OAND Ontario Association of Naturopathic Doctors
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OAND Response to CPSO Consultation:
Non-Allopathic (Non-Conventional) Therapies in Medical Practice

Thank you for the opportunity to provide comments on the draft policy on Non-Allopathic Therapies in Medical Practice.

Adopting the current approach of the draft policy will better promote the public interest in patient-centred care, and a collaborative approach with other regulated health professions, including naturopathic doctors. Specifically, the draft policy provides better guidance to MDs practicing non-allopathic medicine, and provides needed advice about how MDs should respond to patients who express an interest in, or might benefit from alternative approaches to conventional medical care.

An increasing number of Canadians are using complementary therapies. A 2006 survey found that over half of Canadians had used at least one alternative therapy.[1]

Clearly, there is public interest in promoting a patient-centred approach to practice where each patient feels their health care preferences are respected. Often, however, patients report to their naturopathic doctor (ND) that they are not being properly supported by their MD. MDs often openly express personal opinion dismissing the value of naturopathic care, counselling patients not to follow the advice of their ND, and refusing a patient's request to confer with their ND. This can, and does, create a safety concern if a patient feels compelled to "hide" from their MD the complementary care that they are receiving, leading to the potential for botanical-drug interactions and other sub-optimal outcomes. This is neither in keeping with a physician's duties to the patient,[2] nor with the government's and public's expectations that regulatory colleges will promote collaborative care with other regulated health professions.

While there are difficulties, opportunities for collaboration between NDs and MDs are increasing. Last year, the OAND estimates that over 100,000 Ontarians received care from an ND, many for conditions also being treated by their MD. Our members tell us that MDs are also increasingly referring patients with an interest in complementary medicine to NDs.

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[1] Esmail, Nadeem (2007). Complementary and Alternative Medicine in Canada: Trends in Use and Public Attitudes 1997-2006. Fraser Forum (July/August): 19-22.
[2] CPSO Practice Guide, Principles of Practice and Duties of Physicians.

In our 2010 submission, we identified a number of needed improvements for the current policy on Complementary Medicine. The new draft substantially achieves the most important goals outlined in our submission. Only minor improvements are still needed.

The effect of the new policy will be to advance safe and effective patient care, and better collaboration among practitioners.

The Importance of a Clear Policy

It is important that the CPSO maintain a policy that recognizes and supports patient-centred care, including respect for preferences, to incorporate non-allopathic approaches from their MD and other practitioners. Recognizing the legitimacy of non-allopathic therapies for primary or secondary care helps to foster a culture of respect for patient choice and for health care professionals practising complementary medicine.

The substantive improvement to this new policy is that it makes patient preferences a focus of this policy, and provides appropriate guidance to MDs about how to mediate these choices within the standards and expectations of medical practice. Specifically, it provides guidance for how MDs should respond to patients, during assessment or treatment, who express an interest in complementary medicine, or would benefit from complementary medicine.

A consultation with our members in 2010 revealed widespread concern that patient care is being harmed by a lack of support by many MDs for a patient choice to seek complementary care from a regulated practitioner, to the point that many patients of NDs report that they still feel compelled to "hide" the naturopathic care they are receiving. As well, almost all NDs responding to our consultation reported a poor working relationship with MDs that is detrimental to patient care. This is not in keeping with the CPSO's expectations of the duties of an MD to their patients and to other practitioners, and as a result the new policy is a welcome addition.

Definition of Non-Allopathic Therapies (Lines 52 to 59)

The focus of the policy on specific therapies that can be classed as non-allopathic is appropriate.

Non-allopathic is a more accurate term than non-conventional. Non-conventional has a negative overtone which is not in keeping with the spirit of this policy.

It would be a useful clarification, perhaps as a footnote, that many other health professions, including naturopathic doctors, provide diagnoses and therapies that would be considered conventional under this policy. For example, naturopathic doctors place substantial focus on evidence-based therapies involving nutrition, lifestyle, and botanical medicine.

General Expectations for Physician Conduct (Lines 83 to 119)

The draft policy provides appropriate support for patient-centred care, including respect for the preference of a patient to incorporate non-allopathic therapies from their MD and

other practitioners. The recognition in the policy that non-allopathic therapies can be a legitimate choice helps to foster a culture of respect for patient choice and for health care professionals practising these therapies.

Medical literature has increasingly emphasized the need to respect a patient's autonomy, and this should extend to the patient's use of non-allopathic therapies. Patient-centred care "affirms the power of knowing and acting on what matters to the patient and the proven benefits from collaborative interaction.... There is a growing recognition that the provision of care centred on a patients' needs and expectations is a key attribute of quality care." [3] It is fundamentally about the right of the patient to determine what will be done to their body. This includes properly responding to patient interest in alternative courses of action that may include care from other regulated health professions.

Finding the right balance between protecting patients and ensuring freedom of choice has moved away from a more paternalistic approach to one that increasingly emphasizes respect for the personal autonomy of the patient.[4]

Medical doctors know that patients have different preferences regarding health care, and that some prioritize non-invasive options to preventing and managing disease, and to maintain wellness and improve quality of life. These preferences should be respected, even when they require care outside of the practice focus on an individual MD.

While there are differences in approaches to diagnosis and treatment, NDs and MDs should be able to collaborate to develop an approach that is in the best interest of a patient and supports the patient's preferences in health care.

MDs Practising Non-Allopathic Therapies (Line 128 to 139)

There is a growing interest in integrative medicine both among patients and a wide range of health professions, including MDs. The OAND strongly supports MDs offering non-allopathic therapies within standards of practice of the medical profession, and collaborating with other regulated practitioners where a patient would benefit from a specialized expert such as a naturopathic doctor.

It is a welcome development that a growing number of MDs are turning to natural solutions for their patients, including dietary interventions, lifestyle changes, botanical medicines, acupuncture, and other natural interventions. Like with any area of practice, MDs should obtain additional skills and knowledge as required to ensure safe and effective practice, including certification where warranted. Appendix II to this submission includes clinical scenarios originally submitted in 2010 that illustrate how patient care can be compromised by MDs practising beyond the boundaries of their personal skills and knowledge of complementary medicine.

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[3] Schall, Marie et al (2009). Making High Quality Patient Care a Reality. Journal of Ambulatory Care Management. 32:1 p. 3.

[4] Iyioha, Ireh (2006). Informed Choice in Alternative Medicine: Expanding the Doctrine Beyond Conventional Alternative Therapies p. 21.

Evidence (Line 185 to 198)
The *Medicine Act* establishes that MDs should not be limited in providing or recommending non-traditional care "unless there is evidence that proves that the therapy poses a greater risk to a patient's health than the traditional or prevailing practice." The new draft policy provides appropriate guidance for MDs, although some specific provisions may need to be rethought. Most notably, the expectations for evidence of efficacy starting at line 185 appear to exceed those for many conventional therapies and hospital protocols where many treatment decisions are not based on peer-reviewed randomized clinical trials. Likewise, there is no equivalent responsibility to consider the socio-economic status of a patient when making prescribing decisions, even though many lower cost approaches including diet and lifestyle changes may be more cost-effective for the patient.

Likewise, line 192 should be changed to clarify that it relates to conclusive proof of a therapy being ineffective. For many non-allopathic therapies, the evidence may still be emergent, with studies reaching a range of conclusions. One study concluding that a therapy is ineffective should not preclude it being proposed. Many conventional therapies could not pass this test.

Because the current evidence requirement may preclude reasonable therapeutic options, it may be beneficial to the patient to allow the physician reasonable scope in evaluating the available evidence about a non-allopathic therapy, in keeping with the expectation of informed choice.

Treating Patients Who Pursue Non-Allopathic Therapies (Lines 228 to 266)
As mentioned above in the section on general expectations, the draft policy provides appropriate support for patient-centred care, including respect for the preference of a patient to incorporate non-allopathic therapies from their MD and other practitioners.

The reference in line 251 to a referral in cases where the patient is seeking care beyond the knowledge, skill and judgment of the practitioner is appropriate. Referral would be similar to the approach currently used by MDs to refer to other regulated health care professions with a unique area of practice focus within the legislated scope of MDs, such as midwives, physiotherapists, or optometrists.

However, the policy should do more to differentiate between regulated and unregulated practitioners. Footnote 13 would be more helpful if it were linked to the contact information for regulatory colleges as an appendix or through a link to the CPSO website. The policy would be improved by providing guidance to MDs that – similar to a referral to another MD – referral to another provincially-regulated health practitioner will not be considered exposing the patient to harm because it can be assumed that that practitioner is working within their scope of practice and competency as a regulated professional, and will have their own malpractice insurance. While respecting a patient's choice to use the services of an unregulated provider, patients' would benefit from their

MD educating them on the benefits of receiving care from regulated health care professions.

Building a Collaborative Culture
The overall approach of the draft policy to patient use of non-allopathic therapies and discussing non-allopathic therapies is positive.

Patient expectations regarding health care are changing. Patients are becoming more empowered, seeking more information about their treatment options, as well as expecting their preferences to be respected and different practitioners to work together on their behalf. In a survey of our members, however, many patients of naturopathic doctors often report hostility from their MD about their decision to seek care from a naturopathic doctor.

It is particularly problematic when MDs, who do not have personal knowledge about the safety and efficacy of naturopathic medicine, may advise their patients not to continue with the care being recommended by their ND, even telling the patient it is ineffective or unsafe, without ever seeking to contact the ND to ask questions and discuss their concerns. This is detrimental to patient care and patient safety, and is not in keeping with the object of the College established in the *Regulated Health Professions Act* to promote inter-professional collaboration with other health profession colleges.

MDs should communicate collegially with other regulated health professionals when this communication serves the best interest of the patient. However, in a survey of OAND members, almost all respondents reported that they were concerned about the poor working relationship with MDs. The following are examples of the concerns for patient care resulting from poor working relationships with MDs:

> "I have had countless encounters with patients who have received conflicting, and in many cases, wrong information from their MD about naturopathic medicine, its efficacy and the qualifications of NDs."
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> "Delayed diagnosis of a condition by an MD gravely affected the care of a patient. This patient presented with classic cholelithiasis symptoms. It is outside our scope to order an abdominal ultrasound. The patient was referred back to their MD to obtain further testing. The MD refused to order the test and the patient ended up not only suffering but in the emergency ward with severe abdominal pain and an emergency cholecystectomy."
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> "I have had several cases of MDs refusing to send me a copy of the patient's lab results, even though a release of records was sent."
>
> "In advancing knowledge, MDs should acknowledge any limitations in knowledge rather than infer to patients that a treatment or therapy is unsupported by appropriate data or research."

According to our members, many MDs are regularly giving misleading advice to patients because they do not have the training to respond to a patient's interest in complementary medicine, such as the difference between the botanical and homeopathic form of an herb. According to our members, many MDs do not know the regulated scope of practice of naturopathic doctors, and convey incorrect information to patients.

The proposed approach of the new policy has the potential to benefit patients by explicitly promoting the expectations of MDs to practise in a manner that fosters a collaborative relationship built on trust and mutual respect. In the interest of patient-centred care and better quality health care, the CPSO policy should specifically require MDs to collaborate with other regulated health professions when requested by a patient to better meet that patient's needs, and MDs should be expected to know the scope of practice of other regulated professions, to make appropriate referrals. MDs should not be permitted to withhold information about clinically acceptable practice available from other regulated health professions from patients expressing an interest. Lines 247 to 249 may currently give too much latitude to an MD to dissuade a patient from further inquiry. Lines 249 to 251 is a more positive approach, encouraging MDs to provide helpful guidance for situations where the MD does not have full knowledge of a given therapy, and that they should disclose this to patients and refer or consult as appropriate.

This is in keeping with the duties of an MD to the patient outlined in the CPSO Practice Guide: "providing the best quality care for the people of Ontario requires physicians to work together effectively—with patients, other doctors and other health professionals…. Collaboration is not only about getting along and treating others with respect—although this is extremely important—it is also about recognizing and accepting the unique roles and contributions of other health professionals. "

Limits on Terminating the Physician-Patient Relationship

Lines 256 to 262 should be updated to clarify that a patient choice of non-allopathic care should not be used as a basis for ending the physician-patient relationship. The draft policy should provide more guidance on the requirement in the recently updated CPSO policy on *Ending the Physician-Patient Relationship* that it is inappropriate to end a relationship because an MD disagrees with a patient's interest in non-allopathic therapies. Our members continue to report patients of MDs faced with threats of their MD withdrawing care because they are also receiving care from an ND. In treating patients, MDs should be reminded that they are not permitted to discontinue care because they disagree with the choice of a patient to receive the services of another regulated health professional. The draft policy is very positive in encouraging MDs to take reasonable steps where there is a concern about an interaction between allopathic and non-allopathic therapies.

Professional Affiliations (Lines 268 to 282)
Some of our members who are working in integrative practices have been reporting cases where MDs are being actively discouraged from forming professional affiliations with naturopathic doctors.

We would presume that this section is built upon the assumption by the CPSO that a professional affiliation with a provincially-regulated health profession like naturopathic doctors is acceptable in all circumstances. The policy must clearly embody the principle that an MD can assume that another regulated health practitioner, working within the standards of practice of their profession, does not unreasonably expose a patient to harm. The MD would then be bound by a general duty in this policy regarding any non-allopathic therapies being offered by other practitioners.

This section should be updated to clarify that this would only apply to unregulated health professions.

Appendix I: Introduction to Naturopathic Medicine

Naturopathic medicine is a well-established health profession in Ontario, having been regulated in Ontario under the *Drugless Practitioner Act (DPA)* since 1925. With the growing interest in a more natural approach to health, new regulation of the profession with the 2007 *Naturopathy Act*, and a continuing search for new solutions to meet Ontario's health challenges, naturopathic doctors are becoming an increasingly important part of Ontario's health care system. Ontario is a leading jurisdiction in North America, with over 1,000 naturopathic doctors (NDs) providing care for over 100,000 Ontarians.

The primary goal of naturopathic treatment is to look beyond symptoms to also address the root cause of illnesses. NDs are highly trained to integrate standard medical diagnostics with a broad range of natural therapies and the use of therapeutic natural substances to promote better health and support and stimulate the body's ability to heal itself. Science-based, safe and effective, patient-centred is are at the heart of all ND care.

Naturopathic care is highly patient-centred, and focused on treating the whole person. The longer length of appointments strongly contributes to the success of naturopathic care, in particular, prevention strategies and the early identification of disorders. NDs place a strong emphasis on lifestyle counselling, dietary modification and the education and empowering of patients to take charge of their health. Treatments used in naturopathic medicine can include the integrated use of clinical nutrition, botanical or herbal medicines, Asian medicine and acupuncture, homeopathic medicine, physical therapies and lifestyle counselling.

Training and Education

Naturopathic medicine closely parallels the training of those who will become MDs. This includes the pre-requisite of three years of undergraduate pre-med education, and a four-year full-time naturopathic medicine program focused on preparing clinicians for the challenges of primary care practice. NDs are specifically trained to collaborate with other health care practitioners and have clear standards of practice. There is a North American-wide system of accreditation for educational institutions that includes a standard curriculum and standardized examination.

Appropriate Referrals

Appropriate referrals to an ND include:

- Patients who express an interest in natural medicine or options to conventional medications;
- Patients who are looking for additional support and counselling to maintain and improve their health;

- Patients who are self-prescribing herbs and natural health products, and there are concerns about potential interactions with medications;
- Patients seeking additional care to manage side effects from medications;
- Patients with digestive problems or who require advanced nutritional advice; or
- Patients who have not had success with conventional options to address chronic or unresolved conditions.

New *Naturopathy Act* and Scope of Practice

In June 2007, the *Naturopathy Act* received Royal Assent as part of Bill 171, *Health System Improvements Act*. The *Naturopathy Act* moves the regulation of NDs from the *Drugless Practitioners Act* to the *Regulated Health Professions Act (RHPA)* with a clear scope of practice and the controlled acts of diagnosis, administration of substances, procedures below the dermis (venipuncture), inserting an instrument, hand or finger, and manipulation. The *Naturopathy Act* was amended in 2009 to include the controlled act of prescribing, dispensing, selling and compounding. These controlled acts confirm the current scope of practice of the profession under the *DPA*. Under the *DPA*, NDs are exempted from the restriction on authorized acts under the *RHPA*. The *Naturopathy Act* will come into force at the completion of the transition process, currently underway.

Appendix II: Clinical Scenarios

The following are clinical scenarios to illustrate areas of caution. The CPSO should continue to advise Ontario physicians to use caution when prescribing or discussing natural interventions with their patients. Specifically, physicians should be encouraged to consider the following scenarios as a way of evaluating when a referral or consultation is beneficial.

Scenario 1: A physician recommends a well-known natural intervention based on solid evidence of clinical efficacy but is unaware of emerging theoretical safety concerns in a specific sub-population.
Example: Folate supplementation in those with ischemic heart disease (Ebbing et al. 2009).
Additional skills/knowledge required: Mandatory continuing education in the pharmacology of natural interventions.

Scenario 2: A physician recommends a novel but seemingly innocuous natural intervention in favour of a natural intervention that has a strong history of safe use.
Examples: Oregano oil as an anti-viral in humans.
Additional skills/knowledge required: Knowledge of the history of natural interventions. The ability to identify novel ('fad') interventions or unusual posologies and non-standard indications where no human data exists.

Scenario 3: A physician claims that 'no evidence exists' for a specific natural intervention where some (perhaps weak) evidence does exist, in the hope that the patient will start a pharmacotherapy that has much better evidence. The patient starts neither therapy and deteriorates.
Examples: Menatetrenone for the treatment of osteoporosis. Underreporting the evidence for Vitamin K2 in hopes the patient will begin Actonel. (Bunyaratavej et al. 2001)(Inoue et al. 2009)(Forli et al. 2010)(Purwosunu et al. 2006).
Additional skills/knowledge required: Comprehensive knowledge of the evidence base. Ongoing education in the field of natural therapeutics. Ability to compare natural interventions along side pharmacotherapy.

Scenario 4: A physician offers a single natural intervention as an alternative to a drug that has been refused by the patient. The natural intervention on its own has a weaker effect than the drug, only reaching a positive therapeutic outcome when combined with multiple lifestyle and/or diet changes. Therapeutic failure ensues.
Example: CoQ10 vs beta-blocker for hypertension in the absence of exercise, breathing exercises, sodium restriction and weight loss.
Additional skills/knowledge required: Direct experience with the magnitude of effect of individual natural interventions. The ability to predict when a weaker intervention will not be sufficient to achieve a specific therapeutic outcome. Knowledge of comprehensive protocols and how to combine therapeutic modalities to provide additive effects.

Scenario 5: A patient asks if it is ok to use a homeopathic preparation in addition to their prescription medication. The physician assumes that the homeopathic preparation contains no active ingredients, unaware that many so-called 'homeopathic preparations' are only mildly diluted and/or contain additional non-homeopathic ingredients at physiological concentrations.
Example: Benzalkonium chloride, quercitin D2 in a 'homeopathic preparation' to treat allergic rhinitis.
Additional skills/knowledge: Knowledge of what is on the shelves. Familiarity with product names and ingredients, as well as ongoing trends and controversies in natural products in the Ontario marketplace. Knowledge of regulatory changes under the NHPD for natural health care products.

Scenario 6: A physician prescribes a therapeutic dose of a natural substance without accounting for occult sources of the natural substance in a patient's diet or supplemental regimen, resulting in overdose.
Example: Pregnant woman consuming vanadium supplements to control elevated blood glucose.
Additional skills/knowledge: Familiarity with toxic minerals and dosages that have the potential to do harm during pregnancy (Domingo 1996).

Scenario 7: A physician fails to warn/dissuade a patient from an ineffective or dangerous therapy in the context of presenting natural interventions as therapeutic options.
Example: A patient asks about 'almond seed extract' to prevent colon cancer. The physician shrugs her shoulders and says, 'I've never heard of that, so I can't recommend it.' She then proceeds to discuss the relation of dietary fibre and vitamin D status to colon cancer risk. The patient purchases the almond seed extract (aka laetrile, aka amygdalin, not legal in Canada) and suffers organ damage.(Bromley et al. 2005)(O'Brien, Quigg, and Tim Leong 2005)
Additional skills/knowledge required: Knowledge of the various forms and alternate names of natural interventions that are illegal and or dangerous. The ability to authoritatively and unequivocally recommend against dangerous, ineffective or illegal natural therapies.

The remaining examples highlight current challenges in patient care in situations where there is a poor working relationship between MDs and NDs:

Scenario A: A physician appears to be generally intolerant or dismissive of natural therapies in front of a patient. The patient conceals the use of a natural intervention which combines in an adverse way with the physician's prescription.
Additional skills/knowledge: Ability to admit gaps in knowledge in front of patient.

Scenario B: A physician appears to be generally intolerant or dismissive of naturopathic doctors. In an attempt to conceal the ND from the family physician, the patient denies to their ND that they have a family physician and have been prescribed a medication. The ND prescribes a natural intervention that interacts adversely with the prescribed medication.
Additional skills/knowledge required: Ability to project a professional image of collegiality towards other practitioners.

Scenario C: A physician refuses to release records to an ND after being asked to do so by a patient. The ND prescribes an incomplete or inappropriate natural intervention as a result.
Example: A patient's lab results display a mild elevation of LDL cholesterol and treatment is implemented by an ND not knowing that the patient's ICA has 85% stenosis. A physician fails to release documentation of the ICA to the ND causing a delay in statin therapy or other medications.
Additional skills/knowledge: Education regarding core competencies of naturopathic doctors and legal authority of patients to direct health information. Increased inter-professional communication and collaboration.