM) is well known by the public, the profession, and most people accept this as being a reasonable term that has stood the test of time. It should be kept by the CPSO policy makers. In any event the description non-allopathic is inaccurate. The term "allopathic" is generally used in contrast to "homeopathic". Homeopathic means a substance that causes similar symptoms to the one's that the patient is experiencing, which can be reversed by serial dilution of that substance. So to use the term allopathic to contrast it with everything else is inaccurate**. Accuracy of terms is of great importance to the CPSO because it is a legal body and these definitions and nominalizations must stand up in court if necessary.** The argument against using the term non-allopathic is also supported by the fact that some complementary therapies are also allopathic such as bio-identical hormones used to treat symptomatic hormone deficiency, and supplements such as folic acid and S-adenosylmethionine to treat depression. The Committee has used the following reference to support its decision to use the term 'non-allopathic' yet nowhere in this reference is the term used![5] The author of the draft appears to have substituted the terms allopathic and non-allopathic in place of CAM presumptuously at best.

2. It appears that the spirit of the new draft policy is not in keeping with the comments by both Drs. Mercer and Gerace made in the December 2006 issue of "Dialogue" [6] for the following reasons. The Committee states:

> *The general expectations for physician conduct expressed in this section mirror existing obligations contained in the CPSO's Practice Guide[7], and the Hippocratic Oath. 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. 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****. (my emphasis) (CPSO footnote: Characteristics of non-allopathic care, including the experimental nature of some therapies, the fact that many*

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[4] "..."racial profiling" is any action undertaken for reasons of safety, **security or public protection that relies on stereotypes** about race, colour, ethnicity, ancestry, religion, or place of origin, or a combination of these, **rather than on a reasonable suspicion, to single out an individual for greater scrutiny or different treatment**. Typically but not always, **profiling is carried out by persons in positions of authority**, and can occur in many contexts involving safety, security and public protection issues. From Ontario Human Rights Commission (emphasis mine) http://www.ohrc.on.ca/en/resources/factsheets/whatisracialprofiling

[5] 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.

[6] *"We are of the view that alternative care is an integral part of the health-care system. Patients should be able to choose the type of health provider from whom they wish to receive health care. In addition, we are supportive that a health system based on* ***collaborative care amongst health professionals*** *is in the best interests of the patient."* (my emphasis)

therapies are privately funded, and that patient may pursue treatment as a matter of last resort, suggest that these principles and obligations will be relevant.)

The argument for re-iterating what is contained in the CPSO's Practice Guide seems to be based on the concept that **CAM physicians** are somehow **different from regular conventional physicians** in that they are more likely to make 'non-clinical judgements' (Line 100 ff.), have more conflict of interest (Line 105 ff.), and exploit, dominate and influence patients to further their own personal interests, as well as charge excessive fees (Line115 ff.), than their conventional counterparts. Once again the Committee seems to be of the opinion that CAM physicians, perhaps simply by choosing to practice differently, may have lost their ethical, fiduciary, and moral marbles. If the CPSO has evidence for this I should certainly like to be privy to that evidence, **before** the Committee makes the mistake of further insulting and profiling us in a public policy! I doubt they can or will provide it. One can hardly call this 'collaborative' as Mercer and Gerace are quoted.

3. **Regarding Line 132 ff.:** *Physicians must always act within the limits of their knowledge, skill and judgement and never provide care that is beyond the scope of their clinical competence. 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. (my emphasis)*

   This appears to be an extension of the *Policy on Physicians and Health Emergencies* and the paragraph *"Practising Outside of Scope of Practice."* [8] However it is not clear from this draft policy what is meant by the phrase in emphasis above. Is the policy suggesting that this **clinical competence is to be determined by allopathic standards or CAM standards?** For example, if the patient has chronic allergies and the CAM physician is trained in complementary allergy treatments and treats the patient because the patient has had no success with standard allergy treatments provided by a conventional allergist, would the CAM physician be considered to be acting 'beyond their level of competence' because they are not 'an allergist'?
   To be equal and fair I must ask and so should the Committee ask itself - **does the converse apply?** So, when a patient of an 'allopathic' physician cannot provide care due to lack of competence in that area (for example the patient is requesting 'complementary' care for their allergies because the treatment has not worked), must they clearly indicate that they are unable to provide the care? Must, for example, conventional physicians consider whether a referral can be made to another CAM physician for care the allopathic physician is unable to provide directly? An answer to this question by the committee is imperative to avoid the misapprehension of bias. There are several aspects of this part of the policy that are confusing and need

[8] In non-emergency situations, there are clear expectations around scope of practice. A physician must practice only in the areas of medicine in which the physician is educated and experienced. CPSO Policy Number 2-09

clarification – particularly, how are the standards for determining CAM competence to be measured?

4. **Re Line 185 ff.:** *Physicians must never propose therapeutic options that have been proven to be ineffective. 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. 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.*

The content of this set of proposals, particularly the first sentence, **provides no guidelines as to how such effectiveness is to be measured.** The implication is that perhaps, as in line 190, an RCT must be utilized. The ludicrousness of this suggestion is immediately obvious when you consider that most 'allopathic' treatments have never been subjected to such evidence, e.g. surgery and cancer therapies, as well as whether parachutes work to prevent death and trauma![9] So why would you ask this of CAM physicians? Again, I also have to ask – **does this proposal also apply to allopathic physicians**? Is it professional misconduct for allopathic physicians to recommend, for example, OTC cold remedies or antibiotics for viral illness – the former 'proven' to be ineffective, and the latter known to be useless and harmful in such illnesses? Only the blind cannot see the double standard you are unveiling here. Holding CAM practitioners to a higher standard that the profession as a whole is discriminatory.

That aside, common medical knowledge recognizes 4 levels of evidence as follows:

Hierarchy of Study Design	Strength of Evidence
I Systematic Reviews & Meta-analysis of Controlled Trials	Strong
II Randomized Control Trials	Strong
III Non- randomized intervention studies (pre-post study design; matched controls; time series)	Moderate
IV Observational studies (cohort studies; cross sectional, retrospective study designs)	Low
V Non-experimental designs (case reports; qualitative research)	Very low
VI Expert Opinion; reports of Expert Committees	Very low

Surely other levels of evidence must also apply, especially given the very strong arguments made by many authors that the RCT is not always the best form of

[9] Smith GC, Pell JP: Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomised controlled trials. BMJ 2003, 327:1459-1461

evidence[10], and because carrying out RCTs for 'proving' CAM treatments is not only practically impossible, it is inherently non-financeable – no one wants to finance treatments that are not patentable. Furthermore the structure of RCTs ignores the very tenets of CAM philosophy - **that each person is an individual with individual biochemistry, neurology and epigenetics, and therefore not subject to group averaging and diagnostic categorization that blurs individuality and confounds outcomes. RCTs were designed to test medications, not people.**

I have only touched on what I consider to be the most important aspects of the CAM Draft Proposal. Below are my recommendations for changes in the policy.

1. **Keep the term Complementary and Alternative Medicine and remove references to 'non-allopathic'.**
2. **CAM physicians are doctors too – treat us with the same respect you treat other physicians. Be inclusive, and require all physicians to have the same standards applied to them. This will serve both the patients and doctors who treat them.**
3. **Publish a policy that is non-discriminatory, has clear guidelines that are practical and helpful, and that authentically helps us all to work together towards a collaborative healing art and science.**
4. **Recognize evidence other than RCTs as measures of efficacy, and please clarify exactly what measures will be used. We must know exactly what is expected of us.**
5. **Outline a policy that is enforceable – an unenforceable policy is worse than no policy at all.**
6. **Consider reverting to the original CAM policy from 2004.**

Respectfully submitted:

[10] In summary, over-reliance on RCTs a) has been influenced in part by market pressures relevant to pharmaceutical companies, b) was stimulated significantly by the 1962 amendments to the American Food, Drug, and Cosmetic Act, and c) is not scientifically sound. As Parker stated (p. 971) [1], "...it seems imprudent to assume that one type of methodology provides the only path to knowledge." There are alternatives to depending solely on RCTs, especially from the perspective provided by the Hill criteria, which enable us to more fully evaluate treatments in health care. Kaplan et al.: Evaluating treatments in health care: The instability of a one-legged stool. BMC Medical Research Methodology 2011 11:65.