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August 31, 2011

Policy Department
Attn: Working Group for Complementary Medicine Policy Revision
College of Physicians and Surgeons of Ontario
80 College Street
Toronto, ON
M5G 2E2

Dear Sirs/Madams:

Re: CPSO "Non-Allopathic (Non-Conventional) Therapies in Medical Practice" Draft Policy

The National ME/FM Action Network appreciates the chance to respond to this proposed policy. The Network became a Canadian charitable organization in 1993, dedicated to assisting those with Myalgic Encephalomyelitis, also known as Chronic Fatigue Syndrome, and Fibromyalgia through support, advocacy, education and research: *People Helping People Helping Themselves.*

Unfortunately, we believe the proposed policy as currently drafted will be **counter-productive for patients and to health care in this province.**

Why do we believe this proposed policy should be substantially revised?

As a patient-led and patient-governed organization, the National ME/FM Action Network helps to develop, promote, and expand the influence of patients and their perspectives in health care. This proposed policy has a strong tone of disrespect and paternalism, and diminishes the patient's role and influence by using confusing language, when regulatory policies should be easy to understand by both the profession and patients. If not revised, it also appears that the therapeutic options physicians in Ontario can offer will be limited because of unrealistic and restrictive evidentiary requirements.

1. In the language of this proposed policy, the CPSO has obvious distaste and disapproval for "non-allopathic" medicine, and it is unclear who would decide and on what basis that therapies were "non-allopathic" and subject to the policy's stringent requirements. The climate of CPSO disapproval places a 'chill' on the profession. It does not encourage physicians to learn more about therapies the CPSO might disapprove of, even when they are asked for information by their patients. It also does not encourage physicians to study and become proficient in certain modalities to be able to provide them in combination with their current care in order to serve their particular patient population better. Increasingly, physicians are being consulted by patients with multiple complex chronic conditions who are insufficiently helped by pharmaceutical and surgical options alone, and request more holistic options to relieve symptoms, enhance quality of life, and prevent worsening of their health. With a chilly climate, physicians may be more likely to be evasive or negative about such options, which in turn creates distrust, diminishes doctor-patient therapeutic relationships, and damages the credibility of the medical profession.

2. Some patients may deliberately avoid topics that they think the clinician would disapprove of, depriving the patient of the opportunity to partner with the physician in determining the best therapeutic options. Such avoidance also would deprive the physician of important information to provide safe ongoing care and prevent adverse treatment interactions. This obviously does not serve patients well as it leaves them to manage perilously on their own or to seek treatment outside the province, or from other healthcare professionals with less knowledge of particular clinical conditions, without the benefit of inter-professional communication and collaboration.

3. The word “allopathic”, and conversely “non-allopathic (non-conventional)” is not understood by most patients, whereas they do understand that western medicine therapeutics tend to be limited to prescription medications and surgery, which are invaluable for acute clinical conditions, but less so for promoting and maintaining good health and quality of life and for managing chronic illnesses. The term “Complementary and Alternative Medicine” or “CAM” is generally recognized by the public and medical profession, and the increasing combination of the best of holistic “CAM” therapies with pharmaceuticals and surgical techniques, now dubbed “Integrative Medicine”, provides many more useful options, given that the population is aging and has more complex chronic health problems. “Integrative Medicine” is defined by the Consortium of Academic Health Centers for Integrative Medicine (www.imconsortium.org) as “the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing”.

4. The Consortium of Academic Health Centers for Integrative Medicine currently has 50 prominent academic institutions as members, including four in Canada, having responded to a “wakeup call for medical education” (JAMA 1998: 279:1548-1553) where a population-based survey revealed that 40% of participants used CAM therapies, 629 million visits were made to CAM practitioners versus 385 million to primary care physicians, 60% of participants did **not** inform their physicians, and 80% of them used CAM therapies in combination with conventional medicine. We believe the policy would be more clearly identified if it were named the “Complementary and Integrative Medicine Policy”.

5. There is a biased, reductionistic ‘us allopaths’ versus ‘them non-allopaths’ stance throughout the proposed policy, emphasized by repetition of requirements for all physicians that are already well-outlined in legislation, regulations, the Canadian Medical Association Code of Ethics, and the CPSO Practice Guide, and that are footnoted in the proposed policy. Besides much unnecessary repetition and negative bias, some language is very unclear and confusing e.g. “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”. Who would judge what a “demonstrable and reasonable connection” was, what would constitute “sound clinical judgement”, and what a “non-allopathic diagnosis” would be? Also, how would it be judged by the CPSO whether a physician was a member of the “allopathic medical community” or the “non-allopathic medical community”, and would CPSO practice reviewers have knowledge of the particular therapies in question to ensure they were being provided proficiently?

6. Every person/patient is different with different genetic heritage, different environments, different medical history, different life circumstances and different preferences/values, and these factors combine in unique, highly complex ways in each individual. Hence, in any area of medicine there are no “unproven” or “proven” (black or white) therapies for individual patients- each time patients embark on a new course of therapy, in collaboration with their physicians and/or other healthcare professionals, it is “a trial of therapy”, an experiment. Conscientious, progressive physicians want to serve each patient optimally through maintenance of a strong working relationship as together they explore what evidence is available to aid treatment decisions in light of the patient’s preferences, and then to determine what works best for each person.

7. There is a long medical tradition of observation and reporting as part of the hierarchy of study designs in the evolution of medical science. As evidence slowly accumulates, physicians communicate and collaborate with their colleagues about ‘best practices’ and research questions, often in professional associations. Randomized controlled trials are valued because randomizing patients who are as alike as possible in demographic and disease characteristics, to either the

treatment of interest or the control group helps to prevent bias while comparing treatments. However, each person is different, and so the results of particular trials may not be applicable to all practice patients with the same disease. Many times new prescription medicines, touted as highly safe and effective for particular conditions on the basis of randomized controlled trials, have had to be withdrawn from the market when they were applied in the 'real' world, and undesirable outcomes ('side effects') were reported. Patients understand evidence is never perfect, wish to be told what evidence is available, and to provide informed consent.

8. CAM therapies used by physicians usually have a long history of safe application in the population at large, with many fewer adverse effects reported than for prescription medications and surgery. Some CAM therapies have a strong historical, clinical or experimental evidence base for efficacy and others do not. Nevertheless, they continue to be used by increasing numbers of patients because they are reported to provide relief, even when pharmaceutical and surgical therapies have not. Randomized trials and other formal study designs are very expensive to implement. They are most often funded by companies who will profit by being able to market patented pharmaceuticals or surgical devices, and there is extreme competition for other scarce research dollars. It is therefore completely unrealistic to demand randomized trials for every potential treatment. Further, it is highly impractical to expect that busy physicians should fund and run randomized trials themselves in order to be able to offer CAM therapies that have no evidence of increased risk of harm than "allopathic therapies", have some evidence of efficacy, and that have their patients' informed consent according to the Health Care Consent Act.

9. We believe there is a quiet revolution taking place in health care, based on the widespread availability of the internet. In a 2010 CBC survey, 41 percent of Canadian adults polled said they consult online sites for information about a specific disease, medical issue or health product. "Without a doubt, the Internet is fundamentally altering all aspects of health care. In these early days, the passive patient of the past is being empowered with online information and tools that enable increased interactivity with both medical professionals and other patients" (Taking charge of your health care: Will the Web replace Doctors? http://patientsassociation.ca/blog/taking-charge-your-health-care-will-web-replace-doctors). As Director of the Health Design Lab at St. Michael's Hospital in Toronto, Dr. Michael Evans says, "In this new world of patients empowered by Web-based information, it's up to medical professionals to become the curators of credible information. Increasingly, doctors will have to winnow out the useful information on the Web for their patients". Hence, encouragement for medical schools to incorporate critical evaluation techniques into undergraduate and post-graduate learning seems appropriate.

10. The social networking site "PatientsLikeMe" allows its 80,000 contributors to post data about all aspects of their disease, including the effects of medications or treatments. Taken as a whole, this bonanza of data could have powerful implications for tracking patterns linked to a disease and responses to various treatments.

11. The proposed policy is requiring physicians to make judgments regarding their patients' socioeconomic status which we view as intrusive and patronizing. It is not up to physicians to decide whether or not they will inform us of available treatment options, along with the available evidence on safety, efficacy, and cost, on the basis of their judgment of our socioeconomic status. Furthermore, what would be considered "a financial burden" might be highly variable in the eyes of various beholders.

12. In order to re-configure a useful "Complementary and Integrative Medicine Policy", clearly new methodology must be applied. It is obviously not enough to ask for input and post it on the CPSO website, saying it will be carefully examined by the Working Group. The implication is that at least some of the input will be included, which, from review of the preliminary consultation responses and the revised policy, is obviously not the case. It is disappointing that patients and doctors with expertise in CAM modalities had little meaningful influence. In the original report of the Ad Hoc Committee on Complementary Medicine 14 years ago, it was suggested that, in assessing complaints or concerns pertaining to the practice of Complementary Medicine, Standing Advisory Panels be constituted that included members respected in the field of complementary approaches, such as members of the Complementary Medicine Section of the Ontario Medical Association. The

policy adopted by the CPSO stated that Standing Advisory Panels should be utilized as discussed in the Ad Hoc Committee's Report, but they have never been implemented, nor has this been stipulated in the proposed policy.

In summary, patients, especially those who are coping with chronic, complex conditions, like many National ME/FM Action Network members, clearly desire and require a wider range of therapeutic options. We would like the regulatory college for physicians in Ontario to scrap this proposed counterproductive policy, and replace it with a forward-looking "Complementary and Integrative Medicine Policy" that promotes continuous quality improvement of holistic, patient-centred clinical care by physicians, as well as inter-professional collaboration.

Yours truly,

Margaret Parlor
President
National ME/FM Action Network

cc Minister of Health Hon. Deb Matthews
Opposition Health Critic (Conservative) Christine Elliot
Opposition Health Critic (New Democratic Party) France Gelinas
Dr. Stewart Kennedy, President, Ontario Medical Association