

# Potions, Promises and Paradoxes: Complementary and Alternative Medicine and Malpractice Law in Canada

*Timothy Caulfield and Colin Feasby\**

## I. Introduction

Over the past decade there has been a phenomenal growth of public interest in complementary and alternative medicine (CAM). Indeed, the provision and sale of CAM has become a major industry and, even, a political force – as witnessed by the federal government’s struggle to regulate natural health products.<sup>1</sup> Not surprisingly, this health care trend has also led to an increasing number of physicians integrating CAM into their conventional practice. For many physicians, the rise of CAM is closely linked to the perceived failures of conventional medicine<sup>2</sup> and, as such, they view CAM as a means of giving their patients the “best of both worlds.”<sup>3</sup> The popularity of CAM has resulted in increased pressure on physicians from the public and even from fellow physicians to keep an open mind or even to provide CAM treatments.<sup>4</sup> In recent years, there have been a number of efforts made to open the medical profession to CAM practices. Some examples of this trend include: the Medical Society of Nova Scotia established a CAM section in 1994; in 1996, a group of physicians formed the Canadian Complementary Medical Association;<sup>5</sup> in Ontario, the College of Physicians and Surgeons has started to make the profession more open to CAM;<sup>6</sup> there is an

---

\*Timothy Caulfield, LL.M., is Canada Research Chair in Health Law and Policy, Associate Professor, Faculty of Law and Faculty of Medicine and Dentistry, and Research Director, Health Law Institute, University of Alberta. Colin Feasby, LL.M., J.S.D. Candidate, Columbia University. We would like to thank Tracy Bailey and Nina Hawkins for their valuable assistance and the Alberta Heritage Foundation for Medical Research for their continued support.

<sup>1</sup>See, for example, Canada, *Natural Health Products: A New Vision* (Report of the Standing Committee on Health) (Ottawa: Library of Parliament, 1998) at 33.

<sup>2</sup>See O. Caspi, K. Koffler & L. Sechrest, “Use of Alternative Medicine by Women with Breast Cancer” Letter (1999) 341 N. Eng. J. Med. 1155 at 1155, where it is suggested that the choice to use a CAM is “a marker of our failure as physicians to fulfill the obligation to ‘cure sometimes, heal often, comfort always.’”

<sup>3</sup>K. Foss, “The New Doctors Without Borders” *The Globe and Mail* (14 December 1999) R10 at R10. See also C. Marwick, “Complementary Medicine Congress Draws a Crowd” (1995) 274 JAMA 106.

<sup>4</sup>P. Mark, “Don’t let message be ‘hopelessness’” *The Medical Post* 34 (27 January 1998) 32.

<sup>5</sup>C. Gray, “Growing popularity of complementary medicine leads to national organization for MDs” (1997) 157 CMAJ 186 at 187. The organization was founded in 1996 in Banff, Alberta and now has over 200 members: P. Wysong, “New organization will address complementary medicine” *The Medical Post* 33 (6 May 1997) 5. See generally, M.J. Verhoef & L.R. Sutherland, “General Practitioners’ Assessment of and Interest in Alternative Medicine in Canada” (1995) 41 Soc. Sci. Med. 511, where it is noted that there is an increased awareness among general practitioners about alternative medicine.

<sup>6</sup>R. Mackie, “Alternative medicine wins doctors’ support” *The Globe and Mail* (23 September 1997) A5.

increasing presence of alternative providers in some Canadian hospitals;<sup>7</sup> and the Vancouver Hospital has established the Tzu Chi Institute for Complementary and Alternative Medicine with a mandate to provide and study CAM.<sup>8</sup>

So, though a segment of the profession remains skeptical, it seems likely that an increasing number of Canadian physicians will be offering their patients the choice of having a combination of conventional and alternative treatments. While this mixed approach to the practice of medicine is undoubtedly attractive to many health care consumers, and may be viewed as an open-minded response to public interests, it is not without legal pitfalls. Specifically, the dearth of available evidence for many CAMs may make it difficult for physicians to meet the relevant legal standard of care.

The legal tensions associated with the provision of CAM therapies by physicians also highlight a number of social paradoxes inextricably linked to the growing popularity of alternative therapies that lack any evidence of efficacy. As health care budgets have come under a higher degree of scrutiny, the need for scientific evidence to justify the use and public financing of conventional treatments has intensified. Moreover, the incredible advances that have occurred in, for example, molecular genetics have revealed an unprecedented amount of information about the biology of many human diseases. Certainly a large percentage of conventional health care practices are not backed by sufficient evidence to justify their use;<sup>9</sup> but there is little doubt that conventional medicine is now more scientifically based than at any other time in history. Though it seems likely that many untested CAMs will turn out to be efficacious, a push for the integration of therapeutic alternatives that have no scientific basis can only be viewed as a practice paradox. How will the law respond? For example, to what standard of care will physicians be held? In a legal environment that is placing increasing emphasis on the physician's obligation to disclose accurate information, how much will a physician be required to disclose about CAM?

Part II of this paper begins with a number of sections that describe the current context in which any discussion of CAM will take place. It will begin by defining CAM and what forms of alternative medicine are being considered in this discussion. Next, the paper will look at the increase in public interest in CAM, which is truly becoming a social phenomenon, and some of the factors that may prompt individuals to turn to CAM for therapeutic treatment rather than to

---

<sup>7</sup>See A. Elash, "Move into hospital sector another sign of complementary medicine's growing popularity" (1997) 157 CMAJ 1589; R. Wigood, "Waiting for alternatives" *The Calgary Herald* (2 August 1997) J8.

<sup>8</sup>"Alternative medicine, it's official" *The Economist* (22 March 1997) 54; R. Wood, "Waiting for alternatives: Despite opening fanfare, Vancouver health-care centre's doors remain closed" *The Calgary Herald* (2 August 1997) J8; S. Maddalena, *The Legal Status of Complementary Medicines in Europe* [draft, Institute of Health Law, University of Neuchatel]; and M. Bitomsky, "Alternative medicine making headway with Aussie docs" *The Medical Post* 34 (6 January 1998) 16.

<sup>9</sup>See O. Miettinen, "Evidence in Medicine: Invited Commentary" (1998) 158 CMAJ 215.

conventional medicine. Undoubtedly, it is related, in part at least, to frustrations with the limits of conventional therapies and the technology-oriented approach of most conventional health care practitioners. The popularity of CAM also seems to be a practical manifestation of lingering postmodern ideology – the view that the biomedical, scientific perspective is but one of many. The ideological and social foundation of CAM will then be reviewed before a brief discussion of the changing attitudes of at least some physicians with respect to the use of CAM. In Part III of the paper, the legal obligations of physicians in relation to CAM will be explored, including an analysis of informed consent and the appropriate standard of care to be applied if a physician practices CAM.

## II. The Current Context

### 1. Defining CAM

Many definitions of “alternative” medicine abound in the literature<sup>10</sup> and, as such, we recognize that no single label will satisfactorily reflect the true breadth of this growing phenomenon. Nevertheless, for the purposes of this article, we have selected the term “complementary and alternative medicine” (CAM) as it includes the most commonly used vernacular term, “alternative,” as well as a preferred term of advocates of CAM, “complementary.”<sup>11</sup> What health care practices do we mean to capture by this term? From the perspective of this paper the most significant defining element is that the practice still falls outside the accepted practice norms for conventional practitioners such as physicians. Professional norms are highly relevant to the deliniation of legal standards. Thus, in this context, CAM refers to the “broad set of health care practices ... that are not readily integrated into the

---

<sup>10</sup>See, for example, D. Eskinazi, “Factors that shape alternative medicine” (1998) 280 JAMA 1621; C.R.B. Joyce, “Placebo and Complementary Medicine” (1994) 344 Lancet 1279; J.B. Houpt & R. McMillan, “Alternative Medicine--The Challenge of *Nicht-Schulmedizin* (or what is *Not* taught in medical schools)” (1997) 24 J. Rheumatology 2280; and M. Angell & J. Kassirer, “Alternative medicine - the risks of untested and unregulated remedies” (1998) 229 N. Eng. J. Med. 839.

<sup>11</sup>The difficulty in describing the scope of CAM is evident in the ongoing debate over the terminology that is used to label the phenomenon. “Alternative medicine” goes by many names: “unconventional”, “unorthodox”, “non-traditional” and “Eastern medicine.” Of course, the proponents of “alternative medicine” prefer appellations that have positive connotations such as “complementary”, “natural” or “holistic.” See W. Sampson, “Antiscience Trends in the Rise of the ‘Alternative Medicine’ Movement” in P.R. Gross, N. Levitt & M.W. Lewis, eds., *The Flight from Science and Reason* (New York: New York Academy of the Sciences, 1996) 188 at 190-91. Sampson argues that the proponents of alternative medicine use labels and terms that create false dichotomies, misrepresent the nature of modern medicine, and put a favourable gloss on alternative therapies. Scientists and medical doctors prefer labels with more negative connotations like “magic” or “quackery.” See, for example, C. Ramos-Remus & A.S. Russell, “Alternative Therapies--Medicine, Magic, or Quackery. Who is Winning the Battle?” (1997) 24 J. Rheumatology 2276; “Homeopathy, acupuncture called quackery by scientists” *Toronto Star* (15 February 1997) A6. All of these labels are unsatisfactory, however, as they are really part of a semantic power struggle between the supporters and critics of CAM.

dominant health care model,"<sup>12</sup> including: acupressure, aromatherapy, art therapy, ayurvedic medicine, chelation therapy, cranial therapy, ear candling, herbalism, homeopathy, hydrotherapy, hypnosis, massage therapy, naturopathy, osteopathy, ozone therapy, polarity therapy, reflexology, reiki, therapeutic touch, transcendental meditation, and, even, some uses of acupuncture and chiropractic.<sup>13</sup> This is not to say that many of these CAM practices are not in the process of being integrated into the mainstream. On the contrary, as we note below, the medical profession is becoming increasingly open to a variety of CAM. However, from a legal perspective, most of CAM is still on the fringe.

## 2. Public Interest

The public interest in CAM is truly remarkable.<sup>14</sup> For example, a study reported that in Australia nearly half (48%) of the general population is reported to make use of CAM therapies and 20.3% visit an alternative practitioner annually leading to an estimated cost of 930 million Australian dollars per annum.<sup>15</sup> Comparable figures can also be found in Europe where the prevalence of CAM use ranges from 24% in Denmark to 49% in France.<sup>16</sup> In the United States, Eisenberg *et al.* found that 42.1% of the general population uses at least one form of CAM treatment at an annual cost of 13.7 billion American dollars.<sup>17</sup> Comparing these

---

<sup>12</sup>Eskinazi, *supra* note 10 at 1622. A similar definition used by The Panel on Definition and Description of the US Office of Alternative Medicine defines CAM as:

a broad domain of healing resources that encompasses all health systems, modalities and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system or a particular society or culture in a given historical period.

Quoted in R. van Haselen & P. Fisher, "Evidence Influencing British Health Authorities' Decisions in Purchasing Complementary Medicine" (1998) 280 JAMA 1564 at 1564.

<sup>13</sup>There is a legitimate question as to whether chiropractic should really be categorized as "alternative." See comments in N. Vuckovic & M. Nichter, "Changing Patterns of Pharmaceutical Practice in the United States" (1997) 44 Soc. Sci. Med. 1285 at 1288. In many provinces, chiropractic is governed by statute (see e.g. *Chiropractic Profession Act*, R.S.A. 2000, c. C-13) and is covered in varying degrees by provincial health insurance programs.

<sup>14</sup>G.M. Shenfield, P.A. Atkin & S.S. Kristoffersen, "Alternative medicine: an expanding health industry" (19 May 1997) 166 Med. J. Austr. 516.

<sup>15</sup>A. MacLennan, D. Wilson & A. Taylor, "Prevalence and cost of alternative medicine in Australia" (1996) 347 Lancet 569. See also E. Ban, "Australian Alternatives" (1998) 4 Nat. Med. 8.

<sup>16</sup>P. Fisher & A. Ward, "Complementary Medicine in Europe" (9 July 1994) 309 BMJ 107.

In contrast to these high numbers, a study of use of CAM in Israel found that only 6% of Israelis had consulted with an alternative provider during the survey year (1993-94): J.H. Bernstein & J.T. Shual, "Nonconventional Medicine in Israel: Consultation Patterns of the Israeli Population and Attitudes of Primary Care Physicians" (1997) 44 Soc. Sci. Med. 1341 at 1344. See also Maddalena, *supra* note 8.

<sup>17</sup>D.M. Eisenberg *et al.*, "Trends in alternative medicine use in the United States, 1990-1997" (1998) 280 JAMA 1569 [hereinafter "Trends"]. Note, however, that Eisenberg *et al.*'s definition of unconventional medicine is quite broad. See also "Popularity of Alternative Medicine Still Growing in US, Canada, Polls Find" (March 1998) 4:2 Alternative Therapies 29 at 29, where it is reported that a poll conducted in November 1997 found that 42% of Americans had used an alternative therapy in the year prior to the poll; and L. Clark Paramore, "Use of Alternative Therapies: Estimates from The 1994 Robert Wood Johnson Foundation National Access to Care Survey" (1997) 13(2) J. of Pain and Symptom Management 83, which concluded that approximately 10% of the US population visited an alternative

figures to a similar study completed in 1990,<sup>18</sup> the data “suggest[s] a 47.3% increase in total visits to alternative medicine practitioners,” to a number which “exceeds the total visits to all US primary care physicians.”<sup>19</sup>

In Canada, a poll conducted in August 1997 by the Angus Reid Group showed that CAM use is also prevalent in Canada with 42% of adults reporting use of alternative therapies<sup>20</sup> – a rate of use comparable to that found in the United States. A 1997 study revealed that 15% of Canadians 15 years and older (approximately 3.3 million persons) consulted an alternative practitioner in 1994-95.<sup>21</sup> Although there are no estimates as to the amount of money expended on alternative therapies and related products in Canada, it is reasonable to conclude that it is a substantial sum indeed.

Though a number of studies have given us a general picture of the demographic which is most likely to use CAMs—a well educated, female, young to middle-aged adult with a higher than average income<sup>22</sup>—it is unclear what draws individuals to CAM. A common belief is that CAM users are individuals seeking more autonomy and personal control over health care decisions.<sup>23</sup> For example, Kellner and Wellman have found that personal responsibility for health is a common value held by many CAM users: “Patients of alternative practitioners clearly see an important role for themselves in their own health care. They emphasize the patient’s responsibility toward his/her own health, as well as making it clear that they know their own body best and trust their own judgement most.”<sup>24</sup> One need only look at the list of non-fiction best-sellers or glance around a local pharmacy or health food store to see evidence of the current Canadian pre-occupation with health, fitness, and self-improvement. The health product craze is characterized by an ethos of self-sufficiency and a rejection of expertise (although, curiously, most authors of self-help books trumpet their own expert qualifications). Self-medication, as Vuckovic and Nichter have remarked, is very much in tune with the spirit of our times: “A self-help ethic implies that individuals, rather than the

---

practitioner for chiropractic, relaxation techniques, therapeutic massage or acupuncture.

<sup>18</sup>D.M. Eisenberg *et al.*, “Unconventional Medicine in the United States” (1993) 328 N. Eng. J. Med. 246.

<sup>19</sup>“Trends,” *supra* note 17 at 1569 [abstract].

<sup>20</sup>“Popularity of Alternative Medicine Still Growing in US, Canada, Polls Find,” *supra* note 17 at 29.

<sup>21</sup>W.J. Millar, “Use of Alternative Health Care Practitioners by Canadians” (1997) 88 Can. J. Public Health 154 at 155.

<sup>22</sup>See “Trends,” *supra* note 17 at 1571; Millar, *ibid.*; and R. Blais, A. Maigo & A. Aboubacar, “How Different Are Users and Non-Users of Alternative Medicine?” (1997) 88 Can. J. Public Health 159 at 162 where it is reported that “users of unconventional therapies are relatively socially advantaged people: well-off, better educated and younger adults who, in turn, are in better health than non-users.”

<sup>23</sup>See generally M. Seidl & D. Stewart, “Alternative treatments for menopausal symptoms: qualitative study of women’s experience” (1998) 44 Can. Fam. Physician 1271.

<sup>24</sup>M. Kellner & B. Wellman, “Health Care and Consumer Choice: Medical and Alternative Therapies” (1997) 45 Soc. Sci. Med. 203 at 210.

state, are responsible for maintaining health. Such an ethic is politically attractive in an era of cost cutting in health care and social services.”<sup>25</sup>

While individual empowerment is undoubtedly an important element of CAM use, numerous other factors seem to be involved, including belief in the efficacy of the CAM,<sup>26</sup> concurrence with a particular philosophical or holistic orientation,<sup>27</sup> failure of standard care, and the existence of chronic health problems. Cultural differences and increasing market pressure are “also likely to affect the availability and use of alternative medicine.”<sup>28</sup> However, it is important to note that a recent study by Burstein *et al.* also suggests that for some populations the “use of alternative medicine [is] a marker of greater psychological distress and worse quality of life.”<sup>29</sup> To some degree, this study conflicts with the picture painted by Kellner and Wellman and “contrasts sharply with the widely held image of the woman who seeks help from alternative medicine as self-assertive, psychologically strong, and well-adjusted.”<sup>30</sup>

From the perspective of the physician who is interested in CAM, the studies on the CAM market show a tremendously strong and growing interest. There seems little doubt that many patients will welcome the opportunity to access physicians who are willing to mix CAM with conventional treatments.<sup>31</sup> In addition, the data suggests that patients may be using CAM for a variety of reasons and, as such, physicians should not allow existing stereotypes of CAM users to affect their clinical judgment.

---

<sup>25</sup>Vuckovic & Nichter, *supra* note 13 at 1295.

<sup>26</sup>J. Astin, “Why patients use alternative medicine” (1998) 279 JAMA 1548.

<sup>27</sup>See Kellner & Wellman, *supra* note 24 at 210.; where this Canadian study found that 28% of respondents turned to CAM because they believed in its holistic philosophy, whereas 22% turned to CAM out of desperation. It should be noted that the people who cited desperation as a motive were more likely to opt for naturopathy or acupuncture than chiropractic or reiki. People seeking naturopathy and reiki were more likely to cite belief than those seeking chiropractic or acupuncture. See also Astin, *ibid.* at 1548 [abstract]: “the majority of alternative medicine users appear to be doing so not so much as a result of being dissatisfied with conventional medicine but largely because they find these health care alternatives to be more congruent with their own values, beliefs, and philosophical orientation toward health and life.”

<sup>28</sup>H. Burstein *et al.*, “Use of Alternative Medicine by Women with Early-Stage Breast Cancer” (1999) 340 N. Eng. J. Med. 1733 at 1733.

<sup>29</sup>*Ibid.* at 1733 [abstract]. Later, the authors report that in this study of women diagnosed with breast cancer it was found that “women may start using alternative medicine in response to psychological symptoms or distress” (*ibid.* at 1738). However, see “Uses of Alternative Medicine by Women with Breast Cancer” Letters to the Editor (1999) 341 N. Eng. J. Med. 1155.

<sup>30</sup>J. Holland, “Use of Alternative Medicine - A Marker for Distress?” (1999) 340 N. Eng. J. Med. 1758 at 1758.

<sup>31</sup>See Blais, Maigo & Aboubacar, *supra* note 22 at 161 where it is summarized that: “[s]ome studies have shown that as many of 83% to 88% of clients of alternative medicine also used conventional medical services.”

### 3. Ideological and Social Foundations of CAM

Though there is no one generalizable description of the “CAM user,” and no one unifying theory that underlies the disparate varieties of CAM, we can make a few broad generalizations about the rhetoric which has surrounded the public discussions of CAM. CAM is largely a populist and anti-scientific approach to health care which, to some degree, is characterized by a rejection of expert judgment in favour of the beliefs and choices of lay persons and a heightened sense of individual responsibility.<sup>32</sup> While a growing number of CAMs are being subjected to rigorous scientific scrutiny,<sup>33</sup> many advocates of CAM “believe the scientific method is simply not applicable to their remedies.”<sup>34</sup>

A related theme is that most CAM advocates and providers would probably characterize CAM as more “holistic” than conventional treatments. “Holistic” refers to an existential view of health<sup>35</sup> wherein the spiritual, social, and physical aspects of an individual are considered to be indistinguishable. By contrast, a “scientific” view of health is one that is governed by objective and rational rules of proof. The holistic and scientific perspectives on health care are not antithetical, nor are they necessarily incompatible.<sup>36</sup> Many doctors—especially primary care providers—treat their patients “holistically,” giving lifestyle advice and providing counselling as well as dispensing prescriptions. Indeed, many medical schools now place a greater emphasis on seeing the patient as a whole person.<sup>37</sup> In some respects, then, the boundary between the holistic and scientific approaches to health is blurred. Nevertheless, holism and science are generally viewed as antagonistic concepts – particularly as they are characterized by the majority of medical doctors and CAM providers.

The idea of holistic medicine as it is viewed by CAM proponents is closely connected with the anti-scientific view of health often associated with CAM.<sup>38</sup> This is evident in the history of many of the major schools of CAM such as chiropractic, osteopathy and homeopathy which arose in reaction to the movement toward

---

<sup>32</sup>Indeed, some commentators suggest that this is the defining characteristic of CAM. See, for example, Angell & Kassirer, *supra* note 10 at 839, who argue that “[w]hat most sets alternative medicine apart, in our view, is that it has not been scientifically tested and its advocates largely deny the need for such testing.”

<sup>33</sup>R. Sikorski & R. Peters, “Researching Alternatives” (1998) 280 JAMA 1631.

<sup>34</sup>Angell & Kassirer, *supra* note 10 at 839.

<sup>35</sup>O. Hellstrom, “The Importance of a Holistic Concept of Health for Health Care. Examples from the Clinic” (1993) 14 Theoretical Medicine 325 at 326.

<sup>36</sup>Indeed, some urge that doctors embrace a more holistic view of health. See S.G. Schwartz, “Holistic Health: Seeking a Link Between Medicine and Metaphysics” (1991) 266 JAMA 3064.

<sup>37</sup>Similarly, it has been suggested that many Canadian naturopaths hold what can be called a “scientific world view” despite practicing an alternative discipline commonly described as “holistic”: H. Boon, “Canadian Naturopathic Practitioners: Holistic and Scientific World Views” (1998) 46 Soc. Sci. Med. 1213.

<sup>38</sup>See Sampson, *supra* note 11.

professionalism and science in medicine.<sup>39</sup> Although CAM has historic roots, it is a quintessentially postmodern critique of modern medicine.<sup>40</sup> From the postmodern perspective, modern medicine is a “master narrative”; it is a product of the European Enlightenment tradition propagated by the dominant white male culture through its principal instrument of power: reason. Postmodernism rejects the idea that there are any absolute or verifiable truths; everything is relative. From this it can be argued that the truths of modern medicine—even a seemingly obvious truth like “smallpox is caused by a virus”—are merely points of view. Many proponents of CAM adopt the language of postmodernism, speaking in terms of theories or perspectives instead of truths. For example, McKee argues that “the analytical reductionism of much of Western medicine—particularly as it is reflected in the germ theory of disease—serves the needs of capitalism for capital accumulation and the commodification of health needs. . . . [T]he alternative assumptions that underlie the holistic view provide a challenge to the Western model and its germ theory.”<sup>41</sup>

This postmodern philosophy permeates the discourse about CAM<sup>42</sup> and creates a number of practical issues in relation to the law’s reaction to CAM. Most importantly, it raises the question of whether scientific evidence regarding efficacy is relevant to the regulation of CAM. For example, it has been argued that the holistic and individualized nature of most CAM make them unsuitable for traditional research protocols.<sup>43</sup> This argument has already been somewhat persuasive with Canadian regulators in the context of natural health products.<sup>44</sup> However, numerous other commentators, most notably in a recent report from the US National Institutes of Health,<sup>45</sup> have concluded that most CAM can be studied

---

<sup>39</sup>R. Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York: W.W. Norton & Co., 1998) at 396 writes:

Alternative medicine’s preoccupations highlight the ambiguities in nineteenth-century medicine. Its new scientific and professional movements generated counter-trends—a populist, anti-elitist backlash. While people wanted their diseases to be cured, they were also seeking far more from medicine: explanations of their troubles, a sense of wholeness, a key to the meaning of life. Craving reassurance from physicians, democratic generations also, paradoxically, wanted to take health into their own hands. Not least, so long as the message of orthodox medicine was pessimistic, alternative medicine instilled hope.

<sup>40</sup>For a discussion of CAM and modernity/postmodernity see V. Stambolovic, “Medical Heresy – The View of a Heretic” (1996) 43 Soc. Sci. Med. 601 and A. Scott, “Homeopathy as a feminist form of medicine” (1998) 20 Sociology of Health & Illness 191. There is also an argument that CAM is not modern or postmodern, but a relic of pre-modern times: see N. Koutouvidis, E. Papamichael, & A. Fotiadou, “Aristophanes’ Wealth: ancient alternative medicine and its modern survival” (1996) 89 J. Royal Soc. Of Med. 651.

<sup>41</sup>J. McKee, “Holistic Health and the Critique of Western Medicine” (1988) 26 Soc. Sci. Med. 775 at 775. Equally alarmist arguments have been made against holism and mystic approaches to health.

<sup>42</sup>A. Williams, “Therapeutic Landscapes in Holistic Medicine” (1998) 46 Soc. Sci. Med. 1193.

<sup>43</sup>See E. Ernst, “Complementary medicine: Common Misconceptions” (1995) 88 J. Social Medicine 244.

<sup>44</sup>See, for example, *Natural Health Products: A New Vision*, *supra* note 1.

<sup>45</sup>A. Margolin, S. Avants & H. Kleber, “Investigating alternative medicine therapies in randomized controlled trials” (1998) 280 JAMA 1626.

using already established methodologies.<sup>46</sup> Indeed, a large proportion of CAM producers and practitioners make specific, measurable, health claims (e.g., “this CAM relieves this specific symptom or ailment”). Such claims seem very suitable for study. So, while Canadian courts and policy makers should remain sensitive to the rationale and desire for a more holistic approach to health care, useful scientific data is nevertheless obtainable in this context. As we will argue below, scientific evidence (or the lack of it) is relevant to the assessment of legal duties.

#### 4. Professional Latitude

While it has been noted that the medical profession has, in the past, used its privileged position to fight aggressively against CAM by setting narrow parameters for licensing and revoking licenses of non-conforming practitioners,<sup>47</sup> there are signs that the profession is becoming more open and, as such, that an increasing number of physicians will be providing some type of CAM. Indeed, encouraged from within its ranks and without, the medical profession is giving an increasing amount of latitude to CAM.<sup>48</sup> For example, in 1996, the Alberta College of Physicians and Surgeons passed a bylaw which is meant to guide and monitor its members who provide CAM.<sup>49</sup> However, the ability of the Alberta College of Physicians and Surgeons to control the therapies provided by its members was significantly curtailed by the *Medical Profession Amendment Act, 1996*.<sup>50</sup> This act amended the *Medical Profession Act* in Alberta to prevent the College of Physicians and Surgeons from restricting the provision of alternative services by its members:

34 (3) A registered practitioner shall not be found guilty of unbecoming conduct or be found to be incapable or unfit to practice medicine or osteopathy solely on the basis that the registered practitioner employs a

---

<sup>46</sup>See, for example, *ibid.*; J. S. Levin *et al.*, “Quantitative methods in research on complementary and alternative medicine” (1997) 35 *Med. Care* 1079; A. Vickers *et al.*, “How Should we research unconventional therapies?” (1997) 13 *Int’l J. of Technology Assessment in Health Care* 111; W. Gaus & J. Hagel, “Studies on the efficacy of unconventional therapies” (1995) 45 *Drug Research* 88.

<sup>47</sup>See L.B. Andrews, “The Shadow Health Care System: Regulation of Alternative Health Care Providers” (1996) 32 *Houston L. Rev.* 1273 at 1288-89 and, for specific examples, see authorities cited on those pages.

<sup>48</sup>See, for example, H. Spencer, “Physicians should keep an open mind on complementary health care, congress says” (1995) 152 *CMAJ* 1787; C. Berkowitz, “Homeopathy: keeping an open mind” (1994) 344 *Lancet* 701; G. Wong, “It isn’t ‘science’ to so quickly dismiss alternate med” Letter *The Medical Post* 34 (9 June 1998) 21.

<sup>49</sup>*Bylaws of The College of Physicians and Surgeons of Alberta*, Part B, ss. 93-95. For example, the bylaw states that a registered practitioner may not provide any CAM therapy until the registrar is furnished with written notice and the therapy is approved (s.94(1)). The notice to be provided by the practitioner must include evidence of the practitioner’s certification and details of the standards of practice of the therapy accepted by the educational centres where it is taught (s.94(3)). A number of physicians have argued that these provisions are too onerous and have refused to comply with the College of Physician’s request for information on the CAM therapies they provide: R. Walker, “Face off over what is alternative medicine shapes up in Alberta” *The Medical Post* 33 (11 February 1997) 34.

<sup>50</sup>S.A. 1996, c. 27. M. Borsellino, “Alternative Altercation: Ontario college and complementary medicine supporters go head to head over new bill” *The Medical Post* 33 (20 May 1997) 1 at 49.

therapy that is non-traditional or departs from the prevailing medical practices, unless it can be demonstrated that the therapy has a safety risk for that patient unreasonably greater than the prevailing treatment.

Other provinces' Colleges have made (or been forced to make)<sup>51</sup> similar concessions to the practice of CAM. For example, the Saskatchewan College of Physicians and Surgeons has relaxed its stance against chelation therapy<sup>52</sup> and in the fall of 1997, the Ontario College of Physicians and Surgeons Ad Hoc Committee on Complementary Medicine made fourteen recommendations concerning the provision of CAM by members of the College. Although these recommendations place limits on the provision of CAM, the conclusion of the committee is conciliatory in tone: "In essence, we believe that physicians [should] be allowed a reasonable and responsible degree of latitude in the kinds of therapies they offer to their patients. We also believe that patients have every right to seek whatever kind of therapy they want."<sup>53</sup>

Of course, the profession remains somewhat skeptical of CAM.<sup>54</sup> Nevertheless, the movement seen at the level of the medical profession's governing bodies to accommodate the growing interest in CAM is a powerful signal that more and more physicians will likely get involved in the provision of these therapies. What legal duties will apply to physicians who embrace this trend?

### III. The Legal Obligations of Physicians in Relation to CAM

#### 1. Informed Consent

Canadian law places onerous disclosure obligations on physicians. Indeed, since the seminal Supreme Court of Canada case of *Reibl v. Hughes*,<sup>55</sup> Canadian courts have taken the patient's "right to know" very seriously. As noted by Picard and Robertson, "one of the most striking features of the post-*Reibl* cases is how liberal and expansive the courts have been in interpreting the scope of disclosure."<sup>56</sup>

---

<sup>51</sup>A. Flynn, "Alternative-medicine bill criticized: OMA says proposal allowing MDs to administer non-traditional remedies 'seriously flawed'" *The Globe and Mail* (9 May 1997) A5.

<sup>52</sup>M. Oliver, "MDs remain sceptical as chelation therapy goes mainstream in Saskatchewan" (1997) 157 CMAJ 750 at 751-52.

<sup>53</sup>*Report of the Ad Hoc Committee on Complementary Medicine to the Council of the College of Physicians and Surgeons of Ontario* (22 September 1997), online: College of Physicians and Surgeons of Ontario <<http://www.cpso.on.ca/newsrelease/NR-alternate0997.htm>> (date accessed:15 March 1999) [archived at the Health Law Institute, University of Alberta].

<sup>54</sup>For example, the Quebec College of Physicians and Surgeons had a campaign to sensitize the public as to the unproven nature of alternative medicine: L. Gagnon, "We're raising awareness, not starting witch-hunt, Que. college says" *The Medical Post* 33 (11 February 1997) 52.

<sup>55</sup>(1980), 114 D.L.R. (3d) 1 (S.C.C.).

<sup>56</sup>E. Picard and G. Robertson, *Legal Liability of Doctors and Hospitals in Canada* (Toronto: Carswell, 1996) at 120. On the scope of the physician's duty of disclosure, see also D. Roy, J. Williams & B. Dickens, *Bioethics in Canada* (Toronto: Prentice Hall Canada, 1994) at 115-19; K. Capen, "Physicians and the Minefield Surrounding Informed Consent" (1996) 155 CMAJ 458; T. Caulfield & D. Ginn, "The

More than ever before, physicians are legally and ethically obligated to disclose a broad range of information to patients about the nature and effect of proposed treatment. How does this well established law of informed consent apply to the provision of CAM treatments?

To begin with, physicians who are involved in the provision of CAM therapies must provide information to patients about known risks.<sup>57</sup> Though there is a perception that many CAM therapies are relatively harmless,<sup>58</sup> there are, in fact, many identified risks and adverse side effects.<sup>59</sup> Given the liberal approach that the courts have taken in the assessment of materiality,<sup>60</sup> there are undoubtedly many risks associated with CAM therapies which could be considered worthy of disclosure.<sup>61</sup> For example, in a survey of individuals using manipulation, acupuncture, homeopathy or herbal medicine, 23.8% of respondents reported one or more adverse side effects from CAM use.<sup>62</sup> Many CAM products have also been identified with specific risks. To name but a few examples, products containing yohimbe extracts, such as those taken for male impotence, have been shown to be able to induce hypertension and, when taken by patients with allergic dermatitis, have also been associated with bronchospasm.<sup>63</sup> It has been shown that spinal manipulation can cause or contribute to vertebral artery damage and neurological complications including stroke.<sup>64</sup> Blue-green algae may contain a toxic substance (microcystin) that, in large doses, “cause[s] acute liver failure in humans, brain

---

High Price of Full Disclosure: Informed Consent and Cost Containment in Health Care” (1994) 32 Man. L. Rev. 328; E. Etchells *et al.*, “Bioethics for Clinicians: Disclosure” (1996) 155 CMAJ 387; and B. Dickens, “Informed Consent” in J. Downie & T. Caulfield, eds., *Canadian Health Law and Policy* (Toronto: Butterworths, 1999) 117 at 131: “The respect for personal autonomy shown by modern health law makes it likely that courts will continue to broaden the scope of required disclosure.”

<sup>57</sup>Dickens, *ibid.* at 129.

<sup>58</sup>The perceived harmless nature of CAMs is a feature that many consumers find attractive. See generally Seidl & Stewart, *supra* note 23.

<sup>59</sup>D.J. Atherton, “Towards the safer use of traditional remedies: Greater awareness of toxicity is needed” (1994) 308 BMJ 673.

<sup>60</sup>For examples of risks held to be material see *Meyer Estate v. Rogers* (1991), 78 D.L.R. (4<sup>th</sup>) 307 (Ont. Gen. Div.) (a 1 in 100,000 risk of a fatal reaction to a contrast media dye); *Arndt v. Smith*, [1997] 2 S.C.R. 539 (0.23% chance of a fetal anomaly); and, in particular, *Leung v. Campbell* (1995), 24 C.C.L.T. (2d) 63 (Ont. Gen. Div.) (1 in 300,000 risk of suffering paralysis as a result of spinal manipulation by a chiropractor).

<sup>61</sup>See, for example, *Meyer Estate v. Rogers*, *ibid.*; *Leung v. Campbell*, *ibid.*

<sup>62</sup>See generally, N. Abbot, A. White & E. Ernst, “Complementary medicine” (1996) 381 Nature 361; and H. Yamashita *et al.*, “Adverse events related to acupuncture” Letter (1998) 280 JAMA 1563.

<sup>63</sup>P.A. De Smet & O.S. Smeets, “Potential risk of health food products containing yohimbe extracts” (1994) 309 BMJ 958.

<sup>64</sup>See, for example, F.C. Powell, W.C. Hanigan & W.C. Olivero, “A risk/benefit analysis of spinal manipulation therapy for relief of lumbar or cervical pain” (1993) 33 Neurosurgery 73; A. Fast, D.F. Zincola & E.L. Marin, “Vertebral Artery Damage Complicating Cervical Manipulation” (1987) 12 Spine 840; K.P. Lee *et al.*, “Neurologic Complications Following Chiropractic Manipulation: A Survey of California Neurologists” (1995) 45 Neurology 1213. See also P. Waldie, “Patient Awarded \$20,000 After Suing BC Reflexologist” *The National Post* (22 October 1999), online: <<http://www.nationalpost.com/news.asp>> (date accessed: 22 October 1999).

damage and death.”<sup>65</sup> Royal jelly has been shown to exacerbate or even induce fatal anaphylaxis in asthmatics.<sup>66</sup> Ill-prepared Chinese herbs have been shown to cause or worsen renal disease.<sup>67</sup> There have also been numerous reports of poisonings due to CAM products.<sup>68</sup> For example, laetrile poisoning and heavy metal intoxication have both been documented.<sup>69</sup>

As scientific research on CAM therapies progresses, knowledge about risks will undoubtedly increase. Until more is known, however, a conservative approach to the assessment and disclosure of risks seems appropriate. Moreover, when advising patients about the risks associated with the use of a CAM, physicians should be sensitive to possible misconceptions about CAMs that may increase the likelihood of an adverse event. For example, patients should be reminded that just because a product is marketed as “natural” does not necessarily mean it is safe; many CAMs, such as herbal therapies, can interact with pharmaceuticals; and the lack of standardization in the preparation of many CAM products may result in poor quality control.<sup>70</sup>

In addition to disclosing known risks, physicians should candidly discuss available information relevant to the efficacy of the proposed or requested CAM therapy.<sup>71</sup> Given the current state of scientific knowledge surrounding many CAM

---

<sup>65</sup>“Praise is Very Faint for Blue Green Algae” [reprinted with permission from The University of California at Berkeley Wellness Letter] *The Globe and Mail* (23 November 1999) R9.

<sup>66</sup>F.C. Thien *et al.*, “Royal jelly-induced asthma” (1993) 159 *Med. J. Austr.* 639. R.J. Bullock, A. Rohan & J.A. Straatmans, “Fatal royal jelly-induced asthma” Letter (1994) 160 *Med. J. Austr.* 44.

<sup>67</sup>J.H. Galloway *et al.*, “Potentially hazardous compound in an herbal slimming remedy” (1992) 340 *Lancet* 179; L. Perharic-Walton & V. Murray, “Toxicity of Chinese herbal remedies” (1992) 340 *Lancet* 674; J.L. Vanherweghem *et al.*, “Rapidly progressive interstitial renal fibrosis in young women: association with slimming regimen including chinese herbs” (1993) 341 *Lancet* 387; M. Vanhaelen *et al.*, “Identification of aristolochic acid in Chinese herbs” (1994) 343 *Lancet* 174; A.B. Abt *et al.*, “Chinese herbal medicine induced acute renal failure” (1995) 155 *Arch. Intern. Med.* 211; and D.W. Gordon *et al.*, “Chaparral ingestion. The broadening spectrum of liver injury caused by herbal medications” (1995) 273 *JAMA* 489.

<sup>68</sup>R.J. Huxtable, “The harmful potential of herbal and other plant products” (1990) 5(Suppl. 1) *Drug Safety* 126; N. Bach, S.N. Thung & F. Schaffner, “Comfrey herb tea-induced hepatic veno-occlusive disease” (1989) 87 *Am. J. Med.* 97; R.J.I. Bain, “Accidental digitalis poisoning due to drinking herbal tea” (1985) 290 *BMJ* 1624; C.C. Culvenor *et al.*, “*Heliotropium lasiocarpum* Fisch and Mey identified as cause of veno-occlusive disease due to an herbal tea” (1986) 1 *Lancet* 978; E.S. Dickstein & F.W. Kunkel, “Foxglove tea poisoning” (1980) 69 *Am. J. Med.* 167; R.P. Hogan, “Hemorrhagic diathesis caused by drinking an herbal tea” (1983) *JAMA* 2679; J.O.D. McGee *et al.*, “A case of veno-occlusive disease of the liver in Britain associated with herbal tea consumption” (1976) 29 *J. Clin. Path.* 788; and P.P.H. But, “Need for correct identification of herbs in herbal poisoning” (1993) 341 *Lancet* 63.

<sup>69</sup>See J. Kew *et al.*, “Arsenic and mercury intoxication due to Indian ethnic remedies” (1993) 306 *BMJ* 506; F. Ingelfinger, “Laetrilomania” (1977) 296 *N. Eng. J. Med.* 1167.

<sup>70</sup>See, for example, M. Cirigliano & A. Sun, “Advising Patients About Herbal Therapies” Letter (1998) 280 *JAMA* 1565.

<sup>71</sup>In fact, Dickens, *supra* note 56 at 129, has argued that a physician must disclose: “the limits of relevant knowledge, and the areas in which it appears that more needs to be learned.” See also Etchells *et al.*, *supra* note 56; *Health Care Consent Act*, S.O. 1996 [being Schedule A to the Advocacy, Consent and Substitute Decisions Statute Law Amendment Act, S.O. 1996, c. 2]. See also J. Maclean, “Alternative Medicine: Special Committee to Examine ‘Alternatives’” (1 May 1996) online: College of Physicians

treatments, this aspect of the disclosure obligation may create problems for physicians, particularly because the pressure to use CAM may come from the patient. Physicians may feel uncomfortable telling a patient who is interested in a particular CAM treatment that it has no proven value. For those physicians who have decided to provide a CAM which lacks a body of supporting scientific data (such as homeopathy),<sup>72</sup> disclosure of information on the lack of scientific efficacy may send patients an odd, mixed message (“why is the doctor offering the treatment if there is no clear evidence that it works?”). Nevertheless, the efficacy of a treatment seems to be central to the informed consent process. Indeed, given that research has shown that perceived efficacy is an important reason why some individuals use CAM,<sup>73</sup> this is information that clearly has a potential to influence treatment decisions and, as such, is something that a reasonable person in the patient’s position would want to know.

The fact that there is little scientific research on many CAM therapies may also have a direct impact on the scope of the physician’s disclosure obligations. Some commentators have suggested that physicians should consider all unproven CAM therapies as experimental treatments and thereby “deserving of a heightened informed consent standard.”<sup>74</sup> Characterizing a treatment as experimental has important legal ramifications. Canadian law demands that all risks, no matter how rare or remote, be disclosed to a patient contemplating a truly experimental treatment.<sup>75</sup> Furthermore, in this context, non-disclosure cannot be justified by

---

and Surgeons of Ontario <<http://www.cpso.on.ca/articles.asp?ArticleId=-133620864>> (date accessed: 8 December 1999) [archived at the Health Law Institute, University of Alberta], where a recent position of the British Columbia College in relation to “unproven and unconventional treatments” is reported thus: “All physicians must use recognized generally accepted methods to establish diagnosis. Unconventional or unproven methods of diagnosis can only be used as an adjunct to generally accepted methods. The patient must be informed of the unproven nature of such a diagnostic method.”

<sup>72</sup>For a discussion of a physician who also provides homeopathy, see Foss, *supra* note 3.

<sup>73</sup>See Astin, *supra* note 26 at 1552 where it is concluded: “The responses [to our survey of 1035 US citizens] suggest that the most influential or salient factor in people’s decision to use alternative health care may be its perceived efficacy.” However, see also T. Truant & M. McKenzie, “Discussing Complementary Therapies: There’s More Than Efficacy to Consider” (1999) 160 CMAJ 351 at 351: “studies have shown that, rather than being based solely on statistical data about treatment outcomes, decisions about both complementary and conventional therapies often reflect lifestyle preferences as well as beliefs about health and illness.”

<sup>74</sup>K. M. Boozang, “Western medicine opens the door to alternative medicine” (1998) 24 Am. J. L. & Med. 185 at 212. She goes on to argue: “The physician should share at some level of detail the lack of evidence to support the patient’s expectations for the treatment, and risks that might attend the patient’s use of the therapy, some of which may be presently unknown.”

<sup>75</sup>See *Halushka v. University of Saskatchewan* (1965), 52 W.W.R. 608 (Sask. C.A.); *Weiss v. Solomon* (1989), 48 C.C.L.T. 280 (Que. S.C.); *Zimmer v. Ringrose*, [1981] 4 W.W.R. 75 (Alta. C.A.); *Archibald v. Kuntz*, [1994] B.C.J. No. 199 (S.C.) (QL); Picard & Robertson, *supra* note 56 at 149-52. Treatments which are viewed as merely “innovative”, as compared to experimental, are subject to a somewhat lower, but still onerous, disclosure obligation. In *Zimmer v. Ringrose*, *ibid.*, for example, even though the treatment in question was innovative, the Court did not characterize it as experimental. However, as noted by Picard and Robertson, *supra* note 56 at 152, “courts have nonetheless held that the patient is entitled to a very wide range of information. In particular, the patient must be informed that the procedure is innovative or experimental.” See also K. Glass, “Research Involving Humans” in Downie & Caulfield, *supra* note 56, 375 at 387-88.

therapeutic privilege or by a waiver of the right to information by a patient.<sup>76</sup> Although there can be no certainty when a Court will deem a treatment “experimental”(particularly if the treatment is provided for strictly therapeutic reasons as opposed to being part of a research protocol),<sup>77</sup> the fact that a procedure has not been subject to “any real research” has led a court to characterize a treatment as “experimental.”<sup>78</sup> Minimally, it seems safe to conclude that the questionable efficacy of many of the CAM treatments reinforces the need for a thorough disclosure process.<sup>79</sup>

Are there reasons why CAMs should be treated differently than conventional treatments in relation to disclosure obligations? That is, are there reasons why physicians should not be required to disclose available information on efficacy and risks? On the one hand, it could be argued that the low physical risks associated with many (but not all) of the unproven CAMs means that a comprehensive disclosure obligation is not justified. In addition, the benefits that a patient could receive, via the placebo effect, may outweigh the possible harms associated with not disclosing information about the lack of scientific evidence. Patients may also have religious or spiritual convictions related to CAM use that may be offended by a frank disclosure of information about efficacy.

While these are all important considerations that should be taken into account in the formulation of disclosure policy (e.g., it is essential that physicians be sensitive to a patient’s values and spiritual convictions),<sup>80</sup> they seem insufficient to allow the creation of a different disclosure standard for CAM. First, though it is true that many CAMs are relatively benign, there are risks which seem worthy of disclosure, as noted above.<sup>81</sup> In addition, the disclosure of efficacy and risk

---

<sup>76</sup>Picard & Robertson, *supra* note 56 at 151;

<sup>77</sup>See Glass, *supra* note 75 at 388.

<sup>78</sup>*Archibald v. Kuntz*, *supra* note 75 at 17.

<sup>79</sup>Indeed, Boozang, *supra* note 74 at 201 has suggested that the experimental standards should apply where there is neither proof of efficacy “nor any scientific expectation of any health benefit.” See also *Coughlin v. Kuntz* (1987), 42 C.C.L.T. 312 (B.C.S.C.).

<sup>80</sup>See, for example, Truant, *supra* note 73 at 352, who notes the importance of understanding the factors that influence patients in their decision to use CAM. See also Cirigliano, *supra* note 70 at 1566: “Advice based on available knowledge should be given in such a fashion that is congruent with the patient’s personal needs and in the physician’s best judgment.”

<sup>81</sup>It is worth noting that the full disclosure of information about risks and efficacy may also assist a physician in defending a claim of malpractice. In one U.S. case, for instance, it was found that a patient had assumed, after full disclosure, the risks associated with a CAM. In the case of *Schneider v. Revici*, 817 F.2d 987 (2<sup>nd</sup> Cir. 1987), Mrs. Schneider, who had been identified as having a cancerous tumor in one of her breasts, visited Dr. Revici because she thought that his non-invasive approach to cancer treatment would enable her to avoid a mastectomy. Dr. Revici’s treatment failed, the cancer spread and Mrs. Schneider sued. Mrs. Schneider won at trial, but Dr. Revici appealed arguing that the jury had not properly been instructed on the defence of assumption of risk. Mrs. Schneider’s attorney argued that “it is against public policy for one expressly to assume the risk of medical malpractice and thereby dissolve the physician’s duty to treat a patient according to medical community standards.” The Court rejected this argument stating: “we see no reason why a patient should not be allowed to make an informed decision to go outside currently approved medical methods in search of an unconventional treatment” (*ibid.* at 995).

information may assist patients in avoiding possible indirect harms. For example, a patient may incur significant financial costs purchasing a CAM (most of which are not covered by provincial health care schemes or private insurance) or forego effective conventional treatment in the belief that a CAM is effective.<sup>82</sup> More importantly, Canadian jurisprudence has generally rejected the paternalistic approach necessary to justify selective non-disclosure – particularly when the use of a treatment is elective.<sup>83</sup> While the idea of withholding information for the good of the patient survives in the text of Canadian informed consent case law (a principle called “therapeutic privilege”),<sup>84</sup> it is a principle that has been overwhelmed by the dominance of autonomy and, as such, should only be applied in rare circumstances (e.g., situations of severe emotional distress).<sup>85</sup> It will be difficult for a physician to argue that she opted not to disclose information on the lack of known efficacy purely for the purposes of, for example, inducing a placebo

---

<sup>82</sup>See, for example, the U.S. case of *Roberson v. Counselman*, 686 P.2d 149 (Kan. 1984), where it was alleged that a chiropractic diagnosis prevented a patient from seeking potentially life saving medical care. The deceased, Roberson, went to see the defendant, Counselman, because he felt pain in his chest and left shoulder, and shortness of breath. The defendant diagnosed the deceased with a “neuromuscular difficulty” and treated him by giving him two adjustments. Roberson died shortly afterwards of a heart attack which might not have been fatal if he had received timely medical attention. See also *Charell v. Gonzalez*, 660 N.Y.S. 2d 665 (Sup Ct. 1997) where a patient received coffee enemas rather than chemotherapy. While these cases deal with the provision of CAM by non-physicians, they serve as examples of the potential problem of foregoing effective treatment in favour of an unproven CAM. For another interesting example, see H. McConnell, “Views of alternative therapies divide U.K. Doctors, patients, govt.” *The Medical Post* 33 (8 April 1997) 34, where it is argued that in the U.K., the most common reason for non-immunization of children is advice from homeopaths. See also Maclean, *supra* note 71: “It is unethical to engage or to aid and abet in treatment which has no acceptable scientific basis, may be dangerous, may deceive the patient by giving false hope, or which may cause the patient to delay in seeking proper care until his or her condition becomes irreversible.”

<sup>83</sup>See, *Videto v. Kennedy* (1981), 125 D.L.R. (3d) 127 (Ont. C.A.) at 136 where it was held that elective surgery is not a situation where a physician would be justified in withholding or generalizing information due to the “patient’s emotional condition or apprehension.”

<sup>84</sup>In *Reibl v. Hughes*, *supra* note 55 at 13, Laskin noted: “it may be the case that a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommended surgery or treatment and the doctor may, in such a case, be justified in withholding or generalizing information as to which he would otherwise be required to be more specific.”

<sup>85</sup>See, for example, *Meyer Estate v. Rogers*, *supra* note 60 where a physician intentionally withheld information about the risks associated with contrast media. The court stated that the “therapeutic privilege” exception to the doctor’s duty of disclosure should not be part of Canadian law because it has the potential to erode the requirement of informed consent. Likewise, in *McInerney v. MacDonald*, [1992] 2 S.C.R. 138, the Court held, in the context of a patient’s right of access to medical records, that the doctrine should only be resorted to in extreme circumstances. See also Picard and Robertson, *supra* note 56 at 147-49; Dickens, *supra* note 56 at 137-40; L. Rozovsky & F. Rozovsky, *The Canadian Law of Consent to Treatment* (Toronto: Butterworths, 1990) at 21-22, for a general discussion of therapeutic privilege.

effect<sup>86</sup> or for fear of upsetting the patient. This is particularly so given that an unproven CAM can only be viewed as an elective treatment.<sup>87</sup>

In the end, for many of the available but unproven CAMs, a legally appropriate consent process has the potential to sound harsh.<sup>88</sup> In general, physicians must tell patients about the lack of evidence concerning efficacy, the fact that patients will need to pay for most CAMs, and that there may be known and/or unknown risks. While this information must be disclosed, the physician should seek to provide it in a manner that is respectful to the patient's beliefs and values. The goal should not be to dissuade the patient from using a CAM but to provide objective information that will allow a well-informed decision about the use of CAMs. Despite the popularity of CAMs, any other approach to the process of informed consent in this context seems legally problematic.

## 2. Standard of Care in the Provision of a CAM

While the growing popularity of CAM treatments creates unique informed consent pressures, a more difficult issue relates to the standard of care to be applied to physicians who decide to provide a particular CAM.<sup>89</sup> Should physicians be held to the same standard as that applied to CAM practitioners or should they be held to the more traditional (and increasingly evidence-based) medical standard? This question is made more complex by the fact that CAMs are gaining prominence at a time when the medical profession is in the midst of a trend toward evidence-based medicine.

### a. Evidence-Based Medicine and the Standard of Care

Evidence-based medicine is founded on a simple premise: whenever possible, doctors should use scientific evidence, usually from clinical research, to inform

---

<sup>86</sup>As an aside, it is worth noting that in the context of true research the circumstances where it is considered ethically permissible to use a placebo are quite restricted. The *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans* (Ottawa: Public Works and Government Services Canada, 1998) concluded that placebo controlled trials are, in general, only justified when there are no other effective treatments for the condition being studied. Even in these situations, the patient must be clearly informed that he may be randomized to a placebo arm.

<sup>87</sup>See, for example, *LaFleur v. Cornelis* (1979), 28 N.B.R. 569 (Q.B.) at 576 where the Court noted that "when the treatment is elective a very high standard of disclosure is required."

<sup>88</sup>There is another issue worth discussing in the context of informed consent. A significant percentage of those who use CAMs also use conventional treatments. There is a potential that some CAM treatments may interact with or adversely affect conventional treatments.

Therefore, it would be prudent for physicians to explore a patient's CAM use as part of the informed consent process, particularly given the fact that 70% of those who use CAM treatments do not tell their physician. D. Eisenberg, "The Invisible Mainstream" [1996] *Harvard Med. Alum. Bull.* 20.

<sup>89</sup>See D. Studdert & T. Brennan, "Legal Implications of Practicing Alternative Medicine" *Letter* (1999) 281 *JAMA* 1699, who argue that this is the "most pressing question in this area." See also, *Shakoor v. Situ*, [2000] 1 N.L.R. No. 137 (QB).

decision-making.<sup>90</sup> Under the evidence-based model, doctors are expected to consult and critically evaluate medical literature so that they may offer patients choices based on the best available evidence. Proponents of evidence-based medicine have described the approach in the following terms: “Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision-making and stresses the examination of evidence from clinical research.”<sup>91</sup> Though evidence-based medicine has been justifiably criticized for having the potential to devalue the contribution of experience to medical decision-making,<sup>92</sup> it is hard to deny that it is an approach on the ascent.<sup>93</sup> Moreover, it is pushing medicine toward a more scientific basis. Therefore, it seems reasonable to conclude that evidence-based principles will have an increasingly important role to play in defining the legal standard of care.

In general, the legal standard of care is determined by examining what “could reasonably be expected of a normal, prudent practitioner.”<sup>94</sup> This rule was affirmed by the Supreme Court of Canada in *ter Neuzen v. Korn* where it was held that doctors “have a duty to conduct their practice in accordance with the conduct of a prudent and diligent doctor in the same circumstances.”<sup>95</sup> This test currently has the potential to allow scientifically unproven conventional practices to be found within the standard of care. Simply because a practice is time-honoured or widely practiced does not necessarily mean that it is appropriate according to the evidence-based approach, but this may be enough to satisfy the legal standard of care.<sup>96</sup> Take, for example, the case of heart attack survivors and the prescription of beta blockers, a common medication to lower the incidence of fatal heart attacks. Although it has been clinically shown that beta blockers improve the life expectancy of heart attack survivors, one study found that only 21% of eligible elderly heart attack survivors were prescribed beta blockers.<sup>97</sup> In other words, 79% of patients were not given a widely available and effective treatment. Under the present model of standard of

---

<sup>90</sup>See, for example, Evidence-Based Medicine Working Group, “Evidence-Based Medicine: A New Approach to Teaching the Practice of Medicine” (1992) 268 JAMA 2420; G. Michaud *et al.*, “Are therapeutic decisions supported by evidence from health care research?” (1998) Arch. Int. Med. 1665; F.M. Sullivan, “Evidence in consultations: interpreted and individualised” (1996) 348 Lancet 941.

<sup>91</sup>Evidence-Based Medicine Working Group, *ibid.* at 2420.

<sup>92</sup>R.I. Horowitz, “The dark side of evidence-based medicine” (1996) 63:5 Cleveland Clinic J. Med. 320. See also T. Hope, “Evidence Based Medicine and Ethics” (1995) 21 J. Med. Ethics 259; and Miittinen, *supra* note 9.

<sup>93</sup>Indeed, Dr. Kathleen Lohr, Health and Social Policy Division, Research Triangle Institute, has noted that virtually every health care system in the Western world has been influenced by this trend.

<sup>94</sup>*Critts v. Sylvester* (1956), 1 D.L.R. 502 (Ont. C.A.) at 508; *affd* [1956] S.C.R. 991.

<sup>95</sup>*ter Neuzen v. Korn* (1995), 127 D.L.R. (4<sup>th</sup>) 577 (S.C.C.) at 588.

<sup>96</sup>“It is generally accepted that when a doctor acts in accordance with a recognized and respectable practice of the profession, he or she will not be found to be negligent”: *ter Neuzen v. Korn, ibid.* at 16.

<sup>97</sup>S.B. Soumerai *et al.*, “Adverse Outcomes of Underuse of B-Blockers in Elderly Survivors of Acute Myocardial Infarction” (1997) 277 JAMA 115.

care, such an omission would not necessarily constitute negligence as it is consistent with the practice of the majority of physicians.<sup>98</sup>

We suggest, however, that as evidence-based medicine becomes more influential, standard practices that have little or no evidential basis will, from a legal standpoint, become increasingly suspect. First, more and more conventional practices will likely be tied to evidence of efficacy (at least that is the goal). As a result, the accepted practices, and thus the legal standard of care, will become more scientifically based. Second, evidence-based clinical practice guidelines are becoming more common.<sup>99</sup> If these guidelines are developed in a rigorous fashion, using well-established clinical evidence and professional consensus, they will likely be viewed as powerful, though not conclusive, evidence of the legal standard of care. Finally, and most importantly, the evidence-based movement is arguably creating an expectation among professionals, the general public, and policy makers that treatment decisions will be informed, as much as possible, by scientific data. For example, many health care reform commentators have suggested that a service should be shown to be efficacious prior to being considered “medically necessary” and thus worthy of coverage by a provincial health care system.<sup>100</sup> Given the continued pressure to rationalize care, contain costs and reduce wasteful health care practices, there seems little doubt that evidence-based principles will remain a significant factor in the future of Canadian health policy.

#### **b. Physicians Providing CAM – A Standard of Care Paradox?**

The rise of evidence-based medicine has been paralleled by a growth in popularity of CAM treatments, many with unproven effectiveness, and a concomitant implied tolerance toward the lack of scientific evidence. Indeed, as noted above, health care providers are increasingly encouraged to keep an open mind in relation to CAMs.<sup>101</sup> This creates a paradox wherein physicians are at once

---

<sup>98</sup>However, there is an exception to the accepted practice approach in the determination of the standard of care. In rare circumstances, where the accepted practice is “fraught with obvious risks” the Court may impose its own standard upon the profession. That is, the Court may hold that the accepted practice is negligent. See *ter Neuzen v. Korn*, *supra* note 95. It will be interesting to see if the growth in evidence-based medicine, and widely available clinical practice guidelines, affects the frequency with which this exception is used.

<sup>99</sup>The growth of Clinical Practice Guidelines is one practical manifestation of the evidenced-based medicine trend. These guidelines, which are formulated by a wide variety of organizations and professional groups, are meant to assist physicians in making decisions based on the best available evidence. See Canadian Medical Association, *Guidelines for Canadian Clinical Practice Guidelines* (Ottawa: Canadian Medical Association, 1994) and Lohr, *supra* note 93.

<sup>100</sup>For example, see R. Deber, “The Use and Misuse of Economics” in M. Somerville ed., *Do We Care?: Renewing Canada’s Commitment to Health* (Montreal: McGill-Queen’s Press, 1999) 53 at 64. Because most CAMs are not covered by the health care system, they are not subject to the same cost containment pressure. On the defining of “medically necessary,” see generally T. Caulfield, “Wishful Thinking: Defining Medically Necessary in Canada” (1996) 4 Health L. J. 63.

<sup>101</sup>See, for example, *Natural Health Products: A New Vision*, *supra* note 1 at 33 where it is recommended that “unlike pharmaceuticals, the evidence that is required for certain NHP claims should be more flexible. ... While the TPP currently accepts traditional references for traditional herbal

expected to critically assess evidence relating to conventional treatments and to open their minds to the possibilities of unproven CAMs. How should the law respond to this mixed message? In general, the standard of care for health care practitioners is based on the common practice of those within the same profession (e.g., chiropractors are measured against chiropractors).<sup>102</sup> However, what standard should be applied to a physician using CAMs?<sup>103</sup> Should it be the usual standard of the reasonable physician (with increased importance being placed on evidence-based guidelines), or the lower standard of the reasonable CAM practitioner, where, arguably, less importance would be placed on the presence of supporting scientific evidence? Can these two standards be reconciled?

This standard of care problem is best illustrated by an example: in this case, a physician-homeopath.<sup>104</sup> The standard of care applicable to a physician-homeopath could either be that of a prudent physician or that of a prudent homeopath. As argued above, when providing conventional treatments, a physician will be increasingly expected to base treatment advice on the best available evidence. Would a physician-homeopath be freed from this obligation when providing homeopathic treatments? If so, a number of problems arise. First, courts will be faced with the factual problem of deciding whether the physician-homeopath acted as a physician or as a homeopath (e.g., should conventional or homeopathic diagnostic principles be applied?). While this may be easily discerned in the case of prescribing a homeopathic solution, other elements of treatment may plausibly be characterized as either medical or homeopathic. In such a situation, should a physician be able to declare that she acted as a homeopath or should the applicable standard be based on the patient's perception? Second, a split standard would have a number of practical, and potentially unjust, implications for the patient. For example, when could a patient rely on the physician to inform her of and use the best available evidence – only when conventional treatments are used?

But if a physician-homeopath is bound to the medical standard of care and its increasingly evidence-based model of practice, then to what effect can she practice homeopathy?<sup>105</sup> As discussed earlier, many CAM treatments are untested, or

---

medicines, the Committee believes that the system must be made more flexible to also recognize other types of evidence." See also Berkowitz, *supra* note 48; Wong, *supra* note 48; Spencer, *supra* note 48; and E. Ernst, "Complementary medicine, changing attitudes on the fringe" (1993) 50 Br. J. Hosp. Med. 299.

<sup>102</sup>See generally D. Studdert *et al.*, "Medical malpractice implications of alternative medicine" (1998) 280 JAMA 1610; *ter Neuzen v. Korn*, *supra* note 95; L. Klar, *Tort Law*, 2d ed. (Toronto: Carswell, 1996); C. Feasby, "Determining standard of care in alternative contexts" (1997) 5 Health L. J. 45.

<sup>103</sup>See Verhoef & Sutherland, *supra* note 5 at 511, where it is noted that 20% of physicians are trained in some form of alternative therapy (in most cases acupuncture or hypnosis).

<sup>104</sup>See C. May & D. Sirur, "Art, science and placebo: incorporating homeopathy in general practice" (1998) 20:2 *Sociology of Health & Illness* 168; and Foss, *supra* note 3.

<sup>105</sup>See Maclean, *supra* note 71, for a summary of a relatively harsh British Columbia College of Physicians and Surgeons policy on unproven and unconventional treatment: "It is unethical to engage or to aid and abet in treatment which has no acceptable scientific basis, may be dangerous, may deceive the patient by giving false hope, or which may cause the patient to delay in seeking proper care until his

available scientific evidence suggests that they are ineffective. The credibility of homeopathy, in particular, has been undermined by scientific study.<sup>106</sup> To force a physician-homeopath to adhere to an evidence-based standard of care in the provision of homeopathic treatments would fundamentally alter or even preclude her practice of homeopathy. Indeed, the very fact that a practice is “alternative” to the conventional therapies may place the physician on shaky legal ground. This predicament was noted in the U.S. case of *Charrell v. Gonzalez*, where the Court noted that it would be very difficult for physicians to rely on the “accepted practice” defence: “it would seem that no practitioner of alternative medicine could prevail on such a question as the reference to the term ‘unconventional’ may well necessitate a finding that the doctor who practices such medicine deviates from ‘accepted’ medical standards.”<sup>107</sup>

Given the current lack of Canadian CAM malpractice actions, this standard of care issue may appear to be of only limited practical concern.<sup>108</sup> However, there are important policy implications that would flow from the adoption of an inconsistent approach to the standard of care. For example, it would send a mixed message to practitioners. Though the evidence-based approach to clinical decision making is not without problems, there are sound justifications for encouraging physicians to use the best available evidence. But when does a prudent practitioner need to be aware and guided by scientific evidence – only when conventional therapies are involved? From the perspective of a patient who has been injured by possible negligence, such a double standard seems illogical and potentially unjust. Patients should be able to rely on physicians to employ the same stringent standards regardless of the nature of the treatment.

#### **IV. Conclusion**

There seems little doubt that CAM will remain a significant feature within Canadian society for the foreseeable future. As a result, Canadian physicians will continue to feel pressure to incorporate CAMs into their daily practice. Numerous policy paradoxes are created by this situation, most notably a conflict between the trend toward evidence-based medicine and the scientifically lax ethos associated with most CAMs.

We are not suggesting that all CAMs are without value. On the contrary, many CAM therapies have been found, scientifically, to be efficacious. In addition, some individuals undoubtedly derive a variety of non-measurable benefits from utilizing

---

or her condition becomes irreversible.” And later: “One of the risks of using unconventional treatment is that more appropriate treatment may be delayed. If there is an unfavourable outcome, the physician using the unconventional therapy will be at risk in litigation by a patient, and of discipline by the College.”

<sup>106</sup>See, for example, J. Vandenbroucke, “Commentary, homeopathy trials: going nowhere” (1997) 350 *Lancet* 824.

<sup>107</sup>*Charrell v. Gonzalez*, *supra* note 82, cited in Studdert & Brennan, *supra* note 89 at 1699.

<sup>108</sup>Feasby, *supra* note 102.

CAMs. Nevertheless, from the perspective of the law, we believe that all health care procedures should, and probably will, be subject to the same legal standard of care. As noted throughout this article, the application of a uniform standard of care—be it in the context of the informed consent process or in the provision of treatments—creates a variety of unique challenges for physicians wishing to provide unproven CAMs.<sup>109</sup> It would, for example, require physicians to disclose to patients a tremendous amount information, including information about the unproven efficacy of many CAM therapies. More problematic, however, is the possibility that existing tort principles would find the provision of all unproven CAMs as substandard practice and, therefore, negligent.

Given that there are, to date, few CAM related law suits, the malpractice issues associated with physician provided CAMs may seem, from a risk management perspective, a relatively minor legal dilemma. But as an increasing number of physicians embrace CAM, more law suits seem inevitable. More importantly, these legal conflicts highlight the broader policy concerns associated with the incorporation of unproven CAMs into our health care system.

---

<sup>109</sup>It is important to note that there are, of course, many other legal issues relevant to this issue. For example, we have not considered the topic of referral liability. See, for example, J.S. Gordon, "Alternative Medicine and the Family Physician" (1996) 54 Am. Fam. Phys. 2205 at 2210.