Feb 11, 2021

OMA Complementary and Integrative Medicine Medical Interest Group

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Re: Proposed changes for the CPSO CAM Policy

Dear CPSO,

The OMA's Complementary and Integrative Medicine Medical Interest Group (CIM MIG) represents the **largest group of physicians in Ontario** who chose to focus their medical practice on complementary and integrative health. We have formed a task force comprised of some of our executive and leading members to respond to the CAM policy draft. We represent our CIM MIG members who are passionate about the comprehensive approach to medical care we offer to our patients as well as advocating for awareness and education on the nature of our integrative medicine practices among our conventional colleagues. We respectfully ask that special attention be given to our recommendations in this document since the policy applies, in particular, quite extensively and profoundly to the work that our group does as physicians.

We fully support the policy's goal to **strike the right balance** between patient safety with patient autonomy and medical innovation. Additionally, we are pleased to see the following improvements in the new proposal:

- **Softening of some of the derogatory and presumptuous language** in the previous version of the policy around "refraining from exploitation" of patients.
- Accepting the possibility of **undifferentiated illnesses** when a conventional diagnosis cannot be made (policy line 100, fine print at bottom of page)
- An informative description in the Physician Advice document on **weighing the nature of evidence** supporting the use of a given therapy with the inherent level of risk of that therapy when considering the use of off-label medications or complementary therapies. This strategy is exactly in line with the "right touch" approach adopted by the college as well as common sense when weighing a risk benefit decision to incorporate a particular treatment.

Despite these advances we would again like to highlight 5 particular areas of concern. The draft policy makes several ambiguous recommendations which, depending on how they are interpreted, may severely affect a physician's ability to offer a range of safe and effective CAM therapies, and our patients' ability to access care that they need and want. This letter outlines the rationales behind our recommendations for change and we have also provided an executive summary of our recommendations at the end of this document.

1) Overall Tone and Language

a. Patient Exploitation vs Vulnerability

We applaud the college for softening some of the language in this section and for shifting the focus to "patient vulnerability". However the ongoing requests to "refrain from patient exploitation" (policy lines 125-128, advice lines 112, 195) still invoke a **hostile and untrusting attitude towards physicians using CAM,** as if such physicians are, in particular, malevolent or more likely to exploit their patients. Furthermore, by citing factors that can make a patient vulnerable to exploitation, such as "potential financial hardship" or "suffering from a serious, life threatening / terminal illness" (policy lines 133-136), physicians using CAM treatments are open to scrutiny simply because they provide care to the poor or very ill. This cannot be a desired outcome for the healthcare system.

We **agree** that prevention of patient exploitation is a crucial aspect of our medical profession, however we **disagree** that this material be explicitly described in the CAM policy. **Refraining from patient exploitation is relevant to ALL physicians and is already part of the whole profession's Code of Conduct**. The college **must** reconsider the explicit referencing of patient exploitation by physicians practicing CAM. We strongly recommend the policy instead refer to the general Physician Code of Conduct and modify the Code of Conduct as required to address patient vulnerability.

b. Health Risks

The advice document also contains text that **portrays inaccurate, unprofessional and unfair biases against complementary and alternative medical practices as being inherently dangerous**. The text refers to media reports, which sensationalizes the "serious risks" of CAM, to invoke fear among conventional physicians. It is unfairly critical of CAM therapies without any reference to the risks and harms of conventional medications and therapies we all consider to be the standard of care. The text currently reads:

> "Cases have been widely reported in the media where the administration of a treatment as an alternative to a more effective medical treatment has contributed to a patient's death. These risks are serious and need to be considered carefully in line with the values and principles of medical professionalism and the expectations set out in the policy" (Advice document lines 69-80)

We **agree** that there are unique health risks inherent to CAM therapies but we **disagree** with the way they are portrayed in this biased and sensationalized manner in this paragraph. This section **must** remove the sensationalized sentence. We recommend it instead reflect a more balanced, reflective and honest tone towards the risk benefit analysis as it applies to patient care. For example:

> *There are two important considerations pertaining to the risks associated with CAM:*

- *1) Complementary therapies are not inherently safe or without risks just because they may be considered to be more "natural".[1] While many therapies may pose little risk, others have the potential to present life-threatening risks including death. Risks are inherent to all interventions in medicine, both conventional and complementary. Physicians offering complementary therapies must be sufficiently knowledgeable of the potential adverse events of the therapies they prescribe and be capable of providing an appropriate risk-benefit analysis of these treatments.*
- *2) The use of CAM primarily as an **alternative** to conventional medical care[2] has the potential to cause harm to patients by displacing the use of effective conventional treatments that are known to be the standard of care. This consideration does not necessarily exclude the option of using such therapies as alternatives,[3] but physicians who prescribe therapies with the intention or perception of using them as an alternative to conventional care **must** be especially mindful of i) any potential risks associated with the cessation of conventional medical care, as well as ii) the potential risk that some vulnerable patients may perceive the efficacy of such "alternatives" as equally effective as conventional care options when this may not necessarily be the case.*

1 "Natural" might pertain to a therapy derived from plants, naturally occurring hormones, or concentrated forms of agents that naturally occur in our diet.
2 Examples include the use of herbal products and supplements instead of immune modulators for the control of rheumatoid arthritis, or dietary changes and anti-inflammatory supplements instead of surgery for the management of Crohn's.
3 For example, a patient with multiple sclerosis may cease to use standard therapies due to intolerable side effects, or a cancer patient may decline chemotherapy due to only modest prolongation of life and high side effect profile.

2) Physician assessments & clinical judgement

a. Conducting an assessment

Physicians who specialize in offering integrative approaches to health are frequently requested to provide care for patients who have been seen by multiple specialists and investigated extensively for their condition(s). Such patients are usually seeking an additional or new approach to their health situation where conventional therapies have either failed to produce acceptable results, or produce intolerable side effects. We **agree** with the requirement that patients *receive* a conventional assessment and diagnosis prior to the use of CAM therapies, however, we **disagree** with the requirement that a comprehensive conventional assessment *be **repeated, by obligation**, for every conventional diagnosis by the physician* prior to offering any complementary or alternative medicine therapies (policy line 55). Family physicians frequently rely on the diagnostic skills of their specialist colleagues when offering medical care to their patients and **it is essential that physicians practicing CAM be given the same professional latitude to rely on the skilled assessments of our colleagues**. The previous version of the policy permitted physicians to rely on another physician's assessment, and even an assessment performed by another health professional provided it was reviewed and found to meet the medical standard of care. The draft policy's omission of a physician's capacity to rely on assessments performed by our skilled colleagues is a step backwards and will result in lost

productivity and a waste of precious patient-physician time spent repeating confirmatory diagnostic tests rather than discussing management options. The policy **must** be rephrased to permit physicians to rely on diagnostic assessments performed by their colleagues; we recommend the following modification:

> Physicians **must** conduct a conventional clinical assessment in accordance with the standard of practice [*OR review a conventional clinical assessment performed by another physician*,] including, *if appropriate,*: …

b. Managing referrals or requests for investigations

We applaud the college for incorporating this excellent topic in the policy (advice document line 262-283). However, it is imperative that the content be phrased in a way that is respectful of our allied health practitioner colleagues. The philosophy of mutual respect and **interprofessional collaboration** is currently a key element of undergraduate medical education, in fact, it is a ***mandatory requirement*** **for medical school accreditation** and a component of the CanMEDS role of "collaborator". The language of the policy **must** be better phrased to reflect elements of respect for interprofessional collaboration of patient care and an appreciation of the contributions that other health professionals provide. We therefore recommend the following changes:

> *In considering the role of interprofessional collaboration in patient care, it is important that physicians attend to the concerns brought up by the other health practitioners and* always consider whether such a referral or the ordering of a test or investigation would be in the patient's best interest, and whether there is a clinical basis for it. However, physicians are not *required* to provide referrals, or order tests or investigations if they believe, using their best judgement, that they are not clinically indicated. Physicians who make a referral or order a specific test or investigation are responsible for them and any follow up that is required (see the Managing Tests policy for more information).

3) Evidence requirements

We applaud the general approach of this section which clearly illustrates how to balance the strength of evidence with potential risk to the patient in order to assist with decision-making with regards to CAM therapies. This text is very much in line with the "**right touch**" philosophy brought forwards by the college, in considering the "**right balance**" of evidence vs harm as it applies to the use of CAM therapies. That said, we have two concerns with this section of the document:

a. Evidence for CAM therapies

The paragraph at lines 88-92 of the advice document contains statements about the evidence supporting CAM therapies that are **false**, and are phrased in a way that invoke a **negative bias** towards CAM, as if all therapies were completely unfounded by science or evidence:

> "Many complementary or alternative treatments have either not been the subject of randomized controlled clinical trials, or the results of the available research do not convincingly demonstrate any positive effect. There may be very little evidence to support the use of some proposed complementary or alternative treatments. As a result, the full risks and benefits of many such treatments are not well understood."

In contrast to what is stated, vast amounts of research on CAM therapies have been performed over the last few decades. Multiple CAM therapies are included in conventional clinical practice guidelines or have Cochrane reviews, systematic reviews, or meta-analyses supporting their use[1]. As the draft policy currently stands, its very description of the nature of the evidence supporting CAM therapies is in and of itself, currently **false**, **misleading**, **and NOT supported by evidence.** This section **must** *truthfully* reflect the nature of evidence pertaining to CAM therapies to properly advise physicians. We suggest the following:

> *The range of evidence available on CAM therapies is extremely variable. Some CAM therapies have substantial high quality evidence supporting their use, yet are still considered as complementary or alternative since their use has not yet been widely adopted by mainstream medicine. In contrast, others have much less evidence available to support their use or have not yet have been subject to clinical trials, therefore the full risks and benefits of some of these therapies may not yet be well understood.*

b. "Supported" by evidence

While we appreciate the desire to focus on evidence-based medicine, the increased evidentiary requirements require that CAM treatments now not only need to be "informed" by, but will have to be "supported" by evidence and scientific reasoning **go against the principles of evidence-based medicine** originally proposed by Sackett et al. in 1996. "Evidence-based medicine" was to be informed by a combination of evidence *with clinician experience and patient values*. This section of the draft policy does not adequately balance patient autonomy with the requirement for evidence, and completely neglects the role of clinician experience in providing patient care. The reality is that while some CAM therapies do have good evidence to support their use, many will **never** be substantiated by the level

[1] Examples include:
- St John's Wort and SAMe (S-adenosylmethionine) for the treatment of depression – the CANMAT depression guidelines quote high quality evidence for the efficacy of these interventions while acknowledging that, due to their nature, they are still considered as complementary or alternative.
- Low FODMAPS diet, peppermint oil, and hypnotherapy are considered valuable evidence-based treatment options for the management of irritable bowel syndrome according to the 2019 Canadian Gastroenterology Association guidelines on the management of irritable bowel syndrome.
- Omega-3 fatty acids or curcumin are valuable therapeutic adjuncts for the treatment of rheumatoid arthritis (supported by Cochrane reviews).
- Acupuncture is indicated for migraine prophylaxis (Cochrane reviews)

And the list goes on.

of evidence recommended by the Draft Policy. Large scale randomized control trials require extensive funding, usually backed by a pharmaceutical company to support a new patentable drug that will create profits to validate expenditures on large scale research studies. Amongst other barriers, natural substances/non-patentable treatments will rarely obtain the financial backing for large randomized control trials to be conducted, and medical reasoning using paradigms that differ from conventional medicine are impossible to study under the context of a "placebo-controlled" environment.

Arbitrarily cutting off a range of safe CAM therapies that are less well studied robs patients of their autonomy to choose CAM treatments. If patients can no longer access or obtain information on a range of therapies from their skilled physicians and are still left with chronic health problems, they may end up doctoring themselves, turning to unqualified people, or going out of province for care. Furthermore, the fact that a CAM physician could be unjustly disciplined by the CPSO simply because they are using a treatment that cannot meet a sufficient evidentiary requirement goes against the principle protected by Section 5.1 of the Medicine Act. This section **must** convey appropriate language on recommendations for evidentiary requirements, for example, by incorporating clinical judgement and patient preference into its discussion on evidence-based medicine. We recommend the policy keep the phrasing from the previous version pertaining to "evidence-informed medicine" and that interventions continue to be "informed and supported by evidence and science" as this best reflects the true philosophy of evidence-based medicine.

4) Documentation & Risk Benefit Analysis – Policy line 171

Documentation requirements from the Medical Records Documentation policy are clear, thorough and reflect a trend over the past few decades towards increasing requirements for documentation among physicians. This draft policy, however, takes this step even further with more onerous documentation requirements for physicians practicing CAM in section 15. The added requirements to document strength of evidence, scientific reasoning, and a complete risk benefit analysis for every treatment offered as well as every conventional alternative will be **impossible** to meet for any reasonable physician. This requirement effectively requires any physician contemplating a CAM therapy to do a literature search and document the literature substantiating the treatment when offering *any* treatment. Physicians who fail to meet the standards of care for documentation can be disciplined by the CPSO. We **agree** that this material be included as part of the risk benefit analysis and consent discussion with patients, however we **disagree** with the requirement to document the full extent of this material in patient charts. This policy **must** relax its documentation requirements or no physician will be able to sufficiently and reasonably document what is required to offer any CAM therapy in accordance with the current policy.

5) Scope of Practice

<u>a. Limitations to a "Conventional Scope of Practice"</u>

We are disappointed with the policy's explicit statement at line 226 of the advice document declaring that "CAM is not a scope of practice for physicians". We sympathize with the aims

of the college only to regulate the practice of "medicine", however, the *Medicine Act, 1991, SO 1991, c 30* states:

> Scope of Practice: 3. The practice of medicine is the assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction. 1991, c. 30, s. 3.

With all due respect, practices considered as "complementary" or "alternative" still fit exactly within that definition of "medicine". The direct refusal to acknowledge complementary or integrative medicine practices as a scope, specialty, or focus of practice suggests that the policymakers have not adequately consulted with or do not have an adequate understanding of how we, the physicians practicing primarily in integrative medicine or CAM, operate.

Physicians who focus their practice on integrative approaches to health are highly skilled and educated, and have accepted the challenge of learning how to manage chronic diseases under very difficult circumstances to achieve better outcomes for our patients, for whom, in many cases, conventional medicine has failed. Most are general practitioners who consider all of a patient's diagnoses and how they fit together within their personal story, timeline of events, and lifestyle practices to determine courses of action and treatments that apply to *multiple* health ailments, rather than narrow in on a set of treatments for one particular diagnosis. Physicians with this type of training are frequently sought out by patients to obtain the type of medical care that suits their values, desires, and personal preferences. Recognition for this integrative approach to health is growing: in the USA, Integrative Medicine is an American board-certified discipline (ABPS). So is its close cousin, Lifestyle Medicine. Closer to home, in Alberta, the medical college invites physicians to declare their focused complementary medicine practices in their physician profile to acknowledge their specialized skill set and to help patients seek out such practicing physicians. Furthermore, in Ontario, the CPSO's own membership profiles allows physicians to declare various practices, including complementary medicine, as a focused clinical activity within their scope of practice (see CPSO membership profiles, clinical activities). Clearly, the denial of the existence of integrative or complementary medicine as a focused type of practice in the current proposed policy revisions *is at odds with the medicine act, the college's own membership legislation, as well as what is increasingly considered the standard of practice* in other Canadian provinces as well as the USA.

The college rationalizes that the application of CAM be restricted to a physician's conventional scope of practice (policy lines 38-39, 96-98, advice lines 214-218). The example provided of an orthopedic surgeon who refrains from treating pancreatic cancer without an appropriate change of scope is clear, intuitive, sensible, and perfectly compatible with the proposed limitations in scope. However, in our experience, our specialist colleagues rarely explore or incorporate complementary approaches into their own patient care. More often than not, it is general practitioners who chose to acquire the skills required to offer integrative and complementary medicine approaches across all domains of medicine. We **agree** that physicians should not cross-treat patients outside their domain, however this restriction provides a huge **knowledge translation gap** when it comes to the

scope of general practitioners. The scope of practice of a general practitioner is wide, and most family physicians *co-manage* a patient's medical conditions in conjunction with their specialist colleagues. The draft policy **must** provide clarification on the scope of CAM therapies as they apply to general practice. For example, the following paragraph could be inserted after line 225:

> Physicians can only provide complementary or alternative treatments to address symptoms, complaints, or conditions that are within their conventional scope of practice to treat, and that they have the knowledge, skills, and judgement to provide. Physicians cannot offer treatments for conditions they would not *typically* manage within their conventional scope of practice. For example:
>
> - A physician practicing orthopaedics may use complementary or alternative treatments that could assist with musculoskeletal injuries but would not be able to provide complementary or alternative treatments relating to, for example, pancreatic cancer. Such cancer treatment would not be within that physician's conventional scope of practice.
> - *General practitioners tend to manage, or co-manage with their specialist colleagues, nearly all medical conditions. A general practitioner may use complementary and alternative treatments that apply to a wide range of medical conditions provided they have the knowledge, skills, and judgement to safely offer and/or co-manage such therapies.*

<u>b. Treatment Modalities</u>

The reference to "using only modalities of treatment that are within their conventional scope of practice" (policy lines 96-98) is **unnecessarily restrictive.** This statement is not even compatible with the definition of CAM *provided within this very draft policy*, which refers to CAM as including "new treatments, practices and products" (lines 8-9). As it currently stands, this phrase has the potential to completely stifle all medical innovation. Furthermore, it is not in line with Section 5.1 of the Medicine Act, which states that "*physicians shall not be found guilty of professional misconduct or incompetence solely on the basis that they practice a therapy that is non-traditional or that departs from the prevailing medical practice*." While this phrase from the Medicine Act is explicitly stated in the current version of the CAM policy, it has been omitted from the new draft policy. **It is imperative that this statement from the Medicine Act be re-instated as part of the CAM policy as it sets an important tone for the choice to use CAM therapies.** Additionally, statements restricting a physician's practice to the use of "modalities within their conventional scope " **must** be removed as they could easily be misinterpreted to disallow the use of any new or innovative therapy.

<u>c. Re-certification</u>

The advice document states that "physicians wishing to practice complementary or alternative medicine more broadly and across traditionally defined scopes of practice will need to train and credential as a complementary or alternative medicine practitioner" (advice lines 229-231). This material is ambiguous and is at odds with the current

Regulated Health Professionals Act[2], which lists a variety of controlled acts that are *already within the scope of a physician*[3]. It is redundant and inappropriate to require a physician to re-certify in a field of practice in order to perform acts with are **already within the scope of practice of a medical doctor**. We **support** the recommendation for physicians to obtain appropriate training and credentialing in order to practice advanced skills in medicine, however, we **object** to mandatory *external* training and credentialing outside the bodies that regulate medical doctors. This paragraph **must** be rephrased to avoid ambiguous and unfounded restrictions on the true legal scope of practice of physicians. Ultimately, we recommend that the educational undertakings by physicians practicing CAM be *acknowledged* within the true scope of "medicine" rather than restricted to "alternative practices":

> *Physicians with additional training or competency in complementary or alternative medicine practices may wish to declare this within their scope of clinical activities as registered by the CPSO.*

<u>d. Physicians who don't use CAM</u>

When it comes to services such as abortion or medical assistance in death (MAID), physicians are *legally obligated* to offer a referral to a physician who performs this service, or make reasonable attempts to find a physician that performs this service if they are unable to do so themselves or are philosophically against the practice. The same general medical standard should be held for patients wishing access to CAM therapies or information and guidance pertaining to these therapies. Physicians with knowledge and competency in complementary and integrative medicine approaches are the ideal professional capable of a comparative evaluation of both conventional and complementary therapies and are in the best position to fully understand, appreciate, and communicate this risk-benefit analysis of these therapies to patients. The policy makers **must** consider a patient's legal right to medical services in alignment with their personal choices. We recommend the following statement inserted at line 260 of the advice document:

> *Physicians who lack the knowledge and/or skills to advise patients on CAM therapies or who are philosophically oppose to the use of specific CAM therapies must make reasonable efforts to accommodate their patients' requests for information or access to therapy, for example by referring patients to other practitioners to meet their health care needs, such as physician colleagues who are competent, knowledgeable and skilled in the provision of CAM therapies or integrative health approaches.*

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[2] Regulated Health Professions Act, 1991, S.O. 1991, c. 18

[3] Physicians already have the following acts within their scope of practice: prescribe medications, natural products and supplements; perform manual manipulations i.e. of the spine; prescribe hormones; perform acupuncture and counsel patients on diet. No physician needs to *re-certify* as a naturopath, chiropractor, acupuncturist, or dietician to be legally allowed to perform these acts.

Executive Summary

While there have been some improvements in this draft policy, in other domains it appears this policy has taken steps backwards compared to the previous version. It is crucial that this policy be adapted to appropriately reflect the practices of physicians who focus on the use CAM as this policy is the primary benchmark on which their medical care will be judged in the case of a complaint or investigation. If non-compliance with this policy is to be considered grounds for discipline, it is imperative that the document provide clear recommendations and reflect an appropriate, acceptable, and actual standard of care.

We strongly recommend the following changes:

1) Overall Tone and Language
    a. The draft policy remove language pertaining **patient exploitation**; we recommend instead referencing the general Physician Code of Conduct.
    b. The policy remove unprofessional language sensationalizing the **risks of CAM therapies** and portray a more honest, truthful, and balanced view of the risks of CAM and conventional therapies.
2) Physician assessments & clinical judgements
    a. Physicians be given the professional latitude to **rely on or review clinical assessments performed by their colleagues** in conducting assessments.
    b. The draft policy reconsider the language used when referring to other health professionals to maintain the standards of **interprofessional collaboration** set out under CanMEDS roles as well as medical education standards.
3) Evidence requirements
    a. The advice document depicting the evidence for CAM therapies be rephrased to **more accurately reflect the true state of evidence** pertaining to CAM.
    b. The draft policy return to the original language of "**evidence-informed**" therapies to be more in line with the original philosophy of evidence-based medicine, and that the roles of *patient preference* and *clinician experience* be incorporated into the definition of evidence based medicine.
4) Documentation
    a. The draft policy relax its documentation requirements so as not to overly burden physicians with unrealistic requirements that go **drastically above and beyond the requirements** set out in the Medical Records policy.
5) Scope of practice
    a. Clarification is required as it relates to the scope of practice of **general practitioners** who offer CAM.
    b. Remove language restricting physicians to the use of **treatment modalities within their conventional scope of practice** as this is unnecessarily restrictive, ambiguous, and stifles innovation.
    c. Remove the requirement for physicians to cross-certify as another regulated health professional in order to provide **services already considered to be within the scope of practice of a physician**.

Closing

We thank you for your attention to these issues and are grateful for your receptiveness to feedback in modifying this policy. We highly encourage you to reach us as designated representatives of the OMA Complementary and Integrative Medicine Medical Interest Group (CIM MIG). We will happily provide your policymakers with feedback, clarification, and guidance as to the roles of integrative medicine physicians. We also strongly recommend that you add a physician who is familiar with CAM or Integrative Medicine to your CAM policy committee to achieve the required balance and right touch for this policy. Please contact us using the information below.

Sincerely,

On behalf of the OMA Complementary and Integrative Medicine Medical Interest Group CAM policy Task Force.