

The Increasing Involvement of Physicians in Complementary and Alternative Medicine: Considerations of Professional Regulation and Patient Safety

*Nola M. Ries & Katherine J. Fisher**

Patients now often ask physicians to integrate complementary and alternative medicine (CAM) treatments into conventional medical practice, creating a tension between respect for patient autonomy and the ideal of evidence-based medicine. Alternative practitioners have sought to capitalize on this growing patient demand by pushing for the right to self-regulation, arguing that they are in the best position to develop policies with respect to their own services. Provincial and territorial legislatures and medical colleges have developed policies on the use of CAM by physicians, on physicians' referral of patients to CAM, and on physicians' acquiescence in the recourse to CAM by patients on their own initiative. Some jurisdictions continue to follow the long-standing pattern of having different regulatory regimes for specific professions, while others have moved to an umbrella statute covering all regulated health professions. Whatever the form of the existing policies, their thrust tends to be quite restrictive, as the medical community has been hesitant to allow physicians to provide or recommend treatments that have not been proven to be scientifically sound by traditional standards. However, some provinces and territories have adopted "negative proof" provisions that allow physicians to offer CAM treatments which pose no more risk than conventional practices.

The authors conclude that existing regulatory models send contradictory messages, and should be revised to give physicians clearer guidelines on how to balance patient demand with concerns for patient safety. They point to the need for more research on the practical impact of regulation in this area, and on the impact of CAM in certain fields where patients are likely to be particularly vulnerable.

* Nola M. Ries, JD, MPA, LL.M., External Research Fellow, Health Law and Science Policy Group, Faculty of Law, University of Alberta. Katherine J. Fisher, BScN, MN, JD, Faculty of Law, University of Alberta. Funding support is gratefully acknowledged through the Canadian Institutes of Health Research-funded SafetyNet project and the Allergy, Genes and Environment Network of Centres of Excellence. The authors thank Timothy Caulfield, Canada Research Chair in Health Law and Policy and Professor, Faculty of Law and School of Public Health, University of Alberta, for very helpful insights. They are also grateful to anonymous peer reviewers, whose recommendations helped to improve the analysis of regulatory college policies.

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Introduction

Growing interest in complementary and alternative medicine (CAM) represents an important development in Canadian health care and raises difficult questions about the relationship between CAM and conventional medicine. Patients are increasingly seeking access to CAM, and some conventional practitioners, including physicians, want to integrate it into their practice or collaborate in other ways with CAM practitioners.

CAM can be defined as any form of medicine not considered to be part of conventional medical practice.¹ The United States National Center for Complementary and Alternative Medicine divides CAM into five broad categories: (1) alternative medical systems, including homeopathy and naturopathy; (2) biologically based therapies, including herbal and botanical remedies; (3) mind-body interventions, including guided meditation, hypnotherapy and yoga; (4) manipulative and body-based practices, including spinal manipulation, massage therapy and acupuncture; and (5) energy therapies, including biofield and bioelectromagnetic-based therapies.² While conventional health care therapies are practiced by physicians, registered nurses and allied health

1. United States Department of Health and Human Services, National Center for Complementary and Alternative Medicine, *What is Complementary and Alternative Medicine?*, online: Students for Integrative Medicine <<http://cim.ucdavis.edu/clubs/camsig>> at 1 [*What is CAM?*].

2. *Ibid* at 2–3. For a comprehensive list of therapies classified as complementary or alternative, see L Susan Wieland, Eric Manheimer & Brian M Berman, “Development and Classification of an Operational Definition of Complementary and Alternative Medicine for the Cochrane Collaboration” (2011) 17:2 *Alternative Therapies in Health and Medicine* 50 at 53. See also Cochrane CAM Field, “Operational Definition of CAM”, online: University of Maryland School of Medicine <<http://www.compmmed.umm.edu/cochrane>> .

professionals (such as physiotherapists), CAM is generally practiced by less formally trained and regulated practitioners.³ Upwards of 20% of Canadians—over 6 million people—now use some form of CAM in any given year.⁴ Patients express a wide range of reasons for seeking out alternative therapies, including preventing or treating a disease, boosting the immune system, promoting overall health and enhancing well-being and quality of life.⁵

Physicians may be involved in CAM in several ways: they may use alternative therapies in their own practice; they may advise and treat patients who obtain CAM therapies from other health practitioners; and they may engage in collaborative practice with CAM practitioners.⁶ A 1998 international literature review found that “[r]ates of CAM practice by conventional physicians varied from a low of 9% for homeopathy to a high of 19% for chiropractic and massage therapy.”⁷ Physicians most commonly used or made referrals for alternative therapies for “chronic pain, back problems, psychological problems, headaches and chronic illnesses”.⁸ In the mid-1990s, a survey of 200 general practitioners in Alberta and Ontario found that 16% practiced CAM, 20% had some CAM training and half of those with no such training expressed interest

3. *What is CAM?*, *supra* note 1 at 1.

4. For a review of relevant studies, see Gavin J Andrews & Heather Boon, “CAM in Canada: places, practices, research” (2005) 11:1 *Complementary Therapies in Clinical Practice* 21 at 22. CAM uptake is higher among some specific patient groups, such as people who are HIV-positive and using anti-retroviral therapies. See Shayesta Dhalla et al, “Complementary and alternative medicine use in British Columbia: A survey of HIV positive people on antiretroviral therapy” (2006) 12:4 *Complementary Therapies in Clinical Practice* 242.

5. See E Ernst & SK Hung, “Great Expectations: What Do Patients Using Complementary and Alternative Medicine Hope For?” (2011) 4:2 *Patient* 89.

6. See College of Physicians and Surgeons of Ontario, *Complementary/Alternative Medicine*, Policy Statement #3–11 (2011), Scope, online: College of Physicians and Surgeons of Ontario <<http://www.cpso.on.ca>> [CPSO Statement on CAM].

7. John A Astin et al, “A Review of the Incorporation of Complementary and Alternative Medicine by Mainstream Physicians” (1998) 158:21 *Archives of Internal Medicine* 2303 at 2303.

8. *Ibid* at 2308. The literature review also found that “[a]cupuncture had the highest rate of physician referral to CAM professionals (43%) . . . followed by chiropractic (40%) and massage (21%).” *Ibid*.

in acquiring some.⁹ Additionally, results from a 2001 survey of Canadian family practitioners reported that 12% offered CAM services in their practice.¹⁰

CAM practitioners have sought professionalization in an effort to gain greater legitimacy, in particular by pushing for legislative approval to self-regulate—a status that has historically been reserved for conventional medical professions. At the same time, there has been significant debate in the medical community about whether and how physicians should use alternative therapies, many of which lack scientific evidence of their efficacy. In response, and in light of growing patient demand for alternative treatment options, legislatures and colleges of physicians and surgeons have begun to develop policies on the use of alternative medicine by physicians in order (as one study has put it) to “simultaneously prioritize patient safety and treatment efficacy yet offer choices that promote patient ownership of health”.¹¹

Efforts to meet the challenge of addressing CAM use in conventional health care practice are relatively new in Canada. This paper’s aim is to provide an account of the current state of regulatory development in the area, and thereby build a foundation for further research. Part I of the paper offers an overview of the regulation of conventional health professions in Canada. Part II discusses the move toward the professionalization and self-regulation of alternative health practitioners. Part III reviews practice standards and policies implemented by provincial legislatures and medical colleges, and considers some issues relating to those policies. Part IV focuses on the interface between patient choice and the professional judgment of physicians. Part V considers the need for more collaboration

9. See Marja J Verhoef & Lloyd R Sutherland, “Alternative medicine and general practitioners: Opinions and behaviour” (1995) 41 *Canadian Family Physician* 1005 at 1006, 1008.

10. See Kristine A Hirschhorn, Robert Andersen & Ivy L Bourgeault, “Canadian Family Physicians and Complementary/Alternative Medicine: The Role of Practice Setting, Medical Training, and Province of Practice” (2009) 46:2 *Canadian Review of Sociology* 143 at 151. CAM use was highest among family doctors practising in British Columbia (22%) and among those in solo practice generally (20%). *Ibid.*

11. Kjersti E Knox, Vinjar Fønnebø & Torkel Falkenberg, “Emerging Complementary and Alternative Medicine Policy Initiatives and the Need for Dialogue” (2009) 15:9 *Journal of Alternative and Complementary Medicine* 959 at 959.

between practitioners of conventional and alternative medicine. The paper concludes with some suggestions for future study.

I. Regulation of Health Professions in Canada

A. An Overview of Self-Regulation

The vast majority of conventional health professions in Canada are self-regulated by provincial colleges.¹² For example, the College of Physicians and Surgeons of Ontario is the self-regulating body for medical doctors in that province, and the College of Nurses of Ontario is the equivalent for nurses. Among the responsibilities of these colleges is the development and maintenance of standards of qualification, professional practice and ethics for their members.¹³

Proponents of self-regulation argue that the members of a profession have more expertise in their practice area than a government regulatory agency and are thus better suited to determine the standards for practitioners.¹⁴ Critics, on the other hand, focus on issues of weak and ineffectively enforced regulatory standards and inadequate disciplinary mechanisms.¹⁵

Although self-regulated professions are granted a large degree of autonomy, they enjoy their powers through statutory delegation by provincial governments, which can modify those powers by amending

12. There are two categories of regulatory control over health professionals: input regulation and output regulation. Input regulation determines who is entitled to provide health services through a licensure or similar system. It includes the establishment of credentials (such as formal education and experiential training) required for admission into a profession. Output regulation governs licenced practitioners. It includes setting practice standards, investigating complaints and disciplining members who have failed to meet the required standards. Tracey Epps, "Regulation of Health Care Professionals" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham, Ont: LexisNexis Canada, 2011) 75 at 79–83. For further elaboration on the theory and practice of input and output regulation, see Michael J Trebilcock, "Regulating the Market for Legal Services" (2008) 45:5 *Alta L Rev* 215. See especially *ibid* at 219–27.

13. See Epps, *supra* note 12 at 84.

14. See Neil Gunningham & Joseph Rees, "Industry Self-Regulation: An Institutional Perspective" (1997) 19:4 *Law & Pol'y* 363 at 366.

15. See Epps, *supra* note 12 at 81.

legislation and approving regulations and bylaws.¹⁶ As part of their delegated authority, self-regulating colleges are entrusted with protecting and promoting the public interest and patient safety.¹⁷ To this end, they are mandated to establish continuing education and professional development programs, to develop and update standards of practice and to implement processes for self- and peer-assessment.¹⁸ Colleges must also establish procedures for handling complaints and allegations of professional misconduct and must establish codes of professional ethics.¹⁹

B. The Move Toward Umbrella Legislation

British Columbia, Alberta, Manitoba, Quebec, Ontario and—most recently—Nova Scotia have adopted an “umbrella” approach to regulating health professions.²⁰ This approach aims to strike a balance between professional self-regulation and government oversight.²¹ In those provinces, a single statute covers all of the regulated professions. Profession-specific regulations or bylaws are promulgated under

16. See Margot Priest, “The Privatization of Regulation: Five Models of Self-Regulation” (1997–1998) 29:2 *Ottawa L Rev* 233 at 238, 252.

17. See *Health Professions Procedural Code*, being Schedule II of the *Regulated Health Professions Act, 1991*, SO 1991, c 18 [Ontario *Health Professions Procedural Code*] (“[i]n carrying out its objects, the College has a duty to serve and protect the public interest”, s 3(2)); see also *Health Professions Act*, RSBC 1996, c 183 [BC *Health Professions Act*] (which sets out the general duties of a health profession regulatory college: “It is the duty of a college at all times a) to serve and protect the public, and b) to exercise its powers and discharge its responsibilities under all enactments in the public interest”, s 16(1)).

18. See e.g. Ontario *Health Professions Procedural Code*, *supra* note 17, ss 80–80.1; BC *Health Professions Act*, *supra* note 17, ss 16(2)(d)–(e); *Health Professions Act*, RSA 2000, c H-7, ss 3(1)(c), 50 [Alberta *Health Professions Act*].

19. See *ibid*, ss 3(1)(d), 54–96.1, 133; Ontario *Health Professions Procedural Code*, *supra* note 17, s 3(1)(5); BC *Health Professions Act*, *supra* note 17, s 16(2)(g).

20. *Ibid*; Alberta *Health Professions Act*, *supra* note 18; *The Regulated Health Professions Act*, CCSM 2009, c R117 [Manitoba *Regulated Health Professions Act*]; *Regulated Health Professions Act*, SO 1991, c 18 [Ontario *Regulated Health Professions Act*]; *Professional Code*, RSQ c C-26 [Quebec *Professional Code*]; *Regulated Health Profession Network Act*, SNS 2012, c 48 [Nova Scotia *Health Profession Act*].

21. See British Columbia Ministry of Health, Health Professions Council, *Safe Choices: A New Model for Regulating Health Professions in British Columbia*, part 1, vol 1 (British Columbia Ministry of Health, 2001), IV(B), online: British Columbia Ministry of Health <<http://www.health.gov.bc.ca>> [Safe Choices].

that statute. In contrast, the traditional approach, which applies in Saskatchewan, New Brunswick and Nunavut, uses a separate statute for each health profession. The traditional model has been criticized for resulting in “fragmented, complex and inconsistent” regulation.²² The Appendix sets out each province and territory’s regulatory model and their relevant statutes.

The move to umbrella legislation has led to non-exclusive and non-exhaustive descriptions of each regulated profession’s activities and areas of practice.²³ This means that different regulated professions may have overlapping or shared activities. Restricted or controlled practices remain, but in the form of a narrowly defined list of invasive, higher-risk activities that may be carried out only by members of those regulated professions that have been given specific authority to do so.²⁴

In a major report, the Health Professions Council in BC observed that regulatory policy for health professions has seen a trend toward “reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility for population groups to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public”.²⁵ As discussed below, the goals of expanding consumer choice and protecting the public may come into conflict in the area of CAM.

22. Epps, *supra* note 12 at 88. In Newfoundland and Labrador and in the Yukon, there is a hybrid model: umbrella legislation governs some health professionals groups, but separate statutes continue to apply to others (typically traditional professions such as medicine, dentistry and nursing). Prince Edward Island and the Northwest Territories currently have individual statutes, but umbrella legislation is on the government’s agenda in both jurisdictions. See the Appendix for further details.

23. See Joan M Gilmour, Merrijoy Kelner & Beverly Wellman, “Opening the Door to Complementary and Alternative Medicine: Self-Regulation in Ontario” (2002) 24:2 Law & Pol’y 149 at 170.

24. Examples of controlled acts include cutting bodily tissue below the dermis and setting a bone fracture.

25. *Safe Choices*, *supra* note 21.

II. The Move Toward Professionalization and Self-Regulation of CAM

CAM practitioners have sought recognition as regulated health professionals, both to gain legitimacy and to reap benefits such as enhanced income, status and power.²⁶ They commonly seek such recognition through self-regulation,²⁷ which as we have seen, was previously reserved for traditional health care providers.

Currently, most CAM practitioners are not regulated in any way. This means that an individual with any level of experience and training may practice, creating a “buyer-beware” market for patients.²⁸ CAM groups have argued that increased regulation of their services would protect both practitioners and patients.²⁹ In the same vein, an article in the *Medical Journal of Australia* has argued that “occupational regulation of CAM practitioners will minimise practice risks by restricting practice to individuals with acceptable educational qualifications and by enforcing appropriate practice standards”.³⁰ The article claims it would allow quality standards to be identified and enforced, and would thereby provide a safer environment for patients.³¹ The field of naturopathy offers an example of a successful campaign by a group of CAM practitioners to gain professional recognition. The scope of naturopathic practice was extended in BC and

26. See Sandy Welsh et al, “Moving forward? Complementary and alternative practitioners seeking self-regulation” (2004) 26:2 *Sociology of Health & Illness* 216 at 221.

27. See Epps, *supra* note 12 at 107.

28. Heather Boon, “Regulation of complementary/alternative medicine: a Canadian perspective” (2002) 10:1 *Complementary Therapies in Medicine* 14 at 16.

29. See e.g. Gilmour, Kelner & Wellman, *supra* note 23. See also Michael McIntyre, “Can CAM Come in from the Cold? An Update on the Ongoing Regulatory Process with Regard to Herbal and Acupuncture Practitioners in the United Kingdom” (2003) 9:6 *Journal of Alternative and Complementary Medicine* 809.

30. Stephen P Myers & Phillip A Cheras, “The other side of the coin: safety of complementary and alternative medicine” (2004) 181:4 *Medical Journal of Australia* 222 at 225.

31. *Ibid.*

Ontario in 2010,³² and naturopaths gained status as a health profession in Alberta in 2012.³³

To achieve legal designation as a self-regulating professional group, CAM practitioners must bring themselves within provincial statutory definitions of a “health profession”, which generally requires that they study a specific, integrated body of knowledge and that they practice in accordance with it. For this reason, practitioners in areas that have defined bodies of theory and practice (such as naturopathy, chiropractic and traditional Chinese medicine) are the most likely to attain status as a regulated profession. In contrast, yoga, for example, faces higher hurdles because it comprises many different traditions and has less standardized practices.³⁴ For some groups of CAM practitioners, an even more important obstacle to attaining self-regulatory status lies in the requirement that their activities be shown to pose no greater risk of harm to the public than traditional health practices. The concerns over CAM posing a risk to the public will be further discussed below.

In light of these requirements, the strategies adopted by CAM groups in the pursuit of self-regulation have focused on standardizing their practices and establishing an evidence base for their interventions.³⁵ Such strategies call for improving education and practice standards, engaging in peer-reviewed research and increasing the degree of cohesion within the particular group.³⁶

32. See Laura Eggertson, “Naturopathic doctors gaining new powers” (2010) 182:1 Can Med Assoc J E29.

33. See Government of Alberta, Press Release, “Naturopath profession recognized under Health Professions Act” (25 July 2012) online: Government of Alberta <<http://alberta.ca>>. The Northwest Territories also recently considered whether to enact legislation regulating naturopaths. Government of the Northwest Territories, Department of Health and Social Services, *Regulation of the Naturopath Profession in the Northwest Territories: Discussion Paper* (Field LLP, 2012).

34. Voluntary forms of regulation may apply to such activities. For example, fitness facilities that hire yoga instructors may require that they hold certification from specific bodies that offer specialized training.

35. See Welsh et al, *supra* note 26 at 222.

36. See *Ibid.*

III. The Structure and Objectives of Regulatory Policies on Physician Use of CAM

Patient safety in CAM therapies is a major ongoing concern. Manipulative body-based treatments clearly pose a risk of physical harm. For example, cervical spinal manipulation may bring post-treatment reactions, including cerebrovascular injury.³⁷ Acupuncture presents a risk of infection from needles,³⁸ and natural health products may cause allergic reactions or adverse interactions with other drugs.³⁹ Physical harm may also result if patients reject drugs with known results in favour of substances of uncertain effect, or if they forego proven conventional therapies in favour of alternative approaches.⁴⁰ Out of these concerns for patient safety, Canadian legislatures and colleges of physicians have set limitations on the extent to which physicians may incorporate CAM into their own practices.

Several provincial and territorial legislatures have passed legislation in an effort to clarify physicians' rights and responsibilities with respect to CAM and patient safety. Nearly identical provisions in BC, Alberta, Manitoba, Ontario and the Northwest Territories permit medical practitioners to provide complementary and alternative therapies if they

37. There is debate over whether the risks of spinal manipulation therapy outweigh the benefits. See e.g. Kirk Eriksen, Roderic P Rochester & Eric L Hurwitz, "Symptomatic reactions, clinical outcomes and patient satisfaction associated with upper cervical chiropractic care: A prospective, multicenter, cohort study" (2011) 12:1 *BMC Musculoskeletal Disorders* 219; Edzard Ernst, "Adverse effects of spinal manipulation: A systematic review" (2007) 100:7 *Journal of the Royal Society of Medicine* 330.

38. See e.g. Adrian White, "A cumulative review of the range and incidence of significant adverse events associated with acupuncture" (2004) 22:3 *Acupuncture in Medicine* 122.

39. See Mano Murty, "Postmarket surveillance of natural health products in Canada: clinical and federal regulatory perspectives" (2007) 85:9 *Canadian Journal of Physiology and Pharmacology* 952 (Murty states that "[a]lthough the vast majority of [natural health products (NHPs)] are considered to be low risk, there have been some serious, life-threatening adverse reactions associated with the use of several NHPs that have required regulatory action" at 952).

40. A 2010 American study of people who avoided using conventional health care found that a quarter of them used alternative medicine instead. See Richard L Nahin, James M Dahlhamer & Barbara J Stussman, "Health need and the use of alternative medicine among adults who do not use conventional medicine" (2010) 10 *BMC Health Services Research* 220 at 228.

pose no more risk than traditional practices.⁴¹ These are called “negative proof” statutory provisions. For example, the BC *Health Professions Act* states that the regulatory college cannot take action against a physician “unless it can be demonstrated that the therapy poses a greater risk to patient health or safety than does prevailing medical practice”.⁴² Alberta’s *Health Professions Act* also allows physicians to provide non-traditional therapy, and specifically indicates that:

A regulated member is not guilty of unprofessional conduct or a lack of competence solely because the regulated member employs a therapy that is non-traditional or departs from the prevailing practices of physicians, surgeons or osteopaths unless it can be demonstrated that the therapy has a safety risk for that patient that is unreasonably greater than that of the traditional or prevailing practices.⁴³

Interestingly, a study based on 2001 data found that the existence of negative proof legislation in a province was not associated with a greater likelihood of physicians incorporating CAM into their practice. That study offered the following explanation: “While such legislation provides legal protection, should physicians choose to offer CAM services, its presence has either *not yet* influenced physicians’ behavior, or in and of itself, it is simply not an important factor in physicians’ decision-making around CAM”.⁴⁴

Several provincial colleges of physicians require their members to undertake a risk/benefit analysis before engaging in CAM practices. The College of Physicians and Surgeons of Manitoba, for example, states that physicians can refer patients for non-traditional therapies “when there is no reason to believe that such a referral would expose the patient

41. See BC *Health Professions Act*, *supra* note 17, s 25.4; Alberta *Health Professions Act*, *supra* note 18, Schedule 21, s 5; *The Medical Act*, SM 2005, c 45, CCSM c M90, s 36.1 [Manitoba *Medical Act*]; *Medicine Act, 1991*, SO 1991, c 30, s 5.1 [Ontario *Medicine Act*]; *Medical Profession Act*, SNWT 2010, c 6, s 43(2) [Northwest Territories *Medical Profession Act*]. For discussion, see Ann Silversides, “More provinces protecting MDs who practise alternative medicine” (2002) 166:3 *Can Med Assoc J* 367.

42. *Supra* note 17, s 25.4.

43. *Supra* note 18, Schedule 21, s 5.

44. Hirschhorn, Andersen & Bourgeault, *supra* note 10 at 155.

to harm”.⁴⁵ The Ontario College allows physicians to use alternative therapies that have “a favourable risk/benefit ratio”, but insists that they “must never recommend therapeutic options that have been proven to be ineffective through scientific study”.⁴⁶ The College of Physicians and Surgeons of British Columbia requires that physicians “choose [the] course most likely to restore the patient to good health”, and that they weigh the risks and benefits of conventional and alternative therapies.⁴⁷

All of the colleges’ policies emphasize the importance of counseling patients on the potential harms and benefits of both conventional medicine and CAM, whether separately or in interaction with each other, so that the patient can give informed consent.⁴⁸ Medical faculties have considered incorporating education on CAM into their curricula,⁴⁹ and have embarked on initiatives to provide professional development opportunities with respect to CAM to both traditional and alternative practitioners.⁵⁰

45. College of Physicians and Surgeons of Manitoba, *Non-Traditional Therapy Provided by Members*, Statement No 108 (2005), s 2(e), online: College of Physicians and Surgeons of Manitoba <<http://cpsm.mb.ca>> [CPSM Statement on Non-Traditional Therapy].

46. CPSO Statement on CAM, *supra* note 6, B(1)(iii).

47. College of Physicians and Surgeons of British Columbia, *Complementary and Alternative Therapies*, Professional Standards and Guidelines (2009) at 2, online: College of Physicians and Surgeons of British Columbia <<http://www.cpsbc.ca>> [CPSBC Guideline].

48. For further discussion of informed consent, CAM and the ethical obligations of physicians, see Jeremy Sugarman, “Informed Consent, Shared Decision-Making and Complementary and Alternative Medicine” (2003) 31:2 *JL Med & Ethics* 247.

49. See CAM in UME Project, “About the Project”, *Complementary and Alternative Medicine in Undergraduate Education* (2013), online: Complementary and Alternative Medicine Issues in Undergraduate Medical Education <<http://www.caminume.ca>>. See also Marja Verhoef et al, “Complementary and alternative medicine in undergraduate medical education: Associate deans’ perspectives” (2004) 50:6 *Canadian Family Physician* 847.

50. For example, in British Columbia, the Complementary Medicine Education and Outcomes (CAMEO) research initiative was established at the British Columbia Cancer Agency. This program supports health professionals and patients in making safe and informed decisions about CAM use, and produces new knowledge about CAM use in patients with cancer. Those involved with CAMEO posit that “[w]ith more open and unbiased communication about [CAM] comes the possibility that evidence-based [CAM] therapies may one day be safely embedded into the everyday care of people experiencing cancer.” Lynda G Balneaves et al, “The Complementary Medicine Education and Outcomes (CAMEO) program: A foundation for patient and health professional education

Several policies have addressed the physical risks associated with CAM by drawing a distinction between diagnosis and therapy. These policies stipulate that physicians must use diagnostic tests “acceptable to orthodox medicine”⁵¹ to reach a conventional diagnosis, after which it may be acceptable to provide CAM-based treatment. For example, the BC College states that “the ethical physician must carry out appropriate and conventional examinations and investigations in order to establish a diagnosis and basis for treatment [and] must employ a rigorous medical approach before offering any unorthodox therapy”.⁵²

Some colleges require physicians to demonstrate that they have adequate training to deliver a particular alternative therapy safely. For example, the Alberta College says that physicians must not use CAM in their practices unless they have “been approved by the [College] to provide such therapy”.⁵³ It maintains a publicly available list of members who have that approval. Quebec has a similar policy specifically for acupuncture.⁵⁴

The colleges’ concerns for patient safety extend to the risk of financial harm from unconventional therapies, because patients who seek relief when conventional treatments have failed may be more vulnerable to exploitation. The Manitoba College says that “[p]hysicians must be aware

and decision support programs” (2012) 89:3 Patient Education and Counseling 461 at 465. Additionally, in 2003 the Department of Pediatrics at the University of Alberta launched a program called Complementary and Alternative Research and Education (CARE). The program combines research, education and clinical assessment to “create a supportive and collaborative environment where conventional health care providers, CAM practitioners, and trainees can investigate and learn about CAM therapies and products from a rigorous evidence-based perspective”. University of Alberta, CARE Program for Integrative Health & Healing, *Overview*, online: University of Alberta <<http://www.care.ualberta.ca>>.

51. College of Physicians and Surgeons of Manitoba, *Unproven Therapies*, Statement No 149 (1999) at 1, online: College of Physicians & Surgeons of Manitoba <<http://cpsm.mb.ca>> [CPSM Statement on Unproven Therapies]. See also CPSO Statement on CAM, *supra* note 6 (“[a]ll patient assessments and diagnoses must be consistent with the standards of conventional medicine and be informed by evidence and science” at B(1)(ii)). It further states: “Physicians providing CAM must reach a conventional diagnosis.” *Ibid.*

52. CPSBC Guideline, *supra* note 47 at 2.

53. College of Physicians & Surgeons of Alberta, *Complementary and Alternative Medicine*, Standards of Practice, Standard 10 (1 January 2010), s 2, online: College of Physicians & Surgeons of Alberta <<http://www.cpsa.ab.ca>> [CPSA Standard on CAM].

54. See *Regulation Respecting the Training of Physicians Who Wish to Practise Acupuncture*, RRQ 1996, c M-9, r 23, s 2.

of the economic well-being of their patients, and advise regarding [the] cost/benefit of any unproven therapy they may propose.”⁵⁵ Some colleges also address the potential for conflicts of interest on the part of physicians. The BC College, for example, cautions that a physician “[m]ust not exploit the emotions, vulnerability, or finances of a patient for personal gain or gratification”.⁵⁶ This would clearly prohibit such conduct as the promotion of alternative products in which the physician has a financial interest. The Canadian Medical Association’s Code of Ethics states that physicians must “[r]ecognize and disclose conflicts of interest . . . and resolve them in the best interest of patients”,⁵⁷ and that they must advise a patient if their “personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants”.⁵⁸

Many of the medical community’s concerns about CAM are based on the view that “unless a CAM group [has] a body of knowledge based on ‘scientific’ evidence and a way of delivering care in an objective, standardized fashion, it [is] unsafe to allow them to treat patients”.⁵⁹ In

55. CPSM Statement on Unproven Therapies, *supra* note 51. The consultation draft of a proposed new policy on CAM by Ontario’s College included an obligation to consider patients’ financial circumstances, but this requirement was removed from the final version. The draft stated that, in proposing CAM therapies, a doctor must “take into account the patient’s socio-economic status when the cost will be borne by the patient directly”. College of Physicians and Surgeons of Ontario, *Non-Allopathic (Non-Conventional) Therapies in Medical Practice* (formerly, *Complementary Medicine*), Draft Policy, s B1(iii) [on file with authors] [CPSO Draft Policy on Non-Allopathic Therapies]. It further stated:

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.

Ibid, s B2(iii).

56. CPSBC Guideline, *supra* note 47 at 2.

57. Canadian Medical Association, *CMA Code of Ethics* (2012), s 11, online: Canadian Medical Association <<http://www.cma.ca>> [*CMA Code of Ethics*].

58. *Ibid*, s 12.

59. Merrijoy Kelner et al, “Responses of established healthcare to the professionalization of complementary and alternative medicine in Ontario” (2004) 59:5 *Social Science & Medicine* 915 at 920.

one physician's words: "[our] profession should be worried by these trends, which see many doctors practising a form of medicine that would be rejected by most of their peers".⁶⁰ The Ontario College states that any CAM option recommended by physicians must be "informed by evidence and science".⁶¹ The BC College policy on CAM states that "although some untested remedies may be harmless, the absence of good evidence . . . makes recommendation of [a] treatment unethical",⁶² and that unproven treatments may be used only "within a clinical trial designed to establish the therapy's safety and efficacy".⁶³ The Manitoba College says that a therapy which is "not [yet] scientifically acceptable" may be used by a physician only as part of "an approved research project".⁶⁴

Some commentators argue that this sets the bar too high; in one writer's words, "as little as a quarter of conventional medicine is based on level-1 evidence".⁶⁵ Proponents of alternative medicine contend that the holistic nature of CAM demands that outcomes be evaluated on criteria that are broader than biomedical measures, because alternative therapies "are often aimed at affecting more than one aspect of a patient's life, and instead focus on maximizing the individual patient's capacity to achieve mental and physical balance and to, globally, restore his/her own health".⁶⁶ "It is becoming increasingly clear," the argument runs, "that commonly used outcome measures fall short in addressing these

60. John M Dwyer, "Is it ethical for medical practitioners to prescribe alternative and complementary treatments that may lack an evidence base?—No." (2011) 195:2 *Medical Journal of Australia* 79 at 79 ("[t]o see how professional standards can be consumed by the attractions of less scientifically rigid approaches, one has only to look at what has happened to the scientifically trained men and woman of pharmacy, whose shelves are stacked with useless products they knowingly promote to trusting customers" at 79).

61. CPSO Statement on CAM, *supra* note 6, B(1)(iii).

62. CPSBC Guideline, *supra* note 47 at 1.

63. *Ibid.*

64. College of Physicians & Surgeons of Manitoba, *Scientific Acceptability—Procedure Approval*, Statement No 153 (April 2001), 1–S38, online: College of Physicians & Surgeons of Manitoba <<http://cpsm.mb.ca>>.

65. Marie V Pirota, "Is it ethical for medical practitioners to prescribe alternative and complementary treatments that may lack an evidence base?—Yes." (2011) 195:2 *Medical Journal of Australia* 78 at 78. Level-1 evidence refers to evidence from at least one randomized controlled trial.

66. Marja J Verhoef et al, "Evaluating complementary and alternative medicine interventions: in search of appropriate patient-centered outcome measures" (2006) 6:38 *BMC Complementary and Alternative Medicine* at 2.

aspects”⁶⁷ and that “both individualized and global outcome measures appear necessary”.⁶⁸ Indeed, the broader claim is often made that the distinction between conventional and alternative medicine is fallacious—that because there is considerable evidence to support the effectiveness of some alternative medical practices, the appropriate distinction is between therapies that are proven and those that are not.⁶⁹

Continuing study of the safety and efficacy of CAM therapies and the development of robust and comprehensive assessment frameworks will help to address controversy over the use of those therapies in conventional medical practice. In line with the nascent state of the evidence base on CAM therapies, the current goal of physicians’ colleges seems to be limited to setting out basic guidelines for members who wish to offer CAM services. As one scholar has noted, “[t]he policy perspective underpinning these guidelines might be that the medical profession has accepted that physicians will be providing CAM and it is impractical to ban its use for political, economic or strategic reasons.”⁷⁰

IV. Patient Choice and Professional Judgment

Growing patient interest in alternative therapies highlights a tension between patient choice and the role of the physician in applying expert judgment based on their medical training. Some proponents of CAM argue that “[e]thically, consumers have the right to use alternative medicine therapies as a matter of autonomy.”⁷¹ More provocatively, some contend that if “patient-led [health care] is to become a reality, [conventional health care] professionals need to cede the power that they wield with evidence rhetoric and acknowledge the legitimacy of patient preferences, views and alternative sources of evidence”.⁷²

67. *Ibid.*

68. *Ibid.*

69. See e.g. Michael Weir, “Legal issues for medical doctors in the provision of complementary and alternative medicine” (2007) 26:4 *Med & L* 817 at 818.

70. *Ibid* at 825.

71. Peter A Clark, “The Ethics of Alternative Medicine Therapies” (2000) 21:4 *Journal of Public Health Policy* 447 at 470.

72. Lesley Wye, Alison Shaw & Debbie Sharp, “Patient choice and evidence based decisions: the case of complementary therapies” (2009) 12:3 *Health Expectations* 321 at 329.

Colleges have struggled to reconcile respect for patient autonomy with physicians' professional obligation to adhere to the ideal of evidence-based medicine. The Health Professions Council in British Columbia has recognized the tension between making more "choices available to the public in determining its health care needs while [at the same time] ensuring that the choices are within safe parameters".⁷³ This tension is also apparent in other forms of institutional guidance provided to physicians. The Canadian Medical Protective Association (CMPA), a national organization that represents the legal interests of physicians, offers this direction:

Physicians should respect the autonomy, health goals, and treatment decisions of their patients. Patients have the right to make decisions about their health in accordance with their values and preferences, including the right to pursue complementary or alternative forms of health treatments.⁷⁴

The CMPA goes on to say, however, that "physicians' professional, ethical, and legal obligations require them to act within the limits of their knowledge and provide care which is within the scope of their clinical practice and supported by current scientific evidence".⁷⁵

The Saskatchewan bylaw on chelation therapy illustrates the tensions surrounding CAM services that are in public demand but have no clear evidence of their effectiveness.⁷⁶ Chelation treatment is accepted as appropriate for removing heavy metals from the body.⁷⁷ Some health care providers also offer it to individuals with chronic inflammatory conditions and cardiovascular disease. Advocacy groups are pressing for wider access to it for these purposes, though research trials have produced inconsistent

73. *Safe Choices*, *supra* note 21, IV(D).

74. Canadian Medical Protective Association, "Alternative Medicine: What are the Medico-Legal Concerns?", (March 2012), online: Canadian Medical Protective Association <<http://www.cmpa-acpm.ca>> at 1.

75. *Ibid* at 2.

76. *College of Physicians and Surgeons of Saskatchewan Standards for Performance of Chelation Therapy*, Bylaw 52/1997, made pursuant to the *Medical Profession Act, 1981*, SS 1980-81, c M-10.1 [Saskatchewan Bylaw on Chelation Therapy].

77. See e.g. Health Canada, Drugs and Health Products, Fact sheet, "Exjade (deferasirox)" (October 2006), online: Health Canada <<http://www.hc-sc.gc.ca>> (Health Canada has approved chelation therapy to treat iron and lead overload).

evidence of its efficacy.⁷⁸ The Saskatchewan bylaw sends a confusing message. It states that although the provincial College of Physicians and Surgeons is “not convinced of the efficacy of chelation therapy, and does not endorse its use for any purpose other than heavy metal poisoning, it recognises that there is public demand for safe access to this treatment”.⁷⁹ The bylaw goes on to say, more forcefully, that “[c]helation therapy is an unproven therapy with an unproven record of safety and efficacy”,⁸⁰ and that “[n]o physician shall, by any method, state or imply that chelation therapy has been approved by the College of Physicians and Surgeons or that any particular physician has been endorsed by the College to perform chelation therapy.”⁸¹

The recent debate over a draft CAM policy from the Ontario College provides another illustration of the difficulties in reconciling patient safety and professional judgment. The version of the draft released for public consultation said:

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.

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.⁸²

78. See e.g. Antonio L Dans, Flordeliza N Tan & Essie C Villarruz-Sulit, “Chelation therapy for atherosclerotic cardiovascular disease (Review)” (2009) 4 Cochrane Database of Systematic Reviews, online: <<http://www.thecochranelibrary.com>>. For discussion of recent study results, see Andrew Pollack, “Much-Debated Treatment for Heart Disease Shows Slight Benefit in Clinical Trial”, *New York Times* (4 November 2012), online: *New York Times* <<http://www.nytimes.com>>.

79. Saskatchewan Bylaw on Chelation Therapy, *supra* note 76, s 1.

80. *Ibid.*, s 18.

81. *Ibid.*, s 12.

82. CPSO Draft Policy on Non-Allopathic Therapies, *supra* note 55, s A(i) [emphasis added].

After this language was criticized as representing an unjustified shift away from accepted standards of evidence and practice,⁸³ the College removed the instruction that a physician ought to respect a patient's decision even where the physician considers it unwise, and replaced it with the wording "[t]he College expects physicians to respect patients' treatment goals and medical decisions, even those with which physicians may *disagree*."⁸⁴

In contrast to the Ontario draft, the BC College's policy on CAM-based treatments states explicitly that "[a]lthough the patient is always an active participant in [the decision-making] process, it is the conscientious application of the experience and knowledge of the physician that is essential to determining the patient's best interest."⁸⁵ The BC College's policy goes on to say that as a last resort, a physician may be justified in terminating a relationship with a patient if the patient's insistence in pursuing CAM makes "it impossible for the physician to discharge his or her ethical responsibilities".⁸⁶ The Manitoba College seeks a middle ground between patient autonomy and professional judgment. It states that "[t]he patient has a right to seek health care from any provider even if the health service provided is unproven",⁸⁷ but puts a duty on the physician to inform the patient "[i]f the therapy is known to be harmful".⁸⁸ Furthermore, a Manitoba physician may provide a CAM therapy, but only where no evidence-based option is available.⁸⁹

While some of the provincial colleges' policies are worded in negative language, allowing alternative therapies where they are unlikely to cause harm, the Code of Ethics of the Canadian Medical Association (CMA) imposes on physicians a positive burden to "[r]ecommend only those diagnostic and therapeutic services that [they] consider to be beneficial to [their] patient."⁹⁰ The CMA's policy statement on CAM provides

83. For commentary on the policy consultation, see Lauren Vogel, "Ontario college beats retreat on alternative therapies" (2012) 184:1 *Can Med Assoc J* E41. See also CPSO Draft Policy on Non-Allopathic Therapies, *supra* note 55 (a summary of the consultation feedback compiled by the Ontario College).

84. CPSO Statement on CAM, *supra* note 6, A(ii) [emphasis added].

85. CPSBC Guideline, *supra* note 47 at 2.

86. *Ibid.*

87. CPSM Statement on Unproven Therapies, *supra* note 51.

88. *Ibid.*

89. See *ibid.*

90. *CMA Code of Ethics*, *supra* note 57, s 23.

some insight into the meaning of “beneficial”, stating that a particular therapy’s benefits should be “convincingly proven” before the therapy is recommended to patients,⁹¹ and that proof of its benefit and efficacy should be assessed with the same scientific rigour as would be applied to conventional medicine.⁹² Although the CMA’s Code of Ethics emphasizes patients’ autonomous decision-making rights, instructing physicians to “[r]espect the right of a competent patient to accept or reject any medical care recommended”,⁹³ it is silent on the situation of a patient who pursues alternative therapies in the absence of a medical recommendation.

V. The Benefits of CAM Policies in Promoting Patient Safety

It is clear that existing CAM policies struggle to reconcile the two competing ideals of patient choice and professional judgment. There are, however, three ways in which the ongoing development and implementation of CAM policies by medical regulatory bodies in Canada can play important roles in promoting and protecting patient safety.

First, although debate over the acceptability of alternative therapies within the medical community will likely persist, clearly drafted practice standards and policy statements can help to provide a robust framework for practitioners who wish to integrate CAM into their practice in a safe and ethical manner. Current CAM policies contain contradictory messages, revealing that regulatory colleges must walk a fine line between promoting patient safety and responding to patient demand for “unproven” therapies. The provincial colleges must enhance existing policies and continue to create new policies that are sensitive to this tension to provide physicians with clear practice guidelines.

Second, policies about CAM may promote improved communication between physicians and patients about alternative options and their potential benefits and harms. Many patients do not tell their physicians about their use of alternative therapies—at least half of patients who use

91. Canadian Medical Association, *Complementary and Alternative Medicine*, CMA Policy (2008) at 3, online: Canadian Medical Association <<http://policybase.cma.ca>>.

92. See *ibid* at 2.

93. *CMA Code of Ethics*, *supra* note 57, s 24.

alternative therapies do not discuss it with their primary care physician,⁹⁴ and this percentage is even higher for some patient groups, such as those receiving cancer treatment.⁹⁵ This non-disclosure can elevate the risk of harm if a physician recommends treatment that may interact adversely with alternative therapies. Moreover, there is a lost opportunity to discuss the patient's full range of options. In regard to enhancing the physician-patient relationship, "[t]he ability for a properly trained medical doctor to provide CAM in appropriate circumstances based on properly obtained consent from a patient . . . provides opportunities for strengthening trust and respect between medical doctors and patients."⁹⁶

Growing interest in CAM has resulted in doctors receiving increased patient inquiries about alternative therapy options.⁹⁷ As such, many CAM policies address the duties of doctors to counsel patients about the risks of alternative therapies patients pursue on their own. For example, Ontario's policy states:

If physicians are aware that a patient is receiving CAM, they should turn their minds to this fact when determining which conventional therapeutic options may be suitable. In particular, physicians must consider whether any potential negative interactions may arise between the conventional treatment and the CAM treatment and take reasonable steps to assess whether a negative or otherwise adverse reaction may arise.⁹⁸

To foster improved communication between doctor and patient, and thus maximize patient safety, comprehensive policies regarding the requirements of physicians in such situations are required. These policies must strike a balance between addressing patients' questions about CAM options and recognizing the boundaries of a physician's professional role and expertise.

For example, the 2011 draft CAM policy from the Ontario College appeared to permit physicians to aid patients who pursued alternative therapies. It stated that "[p]hysicians may wish to consider whether

94. See Clark, *supra* note 71 at 455, 457. See also Mandi L Furlow et al, "Physician and patient attitudes towards complementary and alternative medicine in obstetrics and gynecology" (2008) 8:35 BMC Complementary and Alternative Medicine 1 at 2.

95. See Balneaves et al, *supra* note 50 at 461.

96. Weir, *supra* note 69 at 828.

97. See e.g. Lynda Buske, "Popularity of alternative health care providers continues to grow" (2002) 166:3 Can Med Assoc J 366.

98. CPSO Statement on CAM, *supra* note 6, B(2)(iii).

they can assist patients in obtaining information [about an alternative therapy with which the physician is personally unfamiliar]. This may involve suggesting potential resources, or referring patients to other practitioners.”⁹⁹ These suggestions were, however, criticized for placing a burden on physicians to act as an informational clearing house for a wide range of alternative therapies that may be well outside the scope of the doctor’s training and experience. As a result, this language was removed from the final version of the policy, which now states that “[t]he College does not expect physicians to be knowledgeable about every CAM modality or treatment their patients may be pursuing or may wish to pursue.”¹⁰⁰ Future policies should continue to work towards striking a balance that will best enhance patient care without imposing an undue burden on medical practitioners.

Third, the policies of medical regulatory colleges with respect to CAM could, and should, endeavour to set a framework for ethical and productive collaboration between conventional health care professionals and CAM practitioners, particularly those practising in regulated CAM fields. Such collaboration could help mitigate patient safety concerns by ensuring coordinated care for the patient. In Ontario, a major 2006 provincial report on the regulation of health professions recommended that the procedural rules governing colleges “be amended to give the colleges flexibility to deal with multidisciplinary practice and to send a signal encouraging colleges to cooperate and share information”.¹⁰¹ The report noted that the traditional model for regulating health professions, which is based on exclusive scopes of practice, “did not contemplate the emerging trend toward multidisciplinary and collaborative practice”.¹⁰²

The move toward umbrella legislation in many provinces offers more opportunity for collaboration in practice, including “interdisciplinary collaboration on matters such as common scopes of practice, joint investigations and quality programs”.¹⁰³ In BC, for example, the *Health Professions Act* gives the College of Physicians and Surgeons the mandate

99. CPSO Draft Policy on Non-Allopathic Therapies, *supra* note 55, s B(2)(ii).

100. CPSO Statement on CAM, *supra* note 6, B(2)(iii).

101. Health Professions Regulatory Advisory Council, *Regulation of Health Professions in Ontario: New Directions* (Toronto: HPRAC, 2006) at 25, online: Ministry of Health and Long-Term Care <<http://www.health.gov.on.ca>> [*New Directions*].

102. *Ibid.*

103. *Ibid.*

to promote and enhance “interprofessional collaborative practice between its registrants and persons practising another health profession”.¹⁰⁴ Ontario’s *Regulated Health Professions Act* describes the following as one of the objects of a regulatory college: “[t]o develop, in collaboration and consultation with other Colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance interprofessional collaboration, while respecting the unique character of individual health professions and their members.”¹⁰⁵

Despite legislative endorsements of interprofessional collaboration, however, ethical and legal concerns still exist for physicians who engage in collaborative practice or refer patients to CAM practitioners.¹⁰⁶ The policies of some colleges already offer guidance on those concerns. The BC College, for example, cautions that a physician “[m]ust not associate with, or refer patients to, alternative practitioners who recommend unproven over proven therapies. By doing so, the physician assumes a degree of responsibility for the outcome of the treatment.”¹⁰⁷ Similarly, the Manitoba College states that a physician “may refer a patient to a practitioner who provides non-traditional therapies when there is no reason to believe that such a referral would expose the patient to harm”.¹⁰⁸ It is important that regulatory colleges continue to monitor developments in CAM, to seek feedback from physicians about their experiences using CAM and working with CAM practitioners and to revise policies and practice standards so that they reflect new evidence on alternative therapies.

Conclusion

The move toward umbrella legislation, coupled with the increased legislative recognition of some CAM fields as regulated professions, provide opportunities to standardize the regulation of alternative

104. *BC Health Professions Act*, *supra* note 17, s 16(2)(k)(ii).

105. *Ontario Regulated Health Professions Act*, *supra* note 20.

106. For a discussion of legal issues, see Gabriela Prada et al, *Liability Risks in Interdisciplinary Care: Thinking Outside the Box* (Ottawa: Conference Board of Canada, 2007).

107. CPSBC Guideline, *supra* note 47 at 2.

108. CPSM Statement on Non-Traditional Therapy, *supra* note 45, s 2(e).

health professionals. By applying common frameworks and obligations, regulatory colleges can establish clear guidelines and standards to promote and protect patient safety. Many provincial colleges have already developed policy statements with respect to medical doctors who use CAM in their practices or who interact with CAM practitioners.

Several areas can be identified in which further research is needed on the evolving relationship between conventional and alternative forms of practice. First, because many of the policies on medical practitioners' use of CAM are relatively new and have not yet been closely studied, little is known about their practical impact. For example, how do those policies influence physicians' professional use of alternative therapies and their interaction with CAM practitioners? College disciplinary proceedings could be a source of insight into how policies are interpreted and applied in situations of alleged misconduct.¹⁰⁹

Second, as discussed above, some provinces have statutory provisions that protect physicians from findings of unprofessional or incompetent conduct solely because they use non-traditional therapies. One study, based on data now over a decade old, found that these protections had not influenced professional uptake of such therapies.¹¹⁰ New data collection and analysis could reveal if this situation has changed and could consider the interplay between statutory negative proof protections and the requirements of CAM policies adopted by regulatory colleges. Third, research on the use of CAM in specific areas of health care practice—mental health and palliative care, for instance—would help inform regulatory responses designed to ensure safe care, especially for vulnerable patient groups.¹¹¹

109. See e.g. *Krop v College of Physicians and Surgeons (Ontario)*, 156 OAC 77, 111 ACWS (3d) 616; *Devgan v College of Physicians and Surgeons (Ontario)*, 193 OAC 357, 136 ACWS (3d) 959.

110. See Hirschhorn, Andersen & Bourgeault, *supra* note 10.

111. For a Canadian example of such research, see Joan Gilmour et al, "Pediatric Use of Complementary and Alternative Medicine: Legal, Ethical, and Clinical Issues in Decision-Making" (2011) 128:Supp 4 *Pediatrics* S149 (exploring the legal and ethical aspects of incorporating alternative therapies into pediatric health care).

Appendix

Regulation of Health Professions in Canadian Provinces and Territories

Jurisdiction	Number of Regulated Health Professions	Regulated CAM Practitioners ¹¹²	Regulatory Model	Key Reports or Initiatives
British Columbia	26 regulated health professions: <ul style="list-style-type: none"> • 25 are self-regulated • Emergency medical assistance is regulated under a separate statute 	Chiropractic Massage therapy Naturopathy Traditional Chinese medicine & acupuncture	Umbrella statute ¹¹³	<i>Safe Choices: A New Model for Regulating Health Professions in British Columbia</i> ¹¹⁴
Alberta	30 self-regulated health professions	Acupuncture Chiropractic Naturopathy	Umbrella statute ¹¹⁵	<i>Health Professions Act: A new law for regulated health care professions</i> ¹¹⁶
Saskatchewan	26 regulated professions	Chiropractic Naturopathy	Profession-specific statutes	
Manitoba	22 self-regulated professions	Chiropractic Naturopathy	Umbrella statute ¹¹⁷	<i>Proposed Umbrella Health Professions Legislation: The Regulated Health Professions Act</i> ¹¹⁸

112. CAM is defined here to consist of chiropractic, homeopathy, massage therapy, naturopathy, and traditional Chinese medicine and acupuncture.

113. *BC Health Professions Act*, *supra* note 17.

114. *Safe Choices*, *supra* note 21.

115. *Alberta Health Professions Act*, *supra* note 18.

116. Alberta Health and Wellness, *Health Professions Act: A new law for regulated health care professions* (Alberta Health and Wellness, 2006), online: Legislative Assembly of Alberta <<http://www.assembly.ab.ca>>.

117. *Manitoba Regulated Health Professions Act*, *supra* note 20.

118. Manitoba Health, *Proposed Umbrella Health Professions Legislation: The Regulated Health Professions Act* (Government of Manitoba, 2009), online: Manitoba Health <<http://www.gov.mb.ca/health>>.

Jurisdiction	Number of Regulated Health Professions	Regulated CAM Practitioners	Regulatory Model	Key Reports or Initiatives
Ontario	26 regulated health professions: <ul style="list-style-type: none"> • 21 self-regulated professions • 5 professions with transitional councils 	Traditional Chinese medicine & acupuncture (transitional) Chiropractic Homeopathy (transitional) Massage therapy Naturopathy (transitional)	Umbrella statute ¹¹⁹	<i>Regulation of Health Professions in Ontario: New Directions</i> ¹²⁰
Quebec	25 regulated health professions	Acupuncture Chiropractic	Umbrella statute ¹²¹	
New Brunswick	19 regulated health professions	Chiropractic	Profession-specific statutes	
Nova Scotia	17 regulated health professions	Chiropractic Massage therapy Naturopathy	Profession-specific statutes <ul style="list-style-type: none"> • <i>Regulated Health Professions Network Act</i> governs some professions¹²² • <i>Massage Therapy Act</i> is not yet in force¹²³ 	
Prince Edward Island	13 regulated health professions	Chiropractic	Profession-specific statutes <ul style="list-style-type: none"> • A draft umbrella statute was released for consultation in August 2012 • Naturopathic doctors and massage therapists are seeking regulation 	<i>Umbrella Health Professions Legislation for Prince Edward Island</i> ¹²⁴

119. Ontario *Regulated Health Professions Act*, *supra* note 20.

120. *New Directions*, *supra* note 101.

121. Quebec *Professional Code*, *supra* note 20.

122. Nova Scotia *Health Professions Act*, *supra* note 20.

123. *Massage Therapy Act*, SNS 2003, c 8.

124. Prince Edward Island Health and Wellness, Consultation Paper, *Proposed Umbrella Health Professions Legislation for Prince Edward Island* (Government of Prince Edward Island, 2012), online: Government of Prince Edward Island <<http://www.gov.pe.ca>>.

Jurisdiction	Number of Regulated Health Professions	Regulated CAM Practitioners	Regulatory Model	Key Reports or Initiatives
Newfoundland & Labrador	19 regulated health professions	Acupuncture Chiropractic Massage therapy	Umbrella statute ¹²⁵ • Some health professions are regulated under profession-specific statutes	
Northwest Territories	12 regulated health professions	No CAM professions are regulated	Profession-specific statutes; umbrella legislation is under consideration	<i>Health and Social Services Professions Legislation Discussion Paper</i> ¹²⁶
Nunavut	12 regulated health professions	No CAM professions are regulated	Profession-specific statutes	
Yukon	13 regulated health professions	Chiropractic	Umbrella statute ¹²⁷ • Currently governs two conventional health professions • Other health professions regulated under profession-specific statutes • Guidelines exist on acupuncture	

125. *Health Professions Act*, SNL 2010 c H-1.02.

126. *Health and Social Services Professions Legislation Discussion Paper* (2011). The discussion paper was open for public consultation until May 2011 and the paper itself is no longer available. A news release about the discussion paper is available at: Department of Health and Social Services, News Release, "Health and Social Services Professions Legislation" (8 April 2011), online: Government of the Northwest Territories < <http://news.exec.gov.nt.ca> >.

127. *Health Professions Act*, SY 2003 c 24.

