California Association of Naturopathic Physicians

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We're here today because of the transformation that is occurring in our "disease-management system". The need and desire of the American people to improve their health span and reduce disease has created the shift toward a more patient-focused model that empowers the individual's self-healing capacities. CAM systems and modalities with this vitalistic approach are in particular demand. My comments today will focus on naturopathic medicine, but I want to emphasize that all licensed CAM systems and their educational models and standards are extremely important for the government to study and replicate into the mainstream health care system.

Naturopathic physicians are family care doctors who specialize in integrated natural medicine. NDs integrate many CAM modalities into the naturopathic system of health care. These modalities include nutritional, botanical and physical medicine, among others. NDs attend four year, post-graduate, accredited naturopathic medical schools, where we are trained to diagnose, prevent and treat disease with the use of safe and effective natural therapies. Our practice and method for integrating modalities is built around a set of guiding principles, the most central of which is:

- A profound respect for "the healing power of nature" or *vis medicatrix naturae*

Others include:

- Identify and treat the underlying cause of disease
- Teach the principles of health optimization through an empowered doctor-patient relationship
- Practice prevention
- "First do no harm", by working with the least invasive and toxic therapies, before referring for conventional treatments
- Treat the whole person, by acknowledging the spiritual, mental, and emotional factors determinants of health

With its unique integration of vitalistic, scientific, academic and clinical training, the naturopathic medical paradigm is a potent factor and an important resource in the renaissance that is presently occuring in complementary and alternative medicine.

One of the pressing questions of this commission is:
How do we improve access to safe and effective CAM practices and interventions?
Well, I have the answer from my profession. The key is to **support licensure of naturopathic physicians** in all 50 states, starting with California. NDs are licensed to practice as primary care doctors of natural medicine in a dozen states, including most of California's neighbors. Though I trained 20 years ago in Oregon to become a naturopathic doctor, I must limit my practice in California to that of a licensed acupuncturist, because California has yet to license NDs. This is an unworkable approach and is a waste of well-trained clinicians, who are available to join the work force.

To remedy this situation, the California Association of Naturopathic Physicians is preparing to submit legislation to recognize NDs. Recognition will create access to safe, effective care by well-qualified naturopathic physicians. It provides accountability by a government, public and peer review system. Lack of recognition means anyone can call themselves a doctor of naturopathic medicine, regardless of their training, with little or no recourse if the outcome is negative.

A tragic case in North Carolina occurred in late 1999 when a person calling himself a naturopath persuaded the mother of an 8 year old, insulin-dependent diabetic girl to discontinue insulin injections and treat her with herbs instead. She died soon after. North Carolina has no recognition system in place regarding naturopathic medicine. Now this "naturopath" was not a graduate of one of the accredited four-year naturopathic medical schools and yet was able to use that title, gaining the confidence of the Mother, with a tragic outcome. **To prevent other incidents like this one, it must be mandated that those who call themselves naturopathic physicians have met rigorous standards in education, testing, primary care, and safe practice.**

The existing model of modern naturopathic medical education has resolved the problems of accreditation, credentialling, licensure and scope of practice. It has defined standards for primary care natural medicine. This model can be easily and efficiently articulated with existing medical and CAM education models, into the mainstream health care system. The naturopathic education model provides an excellent training model for conventional physicians for the delivery of low cost, effective, preventive health care solutions. **A key action step is to provide federal funding to accredited naturopathic and CAM Academic Centers of Excellence and fund exchange programs between CAM and conventional medical schools.**

As most of you know, accountability is essential in promoting public safety. The most common pieces of a comprehensive model of professional accountability are benchmarked by:

- Data and research (previously mentioned by colleague Dr. Traub)
- Accreditation and accredited curricula
- Licensure
- National or state board exams
- Practice standards and guidelines
- Code of ethics and peer review system
- Credentialling for reimbursement
- Quality assurance and quality improvement plans
- Continuing education requirements

The naturopathic profession has these benchmarks in place. Because of this, the services of NDs are reimbursed by progressive health plans. The research firm, Jury Verdicts Northwest, has conducted two reviews on the results of health related lawsuits. No malpractice judgments have been found against a naturopathic physician since 1983. An examination of malpractice insurance rating scales for claims show naturopathic physicians have the lowest incidence of malpractice claims of all professions. Washington Health Casualty rates NDs as .7, at the bottom of the scale of risk. **Therefore, services provided by NDs should be uniformly reimbursed in all 50 states.**

The key in promoting the safest, most effective delivery of CAM services centers on the "whole systems approach". Within the philosophy of naturopathic medicine, Chinese medicine and other "whole systems" lies a powerful mandate for health restoration. The development of practice guidelines must honor the distinct knowledge, evidence-base and philosophical perspective of each profession. Respect for these "whole CAM systems" will prevent us from ending up with a diluted version of "green allopathic medicine" in which an herb, nutrient or homeopathic replaces a synthetic pharmaceutical. The trend in primary care and public health is to support behavioral changes to reduce and prevent disease. It is imperative that these whole systems approaches, which do just that, be integrated if we are to be successful in achieving these goals. **Therefore, practice guidelines for all licensed CAM professions must be developed and supported by federal funding.**

As the Town Hall meetings move to the Pacific Northwest, please pay close attention to the work being done at the King County Natural Medicine Clinic. Established in 1995, this is the first publicly funded integrated clinic where MDs, NDs, DCs, acupuncturists, RDs and others co-manage patient care. Naturopathic physicians are primary care providers in this clinic. Bastyr University and Community Health Centers of King County worked hand in hand to develop this clinic which provides integrated CAM services to under-served populations. This is a model that

works. **Another key action step is to provide federal funding for public health clinics and community health centers throughout the United States, to be modeled after this successful partnership.**

Recognize the emerging nature of all of CAM professions. Do not demand a higher level of accountability and evidence for CAM healthcare than is now delivered by conventional medicine. And allow time and funding for these professions to achieve it. And don't reinvent the wheel: Pay close attention to the model for emerging professions that UCSF's Center for the Health Professions is developing. Their task force is creating a model that can be used by many emerging health care professions, to evaluate appropriate standards of education, training, licensure or certification.

There are significant problems in product regulation of nutritional, botanical, and homeopathic medicines. Regulation is critical to ensure public safety. However, the regulations within the FDA are not well designed to fit the unique needs and issues in safely regulating CAM products, thus creating a bottleneck in the dissemination of scientific information and advancement of healthcare for the American public. One model that works is the Canadian Natural Products Division. And I might add that a ND, PhD is the Executive Director of that division. So **a key action step is to replicate the Canadian Natural Products Division within the FDA.**

In closing, I'd like to thank you for hosting these Commission hearings. I'm thrilled to be part of this awakening in health consciousness. Together we can move our country towards a prevention model through which people can express their full health potential. Thank you very much!

I've summarized the recommended action steps and made copies for all the commission members.

In summary, our recommended action steps are:
- Study and replicate the educational models already developed by the naturopathic profession.
- Approve professionally accredited CAM colleges and professions as eligible for grants, residency programs and cross-disciplinary training programs.
- Support licensing of NDs in all 50 states.
- Reimbursement for services provided by NDs and other CAM providers should be uniform in all 50 states.
- Facilitate the integration of co-management teams into State and County Health Department clinics (with training), using successful models such as the King County Natural Medicine Clinic.
- Include and employ licensed CAM professions in Medicare, public health facilities, State and County health boards and clinics, and in the National Health Service Corps Programs.

• Fund the development of practice guidelines that honor the distinct knowledge and evidence base of each profession.
• Address conventional provider access issues for CAM training through collaboration with national CAM associations and educational institutions.
• Provide funding for continued research by the Center for the Health Professions at UCSF, on models to evaluate emerging professions and to facilitate understanding of theses systems by policy makers and the public.
• Produce a report that identifies and evaluates the types of CAM education models, standards and clinical practices in use today.
• Replicate the Canadian Natural Products Division (Health Protection Branch, Ottawa) within the FDA.
• Pass legislation that prohibits discrimination against licensed CAM professions and institutions and that authorizes funding for licensed CAM providers and educational institutions.
• Fund a national CAM and conventional medicine "cross recognition of standards" CREDENTIALLING ROUNDTABLE PROJECT. Charge this group to produce consensus recommendations on integrating CAM systems, standards and modalities standards into mainstream health care training.

Center For Advanced Dentistry

Richard T. Hansen, D.M.D., Director *Tomorrow's Dentistry Today*

Steven Friedman, D.D.S. *Brian Kanarek, D.D.S., L.D.S.R.C.S., F.C.G.D.* *Joseph S. Sarkissian, D.D.S.*

Medicine, Dentistry, and Healthcare are facing many new challenges. While on one hand major advances have been made in science, technology, and the understanding and treatment of the human form, our healthcare systems are being strained by the rise of degenerative disease and associated costs. Conventional medicine is addressing these issues with the same tools they have always counted upon, i.e. surgery, drugs and radiation. Although the technical excellence of these tools, as well as added knowledge on how to improve them, such as with genetic engineering, has increased dramatically, the basic philosophy of medicine and disease has remained unchanged. We do not receive a different outcome using the same process of thinking that got us here.

Complimentary and Alternative Medicine offers another avenue of approaching healthcare and disease. It is not exclusive of conventional medicine but integrative using the best of both. However with the renewed interest in natural healthcare by both patient and practitioner, this new territory is an uncharted wilderness and many are proceeding blindly. This not only becomes potentially dangerous to a patient's health but also threatens the credibility and reputation of alternative healthcare.

The basic philosophy of Complimentary and Alternative Medicine involves more than just looking at symptoms, placing a label on a "disease", or prescribing a drug to eliminate the symptoms and force the body to become what the doctor describes as "normal". CAM involves looking at the complete functioning organism, mind, body, and spirit and determining what cumulative negative factors have led to the malfunction of basic God given body systems which has produced the diseased state and symptoms. Conventional Medicine should be used to support normal body function, remove negative factors that prevent wellness, and not produce any side effects that permanently interfere or damage the body's ability to function, repair, or regenerate. Doctors do not "fix" the body and cannot force it to live. Only the patient's body can ultimately repair itself and sustain life.

A change in the philosophy of medicine is imminently needed to help deal with the "unknown" causes of illnesses, the rise of degenerative disease, and the rise of costs and accesses to modern medicine. Complimentary and Alternative Medicine can help assist conventional medicine achieve these goals. Yet there are tremendous obstacles and hurdles preventing this from happening. Our current healthcare system and conventional practitioners feel confused and uneasy with any change in their present practice. There is a perceived threat to their ego, their power, and their economic stability.

Dentistry is undergoing the same influences as medicine. We now know that bacteria in the mouth contribute to many diseased states; dental materials may leach potentially hazardous materials into the body on a daily basis; metals in the mouth produce voltages and electromagnetic currents hundreds of times greater that the signals from the brain. Most adult dentistry is working on teeth that other dentists have worked on before due to traumatic drilling apart of tooth structure to fill them with large silver/mercury fillings. This leads to continual breakage and decay necessitating further more invasive adult dentistry. Research now shows that the use of a laser to vaporize just decayed tooth and inject in and fuse a biocompatible tooth replacement is not only non traumatic to the patient emotionally and physically, but also may prevent the need for further invasive adult dentistry. Imagine no more root canals or crowns (except for accident or injury). Yet in spite of this, dental schools do not teach these newer techniques stating that they have to graduate students that can pass the licensing exams or they may loose accreditation. The state boards do not test on newer techniques stating that since the schools do not teach these they must not be valid.

What is needed is unbiased scientific research to investigate alternatives in medicine. An end to the confusion, apprehension, skepticism, and fear associated with alternative practice. Legislation guaranteeing rights to use any appropriate therapy by doctors and patients. Schools that have up to date access to all alternatives and research and will introduce all students to these in an unbiased manner. State license boards that recognize and will not persecute practitioners of alternatives.

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Gynecology • Menopause • Women's Wellness • Infertility • Breast Health • Integrative Medicine

September 8, 2000

Comments to the White House Commission on Complementary and Alternative Medicine Policy

INTEGRATIVE MEDICINE= Conventional Western plus Complementary and Alternative Healing Practices

Research and Development

For the past decade I have divided my professional time between the active private practice of gynecology, clinical faculty teaching and CAM clinical research. I am the Principle Investigator at CPMC in a collaborative clinical research pilot with UCSF, (funded through DOD grants as well as private foundation money) evaluating possible effects of Tibetan Medicine in combination with conventional recommended therapies in Metastatic Breast Cancer patients. Institutional review boards at both CPMC and UCSF have been very supportive of the divergent aspects of CAM clinical research and the problems which exist in study design addressing issues relating to placebo effect and the impossibility of "sham" controls. This study is ongoing and no preliminary data are available. Public acceptance and enthusiasm has been widespread throughout the SF Bay Area. An initially reluctant physician community has evolved to embrace CAM treatment options for women with metastatic breast cancer as we currently have no cure for this prevalent life-threatening disease.

More funding support is needed for such projects to succeed and expand. Excessively tight budgets have limited publicity of the study, resulting in sub-optimal enrollment in the study. Patient services to assist with transportation to Tibetan-prescribed care as well as sufficient funds for the herbs themselves have also not been properly funded to address the special needs of the metastatic breast cancer patients in the study. More community outreach funds are necessary if we are to be able to attract a greater diversity of patients, from a broader cross section of ethnic and cultural backgrounds. Caucasian upper middle class women have much better access to CAM studies for many reasons. More funding from government and private sectors is necessary if we are to begin to test the value of CAM in the full spectrum of Americans who are at risk for cancer death.

Access to Delivery of and Reimbursement for CAM Practices and Interventions

In my twentieth year of practicing Obstetrics and Gynecology it is increasingly apparent that there is no system of health care for all Americans. Inadequate access to care plagues a significant percentage of the population in every city in the country. Sadly enough, a majority of health care consumers express dissatisfaction with the medicine that is offered as "standard health care." Too little time for each deserving patient to feel honored, respected and carefully listened to by their "provider." CAM services have even less availability for the general public because they require more personal monetary payments to the CAM practitioners with virtually no hope of reimbursement from health insurance plans. It is well documented that when people seek CAM care they report much greater satisfaction with the interaction, with the practitioner, as well as with the outcome of care. Conventional physicians must pay attention to such surveys as they reflect the feelings of the public which western medicine has failed to address.

Whatever system of financing health care is adopted, it must include a standard panel of CAM services for which routine coverage is assured. The advent of licensing of CAM professionals allows us to utilize these same criteria for "approved providers," whether they hold a D.O., M.D., D. Chir., Lac., CMT, MSW, PhD, or other certified degree and license. Broader support of CAM services by government-supported Medicare and Medicaid Programs will lead the private sector more rapidly to adopt such options as part of standard health care coverage.

Delivery of Reliable and Useful Information on CAM to Health Care Professionals and the Public

Free Internet access to all medical, dental, nursing, pharmacology, physical therapy, herbal medicine, alternative and complementary care journals (entire articles, not simply abstracts) is the first step towards enhancing access to information.

Fund an "expert consensus group" who publishes ongoing reviews of the literature from the widest possible spectrum of research regarding the integrative and exclusive use of CAM to treat disease and promote wellness.

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Such information, interpreted and synthesized by recognized expert professionals who represent divergent backgrounds and integrative thinking, would reduce the task of incorporation and assessment for isolated practitioners who are uncomfortable outside of their customary orientation.

Publish the information over the Internet, send through the mail as printed materials (similar to Medicare bulletins, Board of Medical Quality Assurance updates, etc) or as fax network releases, issue the same format on Quarterly CD-ROM or floppy disks and possibly make audio tapes (such as Audio Digests that professional organizations are currently offering on a regular basis for CME credit) an option for practitioners who so choose.

All of these modes of information delivery could tie into continuing education programs, certified and administered through existing professional organizations. Arrangements could also be made to distribute this information for one introductory year through widely read journals such as JAMA and NEJM. Funding for the development of such endeavors would come from the government NIH-Office of Complementary Alternative Medicine budget.

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My Personal Wish List:

Publish an ongoing series of informational booklets/CD's/Internet documents, etc., addressing

The theory behind the widest variety of healing arts, descriptions of materials and methods for delivery or administration of a healing practice, efficacy data (when available), potential side effects , descriptions of populations or problems/conditions best served by a particular CAM modality and estimated cost of the method for resolution of minimal, moderate and severe cases of a disorder or malady would be of great value to me as I try to broaden my therapeutic offerings to patients. CAM supportive care information for healing disease states, especially when patients are undergoing cancer therapies, surgical interventions and psychological crises organized by disease or condition would serve to fertilize practice options and broaden referrals to supportive practitioners.

Wellness and vitality enhancement approaches, especially with regard to the detailed biochemistry of nutritional foodstuff recommendations, nutriceuticals and herbal supplements would also be tremendously valuable. Include a professional panel discussion by an integrative group of experts of these options. This would help to bridge the information gap that currently exists between CAM literature and more accepted scientific peer-reviewed journals of conventional medical, nursing, public health, physical medicine, dentistry,... etc.

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Concluding Remarks

Ultimately we need to address the enormous discontent that exists with the current state of affairs for practitioners of "Western medicine." It is as if a medical malpractice threat "gun" is held to doctors' right temple while a cost containment "rifle" is pointed at the left. Incomes have dropped in some cases to levels that preclude remaining in practice. Meanwhile there are all of the deserving and frustrated patients who beg for more attention to the heartfelt needs of their care, and better care. There are still hundreds of thousands who have no health care at all. Disappointed in a "system" which has proved unresponsive and often insensitive at vulnerable critical times in families' lives, the public is beyond disenchantment with their doctors, clinics and hospitals. Many doctors openly express their loss of job satisfaction to the point of advising their children not to pursue a career in medicine. Doctors are less able to admit to the "turf battle" and fear of further decreased incomes if CAM practitioners become more accessible through broadly covered insurance benefits.

Social ills, drug abuse and alcoholism most apparently, burden the health care system to the breaking point. Lack of coordinated care and funding for mental health needs of disabled dependent citizens has resulted in cities crowded with homeless people with no where to go but an emergency room or church shelter.

We will not solve these moral socio-political problems with improved CAM access and support alone. But every effort to heal the individual while also addressing the large scale problems we face is progress. Integrating energy healing practices, medicinal herbs, refined nutritional knowledge and wisdom traditions alongside the higher-tech conventional interventions and pharmacy offered in standard health care today facilitates positive change.

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White House Commission on Complimentary and Alternative Medicine Policy

Testimony presented by

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September 8, 2000

San Francisco, CA

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Dear Members of the Commission,

I am submitting these initial comments on behalf of the American Herbalists Guild and the American Herbal Pharmacopoeia. More comprehensive written comments will follow.

The Commission has requested comments regarding various aspects of complimentary and Alternative medicine (CAM) ranging in topics from education of CAM practitioners, research initiatives, reimbursement issues, etc. I have addressed specific issues as outlined by the Commission below. As a general introductory comment, I would like to recommend that the Commission adopt a template for addressing the various issues according to how it effects different aspects of public health from; CAM for prenatal care to care for the elderly and from preventive care to management of chronic illness. When properly applied CAM has a tremendous amount to offer all aspects of American health care. Fundamental to this concept is that all endeavors to integrate CAM into American health care must take the position that the patient is an integral and active partner in the management of their own health. There is a conceptual basis of almost all CAM practices that it is the patient not the practitioner who does the healing. This must be integral to all health care policy regarding CAM.

When determining how CAM policy can best be developed you must also accept CAM, to a large but not exclusive degree, on the merits of the individual modality, actively interfacing with the leaders in those professions. Too often, policy is shaped by conventional medical practitioners who have never practiced CAM, think they are expert in the subject, and believe they know better than the practitioners themselves. Soliciting 5 minute testimonies and written comments from interested parties is grossly insufficient for garnering the type of information needed for establishing a national CAM health care policy. We strongly encourage you to engage in such forums and we would be willing to participate in such forums in issues related to herbal medicine.

Lastly, we feel it is equally imperative that as you deliberate how CAM can be of benefit in American health care, that you also attempt to formulate a philosophical opinion of the differences between CAM and conventional medical practices so the American public can have a clear understanding for making fully informed opinions about both therapeutic options. Much of why CAM exists is due to the inherent limitations of our current health care system: its lack of attention to preventive health care; the excessive use of pharmaceutical medications, most especially antibiotics; its astronomically high cost; its

high rate of iatrogenicity; and its lack of attention to women's health and minority health care issues, especially cultural aspects of healing among traditional peoples.

If your strategy even begins to address these issues your goal will have been achieved. We wish you much success in your deliberations and offer the assistance of our affiliated organizations in helping you to achieve your goals.

American Herbalists Guild

The American Herbalists Guild (AHG) is the only peer review organization in the United States for herbalists specializing in the medicinal use of plants. AHG members include licensed health professionals including acupuncturists, medical doctors, nurses and pharmacists, as well as direct entry herbalists. The AHG was very active in providing the Federal Food and Drug Administration and members of Congress with comments regarding every aspect of the legislative process that led up to the enactment of the Dietary Supplement Health and Education Act (DSHEA), as well as provided testimony to the Presidential Commission on Dietary Supplement Labeling, and participated in the development of the Office of Dietary Supplement's 5 year strategic plan.

American Herbal Pharmacopoeia

The American Herbal Pharmacopoeia™ is a non-profit 501(c)(3) educational foundation dedicated to the development of establishing standards for the manufacture and dissemination of information for herbal supplements. Quality control standards include the proper identification and constituent requirements of raw materials and substantiated methods of analysis and are outlined in the *American Herbal Pharmacopoeia*™. A companion work the *Therapeutic Compendium* critically reviews all of the available data on herbal medicines and provides clear guidelines regarding dosages, actions, indications, contraindications, side effects, interactions, and toxicology. A combined pharmacopoeial and therapeutic monograph is developed on individual botanicals and is then subject to peer review by medicinal plant experts worldwide. To present, American Herbal Pharmacopoeia™ standards have been relied upon by numerous trade associations including the American Herbal Products Association, the National Nutritional Foods Association, and the Consumer Health Products Association. Additionally, adherence to quality control guidelines established by the American Herbal Pharmacopoeia™ for engaging in federally funded depression studies for the botanical St. John's wort *Hypericum perforatum* were required by the Office of Dietary Supplements of the national Institutes of Health.

Comments on Issues Requested by the Commission

What types of CAM practices and interventions should be reimbursable through federal programs or other health care coverage systems?

Making this determination will be a challenge for the Commission. In some cases, such as with well developed traditional systems of healing such as midwifery, herbal medicine, acupuncture, massage, and chiropractic care to name a few, reimbursement is clearly justified. Each of these professions have well developed educational foundations, strong professional organizations with codes of ethics, a large constituency of followers, and, of CAM practices, are most widely available throughout the country.

Specifically for herbal medicine, two issues must be addressed; 1. reimbursement of care provided by herbal practitioners; 2. reimbursement of herbal products prescribed by herbal practitioners.

1. Reimbursement of care provided by herbal practitioners.

A certain amount of reimbursement is currently available for herbal practitioners. However, it is only available in selected states where herbal practitioners, primarily naturopathic physicians and traditional Chinese practitioners, are licensed. Reimbursement for direct entry herbalists is still lacking. Minimally, state and federal reimbursement programs should be developed for herbal practitioners in states where there are legal grounds for the various herbal professions to practice. Currently this is only 13 states for Naturopathy and 30 states for traditional Chinese medicine. Additionally, proper reimbursement programs should be developed for traditional healers in ethnic communities such as among Native American peoples. Such a program was initiated several years ago in Canada, and a limited program was underway on the Dine (Navajo) reservation in Arizona. There is a strong acceptance for herbal medicine among traditional cultures that should be respected and duly acknowledged.

2. Reimbursement of herbal supplements and medicines

Currently, herbal supplements and medicines are not reimbursed under any health care program with the exception of a few private insurance carriers who have initiated small pilot programs to determine its value. Reimbursement programs should be established for herbal products which are prescribed by recognized herbal practitioners. There are two primary issues to be considered. The first is reimbursement of specific preparations which are approved for specific indications. Such a determination would be relatively easy to

make by a collective of herbal practitioners as there is consensus on the relative efficacy of a few hundred botanicals for specific indications. Similarly, numerous authoritative references provide clear guidelines for specific botanicals for specific indications. While the use of botanicals as specific medicines does not adequately represent the practice of herbal medicine, it can provide a foundation by which to make determinations about reimbursements. Reimbursement must further delineate between botanical preparations which are used acutely or for chronic illness, in which case there may also be the need for temporal limits to prevent over-prescribing, and those which may be prescribed preventively, and are thus appropriate for long term consumption. In most cases, health professionals in the given profession should be relied upon to make such determinations with appropriate limitations to minimize practices of over-prescribing and conflicts of interest in the case of herbalists who have a financial interest in a given manufacturing company.

With regards to reimbursement of herbal supplements or medicine, it must be clearly understood that current policies of drug reimbursement, usually determined by approval of the medication by the federal Food and Drug Administration (FDA) do not adequately address herbal medicines. In the United States, there are strong economic disincentives that prevent meaningful botanical medicine research from being undertaken. In pharmaceutical research, there is also an inherent drive to seek to control any substance that has been shown to be safe and effective for a particular use for the express purpose of economic gain. Whatever policy is established with regards to acceptance of herbal medicines, there must be inherent protection of community and intellectual property right, especially in the case when there is long-term historical and cultural understanding of the medical effects of a particular herb. Additionally, it is important that adequate quality control standards be adhered to in determining which particular botanical products should be reimbursed. This would include adherence to manufacturing guidelines and standards as established by authoritative sources of information such as the national and international pharmacopoeias (American Herbal Pharmacopoeia, European Pharmacopoeia, and United States Pharmacopoeia), or other such authoritative sources as are determined.

How can uniform standards of education, training, licensure, and certification be applied to all CAM practitioners?

It is not known whether uniform standards can be applied to all CAM providers due to the diversity of CAM practices that are available. Such standards are relatively easy to apply to all CAM providers who choose to practice as primary health care providers. In such cases,

the primary goal is public safety and core competency. Each of the well developed primary care CAM professions, for example midwifery, traditional Chinese medicine, Ayurvedic herbal medicine, and naturopathic medicine all have well established education programs to assure public safety and establish core competency. Each of these can be improved upon by identifying those areas which are of universal importance to each profession regardless of CAM orientation; i.e. understanding lab work, CPR, handling of infectious disease, knowing the limitations of the profession or practitioners; and then establishing core training modules that can be incorporated into the training of CAM practitioners. Having a uniform program for addressing such core issues will provide for the highest degree of public safety.

Other CAM providers function as health care consultants providing guidance on particular CAM practices and interventions after a diagnosis has been made by a primary care provider. Usually this is done while the patient is involved in a treatment protocol of the primary provider and usually without their knowledge. The education and oversight requirements for secondary care providers may be vastly different than for primary care providers, though some of the core subjects would be the same.

In most cases, it is the profession working in concert with other health care models, who should establish the requirements for core competency and oversight.

How can useful, reliable, and updated information about CAM practices and interventions be made more accessible? How would you like to receive such information?

Dissemination of information requires two primary pathways: delivery to the public and delivery to health professionals. Too often the public is caught in a wave of confusion about CAM, especially when there is not consensus between CAM practices and conventional health care providers who may council against its use. Too often, conventional health care providers are uniformed as to the merit of CAM practices, not because they have adequately reviewed the available data but because there is an automatic assumption that there are little data supporting its use.

Mechanisms for determining effective channels for dissemination of information on CAM practices are limited in our current system. One good model specifically regarding supplements has been developed by the Office of Dietary Supplements (ODS) who has developed a data base of information for dietary supplements. This accessible on-line at no

charge and provides interested parties with access to information they may otherwise have difficulty finding. ODS has also begun developing white papers for dietary supplements that are similarly free to the public. The greatest limitation of ODS is their inability to market their service to a broader audience. Currently this is a result of inadequate funding. Hopefully, as time goes on, the work of ODS will be highly respected for the work it is doing on behalf of public health in this area. With an adequate budget, more truthful information, in this case, about supplements, can be generated and disseminated through broader channels to more diverse markets including schools, hospitals, health professionals, public health care centers, and the public.

Currently the best venue for disseminating such information specifically for CAM practices, besides dietary supplements via ODS, is via the Office of Alternative Medicine who has the same ability to develop white papers on various CAM modalities with clear guidelines of what one needs to know when seeking a particular CAM provider or intervention. Currently, both programs are under utilized and undermarketed.

These conclude the initial comments we would like to make. Thank you for your attention and the opportunity to present these thoughts to you today.

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My name is James Underdown. I am the Executive Director of the Center for Inquiry-*West* in Los Angeles. I represent between 10,000 and 20,000 readers of our *Western Inquirer* newsletter in Southern California and the over 100,000 readers of *Skeptical Inquirer* and *Free Inquiry* magazines.

There is great concern among our readers concerning two issues.

The first issue is that the tens of millions of dollars being spent on the Office of Alternative Medicine is based the false belief that over 40% of Americans are using alternative methods of treatment. Two studies which appeared in the *Journal of the American Medical Association,* and which influenced the large increase in funding for Alternative Medicine, were both done by Dr. David Eisenberg, and financed by the Fetzer Institute, a group which sponsors and promotes mind/body programs, and various alternative methods. In my opinion, Fetzer sponsoring such a study is akin to Firestone sponsoring a study on tire safety.

Eisenberg's studies are flawed and greatly overestimate the use of Alternative Medicine. They have influenced the press, the public, and the moneys spent on this Commission and the Office of Alternative Medicine. Dr. Timothy Gorski, Professor of Gynecology at North Texas State, reported on errors in the studies in 1999. I will not go into the details about the errors and miscalculations in the Eisenberg studies, but Gorski did in his paper, and the paper is available and has been peer-reviewed. Dr. P. Barglow, Professor of Psychiatry at University of California Davis, reported similar errors in Eisenberg's study. A third report, published in JAMA by B. Druss and R. Rosenheck of Yale University, confirmed Gorski's criticisms.

The point is that it is incorrect to assume that 30% or 40% of people surveyed had used an alternative method to treat their illnesses. Druss and Rosenheck's surveys showed that the figure was 10% or fewer. Spending tens of millions of dollars to study and promote Alternative Medicine is simply not warranted for such a small percentage of usage.

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The second great concern our thousands of readers have is that many alternative treatments have been thoroughly discredited by scientifically conducted, peer-reviewed investigations. It is a huge waste of time and money to discuss the integration and training of practitioners of treatment methods proven to have no demonstrated efficacy. We are concerned that there is little government regulation of a gigantic industry based on little more than anecdotal evidence and the placebo effect.

On the day he appointed this commission, President Clinton said, speaking of alternative medicine, "There is no doubt that these therapies should be held to the same standard of scientific rigor as more traditional health care interventions."

The 60,000 member Federation of American Societies for Experimental Biology agrees, and requested in a letter that Federal funding be re-directed to standard and more promising basic and clinical research, rather than to repeating studies already done on implausible methods.

There have been reams of research already published on a range of alternative treatment from therapeutic touch to homeopathy. Most of the findings seriously question the efficacy of the treatments, and the credibility of the claimants.

I urge this commission to consider setting up a dialogue with the kinds of doctors and scientists who have brought humanity away from the primitive and unscientific treatments so many alternative medicines are based on. Set up a dialogue with experts who can truly evaluate medical claims and sift the fantasy from the science.

If a treatment works, let it stand up to the same scrutiny we demand of our surgeons, our drugs, and our researchers. No claim of efficacy should get a free pass simply because we failed to ask the right questions.

Let's test and regulate these claims for the safety of us all.

For Immediate Release

Prevalence of "Unconventional" Medicine in the U.S. Overestimated

In two successive issues of *The Scientific Review of Alternative Medicine*, physician authors report that two surveys grossly overestimated prevalence of "alternative" methods use in the U.S.

The first survey was performed in 1989-90 by David Eisenberg, MD, financed by the Fetzer Institute, and published in the *New England Journal of Medicine* in 1993. The report found 34% of those surveyed had used an "alternative" method in the prior year. The second survey, done eight years later by Eisenberg, again financed by Fetzer, and reported in the *Journal of the American Medical Association* in 1998, found about 44% positive answers. These figures were said to be surprisingly high. They influenced Congress to increase appropriations ($78 million/year) for the Office of Alternative Medicine, and elevate it to a Center.

Timothy Gorski, MD, an Associate Clinical Professor of Gynecology at North Texas State University investigated the errors in the first two surveys that resulted in the surprisingly high figures. He first reported them at a meeting sponsored by the *Scientific Review of Alternative Medicine* in Philadelphia, February, 1999, and published them in the Winter, 2000 issue of the *Scientific Review*. A second analysis in Spring, 2000 *Scientific Review* by P. Barglow, MD, Professor of Psychiatry at U.C. Davis, reported similar errors in the 1998 *AMA Journal* paper.

Dr. Gorski found the Eisenberg studies' definition of "unconventional" was too broad. It included activities long considered normal and non-medical, such as prayer, diets, massage and self-help groups. It also included "conventional" methods long considered part of medicine and psychology such as relaxation techniques, group psychotherapies, and hypnosis. Even counting in those practices, closer examination of the figures showed the actual fraction that had seen an "unconventional" practitioner was only 10%, not the 34% commonly reported to the press.

Furthermore, for comparison to "conventional" care, the 1993 Eisenberg study excluded visits to commonly visited primary care specialties such as gynecology, ear-nose-and throat and physical therapy. The high comparative estimate of out-of-pocket expenses was based on the inflated definition of "unconventional" methods compared to the diminished number of "conventional" medical visits.

The 1993 report also contained a number of other inconsistencies. The number of people consulting an acupuncturist was only 90% of the number reporting having received acupuncture.

A report on "unconventional" usage performed by B. Druss and R. Rosenheck of Yale University, reported in the *Journal of the American Medical Association*, October 1999, confirmed the Gorski analysis. Using a population sample three times the size of the Harvard surveys, and a more realistic and common definition for "unconventional" practices, Druss found only about 8% of the population had visited a scientific and an "unconventional" practitioner, and only 1.8% had seen an unscientific practitioner only.

The Gorski article in the *Scientific Review* also found the 1990-1998 rise in "unconventional" use was not due to visits to practitioners, but due to increased dietary supplement taking. The 1994 Hatch-Richardson (DSHEA) law allowed the extraordinary increase in unsupported advertising claims for supplements, and severely limited Food and Drug Administration control and enforcement. Although the second, 1998 Eisenberg report contained the supplement data, the report did not comment on them.

The financing Fetzer Institute, endowed with over $300 million, is devoted exclusively to sponsoring and approving mind/body programs and research. It also sponsored the PBS TV series "Cancer and the Mind" hosted by Bill Moyers. The *Scientific Review* authors raise the possibility that bias indicated how the data were collected and reported in the two Eisenberg articles. The articles first reported inflated increased public interest, then called for more public funding for research and for integration of the methods.

Dr. Gorski and the *Scientific Review* call attention to the fact that Federal funding for investigations of "unconventional" and "alternative" methods is based largely on misreported and misunderstood information. They find most of the "unconventional" methods to be ineffective. They concur with the 60,000 member Federation of American Societies for Experimental Biology (FASEB) in requesting that Federal funding be re-directed to standard and more promising basic and clinical research, rather than to repeating studies already done on implausible methods.

They also request that the newly formed Presidential Commission on Alternative Medicine look more closely at the scientific information that already disproves "unconventional" methods. The scientific information would blunt any recommendation to integrate those methods into medical care and education. The editor-in-chief of the *Scientific Review* is Wallace Sampson, MD, Clinical Professor of Medicine at Stanford University.

Contact: Timothy Gorski
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(817) 792-2000

FOR IMMEDIATE RELEASE

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White House Commission Begins Series of Town Meetings on Alternative Medicine Policy

Amherst, NY (September 7, 2000)-On Friday, September 8, 2000, the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) will convene a "Town Hall" meeting in San Francisco, California. The event is open to the public and scheduled from 8:30 a.m. to 6:00 p.m. at the Holiday Inn, Golden Gateway, 1500 Van Ness Boulevard, San Francisco. The hotel phone number is (415) 441-4000. Jim Underdown, who heads the Center for Inquiry - *West*, will be speaking to make the case for a truly critical and scientific examination of the alternative medicine claims.

The next two Town Hall meetings are scheduled for October 30 and 31 in Seattle, Washington. Other meetings are being planned, including Albuquerque, New Mexico; Des Moines, Iowa; Houston, Texas; and New York, New York.

On March 7, 2000, President Clinton signed executive order EO 13147, which established the WHCCAMP. According to the order, the commission's function is to provide the President with "legislative and administrative recommendations for assuring that public policy maximizes the benefits to Americans of complementary and alternative medicine." This description assumes that the question of whether alternative medicine provides any concrete health benefits is already settled.

On July 13, 2000, the President appointed thirteen members to the WHCCAMP, including James S. Gordon, MD, as chair. In an official statement released that day, Clinton characterized the commission as the first step in scientifically scrutinizing alternative medicine claims:

"The great potential and possible perils associated with use of complementary and alternative medicine have been well documented. There is no doubt that these therapies should be held to the same standard of scientific rigor as more traditional health care interventions."

However, the resumés of several commission appointees reinforces what some skeptical observers suspect: that alternative medicine's effectiveness is a foregone conclusion for many of the members. Dr. Gordon, for example, heads the Center for Mind-Body Medicine (CMBM) in Washington, DC (www.cmbm.org). CMBM is a think tank dedicated to the promotion of complementary and alternative health care.

According to the center's web site, "[Mind-body medicine] regards as fundamental an approach which respects and enhances each person's capacity for self-knowledge and self-care and emphasizes techniques which are grounded in this approach.... It explores and integrates the healing practices of other cultures, such as acupuncture and acupressure, meditation and yoga, as well as alternative Western approaches including herbalism, massage, musculo-skeletal manipulation, and prayer."

Skeptical Inquirer, the official journal of the Committee for the Scientific Investigation for Claims of the Paranormal (CSICOP), has published several articles critical of claims for alternative medicine's effectiveness. In 1997 the magazine devoted a special "Alternative Medicine in a Scientific World" issue to the debate over the effectiveness of alternative treatments and the validity of certain studies (September/October 1997: Volume 21, Number 5).

Barry Beyerstein, in his contribution to the special issue--titled "Why Bogus Therapies Seem to Work" (pp. 29-34)--writes, "Those who sell therapies of any kind have an obligation to prove, first, that their treatments are safe, and, second, that they are effective. The latter is often the more difficult task because there are many subtle ways that honest and intelligent people (both patients and therapists) can be led to think that a treatment has cured someone when it has not. This is true whether we are assessing new treatments in scientific medicine, old nostrums in folk medicine, fringe treatments in 'alternative medicine,' or the frankly magical panaceas of faith healers."

Several Skeptical Inquirer articles and CSICOP's opinions on certain alternative medicine claims can be found at www.csicop.org, the committee's official web site.

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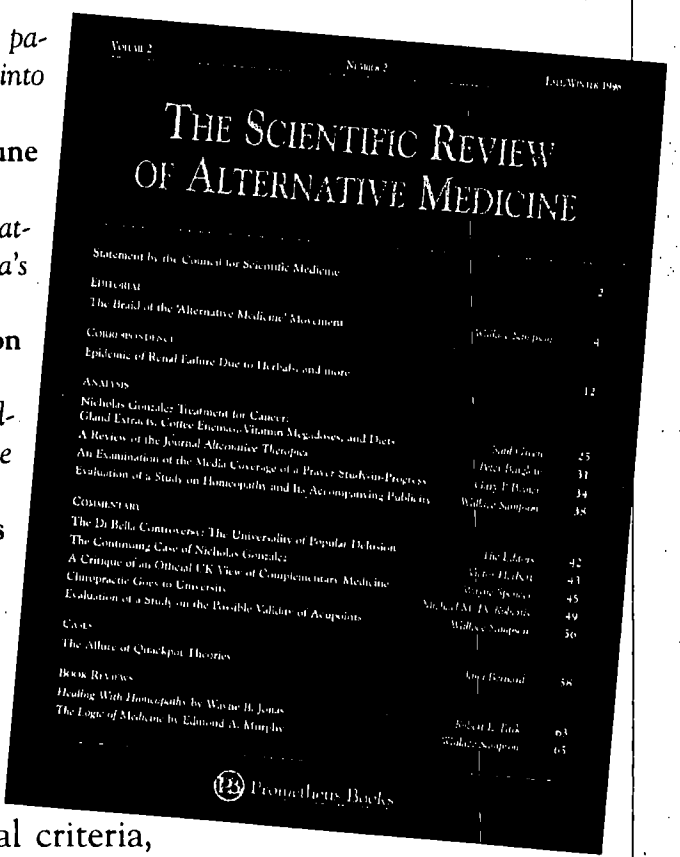

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Prepared Statement for the White House Commission Town Hall Meeting on Complimentary and Alternative Medicine

Prepared By: Dr. Marc Halpern:
President of the California College of Ayurveda
Founding Board Member of the California Association of Ayurvedic Medicine
Founding Board Member of the National Ayurvedic Medical Association
Doctor of Chiropractic
Certified Holistic Health Care Specialist
Clinical Ayurvedic Specialist

This statement represents the views of:
California College of Ayurveda
California Association of Ayurvedic Medicine

I. Coordinated Research and Development to Increase Knowledge of CAM practices and Interventions

What can be done to expand the current research environment so that practices and interventions that lie outside conventional science are adequately and appropriately addressed?

Funding should be made available to support research conducted by experts in each individual field. These experts are capable understanding how to design research so that it addressed the complete approach of a discipline and not it individual components.

What type of incentives are needed to stimulate research by the private and public sector?

Typical incentives for research include patents and financial reward. As many CAM practices are based on healing a person and not the disease, it will be difficult to own a method of healing. Hence, a new incentive will need to be offered. Government grants which pay the salaries of researchers is probably the best incentive. The private for profit sector is not likely to be interested, however, college and organizations promoting a discipline will be. The prestige of running a research center is another incentive for a school or association who makes money in other ways.

How can we more efficiently integrate the CAM and Conventional research communities?

Integration is important. The conventional research community often possesses more skilled researchers and greater funding. However they lack an understanding of most

CAM disciplines beyond an allopathic approach based on isolating a treatment or therapy and testing it against a specific symptom or measurable parameter. CAM research is likely to be more complex and research design will have to be based on the understanding of the discipline.

II. Guidance for access to, Delivery of and reimbursement for CAM practices and interventions

Do you have ready access to CAM practices and interventions?

Most people do not have an understanding of the various disciplines. For those who do, only those who are either wealthy or desperate put their money toward it.

How can access to safe and effective CAM practices and interventions be improved?

Access can be improved by requiring insurance companies to cover CAM practices. Safety can be improved by working with individual disciplines via their National and State Associations to establish proper testing of practitioners, accreditation of schools and standards of practice.

What type of CAM practices should be reimbursable through federal programs or health care coverage?

All practices which meet specific guidelines established by an interdisciplinary panel consisting of representatives of all fields. Then each profession can work toward reaching those guidelines. A support mechanism for each profession should be established to guide the profession on how to meet the guidelines. This mechanism can work with National and State associations.

III. Training, Education, Certification, Licensure and Accountability of Health Care Practitioners in Complimentary and Alternative Medicine.

How can uniform standards of education, training, licensure and certification be applied to all CAM practitioners?

Uniform standards should not be created. Rather, the federal government should work with the individual National and State Associations to establish guidelines for each profession. Each discipline, when it meets basic standards such as the formation of a National and State association, school accreditation council and practice guidelines should then be supported by the Federal government in it quest to establish and individual license for that profession. Uniformity does not take into consideration the individual histories, complexities and scopes of practice of different disciplines.

What training should be required of all health care provides to assure access to safe and effective CAM practices and interventions?

If by health care providers you mean already licensed primary health care practitioners (LPHCP) then they should receive an overview of each discipline in their education including a review of research into that discipline. However LPHCP's should not administer any CAM practices and interventions unless certified to do so by the individual regulatory organizations established by that discipline.

What source of funds exist for the education and training of CAM practitioners?

Funding for Ayurvedic schools comes from tuition's. In California some CAM programs are eligible for student federal financial aid. Additional funding should be made available to schools so they may offer the highest quality program possible. Federal funding for libraries, classroom equipment, clinics and research centers are needed.

Are performance standards and practice guidelines needed to ensure that the public will have access to the full range of safe and effective CAM practices and interventions?

I believe so. However, these standards and practice guidelines must come from within each profession and not be impose on the profession. Incentives can be created for those professions which have not established such guidelines. National and State Associations are the appropriate place to look toward for setting these guidelines.

IV. Delivery of reliable and useful information on CAM to health care professionals and the public

How can useful, reliable and updated information about CAM practices and interventions be made more accessible? How would you like to receive such information?

A federal web site could be designed as an informational center on CAM practices with brief descriptions of each discipline and basic information. Input would be required from each discipline to assure accuracy. National and State associations for each discipline must be involved. Links to each association could be provided. The web site entries would need to be approved by a panel of CAM providers representing each discipline or an appointed individual approved by the profession.

As a provider, what kinds of information about CAM practices and interventions are most needed and important to you?

1. Description of the practice
2. Training of practitioners
3. Licensing / Certification of practitioners
4. Historical background of the discipline
5. Perspective on the cause of disease and healing
6. Modalities utilized
7. Review of research or link to a research data base
8. Practitioner registry

Curriculum Vita
Dr. Marc Halpern
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Updated August 2000

Formal Education

1980 -1983: University of Buffalo, New York. Undergraduate study in biology.

1984: Pre-graduate certification in Bio-Mechanics.

1987: Graduated from Palmer College of Chiropractic-West in Sunnyvale, California. Doctor of Chiropractic. Four-year degree.

1991: Post-graduate certification as a "Holistic Health Care Specialist" completed through New York Chiropractic College. Studies included Homeopathy, Chinese Medicine, Ayurveda, Herbalism, and Holistic Case Management.

1992: Post graduate certification completed in Ayurveda through the American Institute of Vedic Studies under the tutelage of Dr. David Frawley.

1993: Additional Ayurvedic Study with Dr. David Frawley, Dr. Suneil Joshi, and Dr. Subash Ranadé.

1995: Internship with Dr. Subash Ranadé, Principal of the Ashtang Ayurvedic Medical College in Puné, India. (September 1995 and May 1996, performed in the United States)

1995: Certified as a Teacher of Ayurvedic Medicine by the American Institute of Vedic Studies.

1995 – 2000: Numerous Ayurvedic seminars at the California College of Ayurveda presented by noted teachers such as Dr. David Frawley, Dr. Subash Ranadé, Dr. Akhilesh Sharma, and others.

Professional Experience

1989 –1991: Owner and Director, **Peninsula Chiropractic Center**, San Mateo, CA. A full-service chiropractic healing center employing four employees and two doctors.

1992 – 1993: Private Practice in Ayurveda in San Mateo, CA.

1993 – 1996: Director, **Ayurvedic Healing Arts Center**, Nevada City, California. Performed consultations and developed an herbal pharmacy for use with patients.

1995 - Current: Founder and Director, **California College of Ayurveda**, Grass Valley, California. Wrote college curriculum. This is the first California state-approved college to offer comprehensive education and certification in the field of Ayurveda. The College is also recognized by the American Institute of Vedic Studies in the USA and Ayurveda Shikshan Mandal in Puné, India.

1995 - Current: Instructor, **California College of Ayurveda**: Originally taught the entire curriculum of the college. As of 1999, teaching has been focused on the second year clinical studies.

1997 - Current: Founder and Director, **California College of Ayurveda – Center for Optimal Health**, a full-service Ayurvedic and Pancha Karma clinic.

1998 - Founding board member and facilitator, **California Association of Ayurvedic Medicine.** A state association dedicated to licensing Ayurvedic practitioners.

1998 - Selected to the Board of Advisors of the **Australian College of Ayurvedic Acupuncture.**

1998 - Selected to the Board of Advisors to the **International Academy of Ayurveda** in Puné, India.

1999 – 2000: Selected to the Board of Advisors of the journal **Inside Ayurveda.**

1999 – Current: Founding board member, **National Ayurvedic Medical Association.**

Selected Lectures and Seminars Taught by Dr. Halpern

1. 1994: *Principles of Ayurveda* - Mill Valley Yoga Studio
2. 1994: Taught in San Diego as part of a research program exploring the effects of Ayurveda and TM on Stress
3. 1995: Addressed the National Health Federation on the subject of Ayurveda - Sacramento
4. 1995 *Yoga and Ayurveda* with Judy Anderson, Yoga Instructor - Nevada City
5. 1996: *Yoga and Ayurveda* with Judy Anderson, Yoga Instructor - Nevada City
6. 1996: *Yoga, Ayurveda and Stress,* National Convention of Vedic Astrologers - San Diego
7. 1996: *Integrating Yoga and Ayurveda,* First annual Yoga - Mind - Spirit Conference sponsored by *Yoga Journal.*
8. 1996: *Ayurvedic Psychology,* Iyengar Yoga Institute - San Francisco
9. 1996: *Ayurvedic Medicine* , a continuing education program taught to medical doctors and nurses - Northern Arizona University
10. 1997: *The Challenge of Change,* with Dr. Subhash Ranadé - Nevada City
11. 1997: *Fundamental Principles of Ayurveda,* Iyengar Yoga Institute (12-hour workshop) - San Francisco
12. 1997: *Fundamental Principles of Ayurveda,* The Center for Spiritual Awareness 10-hour workshop) - Lakemont, Georgia
13. 1998: *The Spirit of Healing*: (five-day, 20-hour, post graduate, continuing education seminar for health professionals) - Calistoga, California
14. 1998: *Fundamental Principles of Ayurveda,* The Center for Spiritual Awareness (10-hour workshop) - Lakemont, Georgia
15. 1998: *Ayurveda, Yoga and Stress Reduction,* Iyengar Yoga Institute (12-hour workshop) - San Francisco.
16. 1998: Guest lecturer at Consumer Health class (2-hour program), Sacramento State College, California
17. 1998: *Sankhya Philosophy,* Unitarian Universalist Church - Grass Valley, California
18. 1998: *Principles of Ayurveda* (two-day, 12 hour post graduate program for Chiropractors) - Sacramento, California

19. 1999 *Raja Yoga, the Eightfold Path to Enlightenment,* Unitarian Universalist Church - Grass Valley, California
20. 1999 *Introduction to Ayurveda,* Spiritualist Church of the Foothills - Auburn California.
21. 1999: *Ayurveda and Yoga* (3 hour workshop): Sivananda Yoga Ashram - Grass Valley, California.
22. 1999: *Introduction to Ayurveda* (6 hours workshop): Ananda Church of Self Realization, Yoga teacher training program.
23. 1999: *Ayurveda and Yoga* (8 hour workshop): Ananda Center for Self Realization.
24. 1999: *Introduction to Ayurveda*: Sivananda Center, Neyam Dam, India
25: 2000: *Creating Our Future:* Unitarian Universalist Church - Grass Valley, California
26: 2000: *Ayurveda and Yoga:* Sivananda Center (10 hour workshop): Sivananda Yoga Vedanta Center, Paradise Island, Bahamas.
27. 2000: *Ayurveda and Yoga*: Sivananda Yoga Teacher Training Program in Grass Valley. (3 hr. program)
27. 2000: *Ayurveda: Wisdom of Life, Art of Healing*: Two-hour introductory lecture at East/West Book Store in Mountain View, California
28. 2000: *Ayurveda: Wisdom of Life, Art of Healing*: Two-hour introductory lecture at Sivananda Center in San Francisco
29. 2000: *The Healing Art of Ayurveda*: Hope Wellness Center, Carmichael, California
30. 2000: *The Healing Art of Ayurveda*: Caltrans Health Fair, Sacramento

Published Articles and Essays

1. "Asana and Ayurveda," *Yoga Journal,* November 1995 (feature article).

2. A six-article series on Ayurveda that included: "The Journey into Ayurveda," "Tridosha: The Science of Ayurveda," "Pancha Karma: The Ayurvedic Science of Detoxification & Rejuvenation," "Ayurveda, Spirituality, and Meditation," "Ayurveda and Yoga," and "Ayurvedic Education," *Health–Body, Mind and Spirit,* April, 1997 - March, 1998.

3. "Cultivating the Ayurvedic Profession," *The Rose Garden,* April 1997.

4. "Ayurveda: Medicine of the Past, Medicine of the Future," *New Perspectives,* Spring 1997.

5. "Ayurvedic Education in America," *Evolving Times,* January 1998.

6. "Asthma," *Alternative Medicine Digest,* No. 21.

7. "Preventative Medicine, Stress and Ayurveda," *The Share Guide,* January 1998.

8. "Ayurvedic Management and Treatment of Parkinson's Disease," *Inside Ayurveda.*

9. "Pranayama and Ayurveda," *Journal of the International Association of Yoga Therapists,* Fall 2000.

10. "Reflections on Ayurveda in India and the West," *Yoga Life,* Summer 2000.

11. "Ayurveda," in Donald W. Novey, *Clinician's Complete Reference to Complementary and Alternative Medicine.* St. Louis: Mosby, 2000, pp. 246-257.

11. *Principles of Ayurvedic Medicine*, 2 volumes, 745 pp. Grass Valley, CA: California College of Ayurveda, 2000 (textbook).

12. Dozens of smaller articles have appeared in local newspapers and magazines.

Radio and Television Appearances

1. 1997: KVMR Radio, Grass Valley. Interview.
2. 1998: KNCO Radio, Grass Valley, Panel of holistic physicians answering questions and discussing current issues.
3 1998 Radio: House Calls: Conversations at the Edge with host Emmett Miller MD. One-hour interview and discussion on Mind - Body Medicine. Syndicated.
4. 1999: Television: Guest on public access health program in Petaluma, CA.

Memberships

California Chiropractic Association
American Herb Association
California Association of Ayurvedic Medicine
National Ayurvedic Medical Association
Nevada City Chamber of Commerce
Grass Valley/Nevada County Chamber of Commerce

Other Activities

Dr. Halpern has been practicing yoga on a regular basis since 1993. He has studied hatha yoga with Donna Farhi, Asana Editor for *Yoga Journal.*, and taken classes in the Sivananda yoga style.

CAAM's Goals for the Future

To provide a unified voice for the advancement of the Ayurvedic profession

Establish a recognized definition of Ayurveda and the scope of practice for the Ayurvedic profession

Advocate for the creation of a State-approved license for the practice of Ayurveda

Assist in the formation of an accrediting agency for Ayurvedic schools and colleges

Support the development and recognition of a Doctor of Ayurveda degree

Set standards of practice for the profession

Establish ethical standards and a review board to investigate and mediate reports of unethical behavior within the profession

Establish a system for administering a continuing education program for Ayurvedic practitioners

Support research related to Ayurveda

Establish a legal defense fund

Organize malpractice insurance for CAAM members

Publish a peer-reviewed journal.

CAAM Founding Board of Directors

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California Association of Ayurvedic Medicine

A unifying voice for the Ayurvedic profession

California Association Of Ayurvedic Medicine

With the rapid growth of Ayurveda throughout California, today more than ever, a strong Ayurvedic state-wide association is needed. CAAM's purpose is to assure that Ayurveda reaches the public in a manner that is professional and that honors this ancient healing tradition.

The formation of CAAM marks a turning point in the history of Ayurveda in the United States. We are a non-profit professional organization representing and supporting practitioners of the healing art of Ayurveda.

Advocating professionalism and excellence in education and research, CAAM also serves as an advisory body to practitioners, patients and legislators.

CAAM's Mission Statement

The California Association of Ayurvedic Medicine, while embodying and modeling the principles of Ayurveda, exists to serve humankind through:

- Supporting the establishment and growth of Ayurveda as an independent profession,
- Safeguarding the right to practice Ayurveda,
- Ensuring the quality of Ayurvedic practice,
- Ensuring the integrity of Ayurveda as a system of healing that honors the interconnectedness of body, mind and spirit,
- Educating our communities about what Ayurveda is and what makes it a unique and comprehensive health care system.

Why should I join CAAM?

CAAM is the only organization that represents your best interests as a practitioner. We are working hard to ensure that your rights as an independent practitioner are protected.

Will CAAM help me build my practice?

Yes! We are a resource of information to our members in their business. We provide to the public a list of CAAM certified Ayurvedic practitioners, so they know that you are among the best trained and recognized practitioners in the state. We also support public outreach and education in order to raise the awareness of Ayurveda as a natural healing alternative.

What other member benefits will I receive?

CAAM plans to offer our members legal referral and the resources of a legal defense fund (subject to Board approval). We are also planning to offer low-cost liability insurance for our practicing members.

Will CAAM keep me updated on laws that affect my practice?

Through both our newsletters and our website, CAAM will do its best to keep its members abreast of any laws that affect their practice rights and responsibilities.

Will CAAM inform me about upcoming Ayurvedic educational programs?

As a CAAM member, you will receive announcements of Ayurvedic educational programs through our member website, newsletters, and e-mail notification.

How will CAAM help me to connect with other Ayurvedic practitioners?

In addition to annual meetings of members, CAAM supports Ayurvedic continuing educational programs which will provide you the opportunity to network with others in your field. In addition, you will have access to the CAAM member on-line chat room. We also plan to publish a peer-reviewed journal and support Ayurvedic research. By joining CAAM, you are joining others who want to share ideas with fellow practitioners.

How do I join CAAM?

To be considered for membership, refer to our qualification letter and mail your completed application with the appropriate dues to CAAM.

For further information or to request an application for membership call:
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Midwife
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Friday, September 8, 2000
White House Commission on Complementary and Alternative Medicine

Midwifery is the art of safeguarding the natural process of pregnancy and birth. Midwives are experts in the care of normal birth. Midwives tenderly address the heart and soul of the family as it greets its newest member.

Midwives provide preventive care - physical, psychological, social, emotional - with minimal technological intervention during pregnancy, labor and birth, and during the period of postpartum adjustment and breastfeeding. We give the mother and her family individualized education, counseling, health care, support and referrals to resources. Many of us make use of alternative health care modalities in caring for our clients, such as the ones that this Commission is exploring today. At all stages of the childbearing cycle, we identify which women will benefit from alternative care and refer those women whose physical conditions require obstetrical attention.

Midwifery care has excellent outcomes. Hundreds of studies of midwives and of birth settings have been undertaken and published throughout the world over a period of almost 40 years. Virtually all of these studies - from the United States, Canada, Great Britain, Holland, Australia, New Zealand - conclude that midwifery care provides an outstanding standard of care for the vast majority of pregnant women. The excellent safety record of midwifery care holds true in all settings - hospital, freestanding birth center and home.

When midwives are the primary birth attendants, rates of complications are low. New mothers who are attended by midwives have decreased rates, when compared to physician managed birth in the hospital, of low birth weight, fetal distress, neonatal distress, neonatal injury, maternal injury, maternal analgesia and anesthesia, infection in mother and baby, instrument delivery, episiotomy and cesarean birth.

Midwifery is cost effective. These lower rates of problems are attained while using fewer resources, and without sacrificing safety for mother or baby. Our excellent outcomes are purchased with much lower cost that conventional hospitalization for birth. If midwives were utilized for higher percentages of American births, the American health care bill would shrink. By one estimate, if the United States were to use midwives for 75% of pregnancies and births, we could save $8.5 billion per year! Yet, some insurance companies will not cover out of hospital birth or midwife attended birth, which pushes significant numbers of families into care with inappropriate intervention.

For a wealthy country that spends more on birth than any other nation, the United States currently is tied for last place in infant mortality. All of

the countries that rank better than the US utilize midwives as the primary care provider for most pregnant and laboring women. In Europe, 70% of all births are attended by midwives, and all those European nations utilizing midwives have fewer infant mortalities than the US.

Women and families who have midwife attended births are generally well satisfied with their care. Midwives attend to each woman as an a person, and tailor high touch, low tech care to each woman's needs. We give time to our women - generally 20-60 minutes at each prenatal visit. Busy obstetricians cannot afford to devote this kind of time to their prenatal patients. Midwives come to know our clients well. By the time women are in labor, we are trusted and familiar friends who are there to protect and guide them in this most personal and intimate event. Unlike most busy obstetricians, who arrive at a normal birth just in time to deliver the baby, midwives stand by our clients throughout labor, ensuring continuous support and expertise to help keep birth normal and healthy.

I am including for the commissioners a summary of a PhD thesis written by Peter F. Schlenzka at Stanford University in 1999 which studies over 800,000 births. Titled "Safety of Alternative Approaches to Childbirth" it compares outcomes from in-hospital and out-of-hospital births, and concludes that the medicalization of childbirth is not necessarily in the best interests of childbearing families. To quote from his study: "The ...disadvantages of the obstetric approach are of such a large order of magnitude as to raise serious doubts concerning the appropriateness of conventional 'obstetric' treatment for low-risk childbirth." This study includes a bibliography of research on the effectiveness of midwifery care. Another listing of research articles is included with my packet of information.

I am also including a leaflet describing the Mother Friendly Childbirth Initiative - a consensus plan developed by the Coalition for Improving Maternity Services, or CIMS. This coalition is a group of national childbirth organizations and activists, whose goal is to identify "...a wellness model of maternity care that will improve birth outcomes and substantially reduce costs. This...model focuses on prevention and wellness as the alternatives to high-cost screening, diagnosis and treatment programs." One of the recommendations of the Mother-Friendly Childbirth Initiative is to make midwifery care available to all birthing women.

I will close with a quotation from Dr. G.J. Kloosterman, a Dutch obstetrician and former president of the International Federation of Obstetricians and Gynecologists.

"The midwife must be able to advise the expectant mother, give her moral support... and above all, to supervise her in such a way that all ...abnormalities are recognized ...as early as possible. I am convinced that she is able to do this as well as a doctor, and very often better...Without the presence ...of the midwife, obstetrics becomes aggressive, technologic, and inhumane."

The Midwifery Model of Care

The Midwifery Model of Care is based on the fact that pregnancy and birth are normal life processes.

The Midwifery Model of Care includes:

* monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle;
* providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support;
* minimizing technological interventions; and
* identifying and referring women who require obstetrical attention.

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

-- *Midwives Alliance of North America, North American Registry of Midwives, Midwifery Education Accreditation Council, and Citizens for Midwifery, May 1996.*

What is a Midwife?

A midwife is a trained professional with special expertise in supporting women to maintain a healthy pregnancy birth, offering expert individualized care, education, counseling and support to a woman and her newborn throughout the childbearing cycle.

A midwife works with each woman and her family to identify their unique physical, social and emotional needs. When the care required is outside the midwife's scope of practice or expertise, the woman is referred to other health care providers for additional consultation or care.

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SUMMARY OF CRITICAL POINTS

from

"SAFETY OF ALTERNATIVE APPROACHES TO CHILDBIRTH"

by

PETER F. SCHLENZKA

Submitted by

Dr. Susan Virginia Mead

Department of Social Work and Sociology

Ferrum College

August 5, 1999

For his doctoral dissertation written at Stanford University, Peter F. Schlenzka recently finished an extensive study of perinatal outcomes in out-of-hospital and in-hospital births. Outlining his reason for undertaking the study, Schlenzka states that research has suggested that the "medicalization of childbirth and the move of childbirth from home to the hospital might not have improved the outcomes for these low risk pregnancies" which constitute 60-80% of all pregnancies (p. 1). In his own research, Schlenzka sets out to study perinatal mortality of pregnant women with equal risk levels to determine whether or not "the non-interventionist natural approach to childbirth, as administered by midwives and some physicians in free-standing birth centers or at home, is as safe as the interventionist obstetric approach in hospitals." His methodology allows for insights into the outcomes of both low-risk and high-risk pregnancies and births—in and out of the hospital. In addition, Schlenzka examines evidence of the "overall social and economic cost to society" of these

two approaches to maternal care (p. 3).

As is standard in all doctoral research, Schlenzka has conducted a thorough review of scientific literature which pertains to the study he undertakes in this dissertation. His bibliography consists of 189 references and he includes over 50 pages of literature review on such topics of the medicalization of childbirth, the shift from home-birth to hospital birth, the safety of obstetric and natural approaches, and the re-emergence of midwifery. Some critical statements he cites from others' research are cited on pages three and four of this summary.

In his study, Schlenzka examines information from live birth and fetal death records for children in the 1989 and 1990 birth cohort, hospital discharge data reporting medical risk factors, and various information about free-standing birth centers. After careful matching of all appropriate data, Schlenzka examines perinatal outcomes of nearly 816,000 births, comparing low risk births outside and inside the hospital and high-risk births outside and inside the hospital. His findings clearly show that the natural approach and obstetric approach produce the same perinatal mortality outcomes for both low-risk and high-risk births. Thus, he concludes: "the obstetric approach cannot claim to have lower perinatal mortality rates than the natural approach to childbirth," with the natural approach in this case being defined as births planned in out-of-hospital settings—that is, at home or in a free-birth center (p. 175, 174).

To examine the social and economic costs of birth, Schlenzka's study compares "the present hospital-based obstetric care system with a shared maternity care system where midwives are the primary caregivers attending low-risk women (the majority of all pregnancies) and using the natural approach while obstetricians use their interventionist approach only for the remaining cases with complications" (p. 175). His first observation is that "a shared maternity care system would lower the cost for childbirth by roughly 40%, or $13.143 billions" (p. 175).

Schlenzka also suggests that under the shared maternity care model, there would be a lessening of costs from the reduction of unnecessary cesareans and other obstetric interventions. Finally, he reviews research that suggests that a wide variety of social ills that have been linked to birth trauma, such as lack of bonding between the mother and infant, involve a great economic and social cost to society--and that a less interventive birth model would reduce these ills. From this analysis, Schlenzka concludes that the "apparent disadvantages of the obstetric approach have such large order of magnitude, that in any clinical trial it would be considered unethical to continue with the obstetric 'treatment'"

(p. 175).

Schlenzka's data from more than 800,000 births show no advantage of the obstetric approach for either low or high risk women. Furthermore, Schlenzka is able to show a slightly (though not

significantly) better outcome in terms of lower perinatal mortality for low-risk women who opt for out-of hospital settings. After analyzing all of his data on perinatal outcomes, Schlenzka states the following

(p. 153):

> Under no circumstances do the California data for 1989 and 1990 allow the obstetric profession to uphold the claim that for the large majority of low-risk women hospital birth is "safer" with respect to perinatal mortality. Our data also suggest that even for the high-risk levels of our Study Population the natural approach (including transfers) produces the same perinatal mortality outcomes as the obstetric approach.

In his abstract, Schlenzka concludes (p. iv-v)

:

> Given no differences in perinatal mortality it must be noted that the natural approach shows significant advantages with respect to lower maternity care cost as well as reduced mortality and morbidity from unnecessary cesareans and other obstetric interventions, and significant benefits from avoiding negative long-term consequences from unnecessary obstetric interventions and procedures. These advantages of the natural approach are of such a large order of magnitude as to raise serious doubts concerning the appropriateness of conventional "obstetric" treatment for low-risk childbirth.

Critical Quotes from the Review of Literature in

Peter F. Schlenzka, "Safety of Alternative Approaches to Childbirth,"

Stanford University, March 1999.

(Full citations appear in the Reference section)

"The woman's choice itself may influence her level of anxiety and apprehension, and in obstetrics levels of anxiety have been shown to predict obstetric complications" (p. 3--from Wiegers et al 1996).

The "medicalized approach to childbirth (the obstetric approach) is based on medicine's belief that every birth has a high potential for pathology...It is no wonder then that the obstetric approach focuses on the pathologies in the labor and delivery phase, and the physician tends to take charge in the patient-doctor interaction and sees himself as the decisionmaker" (p. 4—with contributions from Davis-Floyd 1994 and Rooks 1997).

"Midwifery is rooted in the natural approach. Pregnancy and birth are considered fundamentally healthy processes which have many normal variations; it is normal part of life, not a medical condition...Only when complications occur which are beyond the midwife's expertise, is the woman transferred to obstetric care" (p. 6—from Steiger 1987).

"Treating normal labors as though they were complicated can become a self-fulfilling prophecy" (p. 6—from Rooks 1997).

"[Birth] can be a most empowering act of creation in a woman's life...Midwives...perceive part of their role to "empower" the pregnant women.... Dr. Michel Odent argues that "experiences have clearly shown that an approach which "demedicalizes" birth, restores dignity and humanity to the process of childbirth, and returns control to the mother is also the safest approach"' (p. 7---with contributions from Odent 1984 and Rooks 1997).

"several observational studies carried out during the last two decades suggest that out-of-hospital birth is as safe as hospital birth for women with comparable low-risk profiles (Kloosterman 1984; Mehl et al. 1976; Tew 1977b; Van Alten, Eskes and Treffers 1989)...Marjorie Tew showed that ...birth in obstetric hospitals was significantly less safe than in general practitioner units or home birth...[and] that birth at home and in General Practitioner Units (GPU) was not only safer for low-risk pregnancies, but also for the high-risk cases (Tew 1990, pp. 241-245)." (p. 12, 13, 16---from studies cited in quote).

"'reluctance of the obstetric establishment to consider the implications of objective evidence which runs counter to their preconceived assumptions – without refuting it on statistical grounds" (Zander 1984, p. 128)'" (p. 17--- quote from Zander).

"For the Netherlands, as the only country with a sizable proportion of natural childbirths (home birth as proxy)...Dutch national perinatal statistics from 1986 ...found that perinatal mortality rates were much higher for obstetricians in hospitals than for midwife-attended home care or midwife-attended hospital care, at all levels of risk when controlling for gestation, maternal age

and parity" (p. 17---from studies by Treffers and Laan 1986 and Tew and Damstra-Wijmenga 1991).

"The WHO [World Health Organization] commissioned in 1979 a Perinatal Study Group to examine the "problems surrounding birth and birth care" and ...the recommendations ...strongly argue for a non-interventionist approach to childbirth" (p. 17---from WHO 1985 #6).

"A recent meta-analysis of planned home birth vs. planned hospital birth of studies published after 1970 found six studies (from Australia, Netherlands, Switzerland, UK, two from the US) which met the selection criteria and concludes that

Perinatal mortality was not significantly different in the home and

Hospital groups in any individual study"

(p. 18---from Olsen 1997).

"Dr. C. Arden Miller, chairman of the Department of Maternal and Child Health at the University of North Carolina School of Public Health and a past-president of the American Public health Association, testified in a 1980 hearing on the obstacles to nurse-midwifery practice. He stated, "If one looks for reasons why this country is deprived in many areas of the services of midwives, one has to look in the political and economic arenas. The answer is not to be found in terms of health outcomes" (pp. 19-20---from Rooks 1997).

"in a double blind clinical trial at the Los Angeles County and USC Women's Hospital, 492 low risk women who qualified for the hospital's Normal Birth Center were randomly assigned to either the midwifery service in the birth center or to the physician service in the maternity ward (Chambliss et al. 1992). While there were no differences in the demographics of the two groups or in neonatal outcome, the physicians had significantly higher intervention rates than the midwives" (pp. 21-22—*this statement is followed by several other studies that showed no differences in fetal or neonatal outcomes but marked differences in intervention and subsequent differences in maternal satisfaction, favoring non-interventive settings).*

"the lower rate of interventions in home births meant a lower risk of subsequent complications for the mother...'Usually it takes a certain tenacity for women to realize a home birth in a health care system in which this is considered irresponsible'" (p. 27---from Ackermann-Liebrich et al. 1996, p. 1317).

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IMPORTANT NOTE: The studies listed here are but a sample of the published reports supporting home birth and midwifery. For an exhaustive survey, discussion, and bibliography, citing hundreds of references, see the book, **THE FIVE STANDARDS FOR SAFE CHILDBEARING**, by Dr. David Stewart, available from NAPSAC International, Box 646, Marble Hill, MO 63764. Price $9.95 ppd. This 484 page publication is the most comprehensive review of the statistics of midwifery and home birth ever compiled. It is used as the difinitive publication by courts of law and government agencies in the U.S., Canada and other countries. It is used by the World Health Organization.

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Ratified by these members of the Coalition for Improving Maternity Services (CIMS), July 1996

Organizations:

Academy of Certified Birth Educators (Olathe, KS), Judie C. Wika, RNC, MSN, CNM, CCE, Linda M. Herrick, RNC, BSN, CCE, CD, Sally Riley, BSEd, CCE, CD, Co-Directors

American Academy of Husband-Coached Childbirth (The Bradley Method[TM]), (Sherman Oaks, CA), Jay & Marjie Hathaway, Executive Directors http://www.bradleybirth.com/

American College of Nurse-Midwives (Washington, DC), Joyce Roberts, CNM, PhD, FAAN, FACNM, President

American College of Domiciliary Midwives (Palo Alto, CA), Faith Gibson, CPM, Executive Director

American Society for Psychoprophylaxis in Obstetrics/Lamaze (Washington, DC), Deborah Woolley, CNM, PhD, FACCE, President http://www.lamaze-childbirth.com/

Association of Labor Assistants & Childbirth Educators (Cambridge, MA), Jessica L. Porter, President http://www.alace.org/

Association for Pre- & Perinatal Psychology & Health (Geyserville, CA), David B. Chamberlain, PhD, President

Association of Women's Health, Obstetrics, and Neonatal Nursing (Washington, DC), Joy Grohar, RNC, MS, President

Attachment Parenting International, (Nashville, TN), Lysa Parker, BS, Executive Director

Birthworks, Inc. (Medford, NJ), Cathy E. Daub, RPT, CCE, President

Center for Perinatal Research & Family Support (Westwood, NJ), Debra Pascali, Executive Director

Doulas of North America (Seattle, WA), Barbara A. Hotelling, RN, BSN, CD, FACCE, President http://www.dona.com/index.html

The Farm (Summertown, TN), Ina May Gaskin, President http://www.gaia.org/farm/index.html

Global Maternal/Child Health Association (Wilsonville, OR), Barbara Harper, RN, President

Informed Home Birth/Informed Birth & Parenting (Ann Arbor, MI), Rahima Baldwin Dancy, CPM, President

International Association of Infant Massage (Elma, NY), Ellen Kerr, RN, BSN, MST, CIMI, President

International Lactation Consultant Association (Chicago, IL), Karen Kerkhoff Gromada, MSN, RN, IBCLC, President

La Leche League International, (Schaumburg, IL), Carol Kolar, RN, Director of Education & Outreach http://www.prairienet.org/lli/homepage.html

Midwifery Today (Eugene, OR), Jan Tritten, TM, Editor http://www.efn.org/~djz/birth/MT/Mtindex.html

Midwives Alliance of North America (Newton, KS), Ina May Gaskin, President http://www.gaia.org/farm/charities/mid.html

Midwives of Santa Cruz (Santa Cruz, CA), Roxanne Potter, CNM, Kate Bowland, CNM, Co-Directors

National Association of Childbearing Centers (Perkiomenville, PA), Susan Stapleton, MSN, CNM, President

National Association of Postpartum Care Services (Edmunds WA), Gerri Levrini, RN, MSN, CNAA, President

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Susanne Arms, Bayfield, CO, Immaculate Deception

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Mary Brucker, CNM, DNSc, Dallas, TX

Raymond Castellino, DC, RPP, Santa Barbara, CA

Robbie Davis-Floyd, PhD, Austin, TX, Birth as an American Rite of Passage http://www.efn.org/~djz/birth/add695/birthasrite.html

Henci Goer, BA, ACCE, Sunnyvale, CA, Obstetric Myths Versus Research Realities

Dorothy Harrison, IBCLC, Edmunds WA

Jack Heinowitz, PhD, San Diego, CA, Pregnant Fathers

Tina Kimmel, MSW, MPH, Berkeley, CA

Marshall Klaus, MD, Berkeley, CA, Bonding-Building the Foundation for Secure Attachment and Independence

Phyllis Klaus, CSW, MFCC, Berkeley, CA, The Amazing Newborn

Judith Lothian, RN, PhD, FACC, Brooklyn, NY

Susan Sobin Pease, MBA, CIMI, CMT, San Francisco, CA

Paulina G. Perez, RN, BSN, FACCE, Houston, TX, Special Women

James W. Prescott, PhD, Newport Beach, CA, Brain Function and Malnutrition

Mayri Sagadi, RN, SNM, CCA, CCE, Goleta, CA

Karen A. Salt, CCE, Highland Park, NJ

Irene Sandvold, DrPH, CNM, Rockville, MD

Roberta M. Scaer, MSS, Boulder, CO, A Good Birth, A Safe Birth (http://www.parentsplace.com/readroom/authors/korte/good1.html)

Betsy K. Schwartz, MMHS, Coconut Creek, FL

Penny Simpkin, PT, Seattle, WA, The Birth Partner: Everything You Need to Know to Help a Woman through Childbirth

Suzanne Suarez, JD, RN, Tallahassee, FL

Sandy Szalay, ARNP, CCE, Seattle, WA

Marsden Wagner, MD, MSPH, Copenhagen, Denmark, Pursuing the Birth Machine

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The Mother-Friendly Childbirth Initiative

The First Consensus Initiative of the Coalition for Improving Maternity Services (CIMS)

Mission

The Coalition for Improving Maternity Services (CIMS) is a coalition of individuals and national organizations with concern for the care and well-being of mothers, babies, and families. Our mission is to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs. This evidence-based mother-, baby-, and family-friendly model focuses on prevention and wellness as the alternatives to high-cost screening, diagnosis, and treatment programs.

Preamble

Whereas:

- In spite of spending far more money per capita on maternity and newborn care than any other country, the United States falls behind most industrialized countries in perinatal morbidity and mortality, and maternal mortality is four times greater for African-American women than for Euro-American women;
- Midwives attend the vast majority of births in those industrialized countries with the best perinatal outcomes, yet in the United States, midwives are the principal attendants at only a small percentage of births;
- Current maternity and newborn practices that contribute to high costs and inferior outcomes include the inappropriate application of technology and routine procedures that are not based on scientific evidence;
- Increased dependence on technology has diminished confidence in women's innate ability to give birth without intervention;
- The integrity of the mother-child relationship, which begins in pregnancy, is compromised by the obstetrical treatment of mother and baby as if they were separate units with conflicting needs;
- Although breastfeeding has been scientifically shown to provide optimum health, nutritional, and developmental benefits to newborns and their mothers, only a fraction of U.S. mothers are fully breastfeeding their babies by the age of six weeks;
- The current maternity care system in the United States does not provide equal access to health care resources for women from disadvantaged population groups, women without insurance, and women whose insurance dictates caregivers or place of birth;

Therefore,

We, the undersigned members of CIMS, hereby resolve to define and promote mother-friendly maternity services in accordance with the following principles:

Principles

We believe the philosophical cornerstones of mother-friendly care to be as follows:

Normalcy of the Birthing Process

- Birth is a normal, natural, and healthy process.
- Women and babies have the inherent wisdom necessary for birth.
- Babies are aware, sensitive human beings at the time of birth, and should be acknowledged and treated as such.
- Breastfeeding provides the optimum nourishment for newborns and infants.
- Birth can safely take place in hospitals, birth centers, and homes.
- The midwifery model of care, which supports and protects the normal birth process, is the most appropriate for the majority of women during pregnancy and birth.

Empowerment

- A woman's confidence and ability to give birth and to care for her baby are enhanced or diminished by every person who gives her care, and by the environment in which she gives birth.
- A mother and baby are distinct yet interdependent during pregnancy, birth, and infancy. Their interconnected-ness is vital and must be respected.
- Pregnancy, birth, and the postpartum period are milestone events in the continuum of life. These experiences profoundly affect women, babies, fathers, and families, and have important and long-lasting effects on society.

Autonomy

Every woman should have the opportunity to:

- Have a healthy and joyous birth experience for herself and her family, regardless of her age or circumstances;
- Give birth as she wishes in an environment in which she feels nurtured and secure, and her emotional well-being, privacy, and personal preferences are respected;
- Have access to the full range of options for pregnancy, birth, and nurturing her baby, and to accurate information on all available birthing sites, caregivers, and practices;
- Receive accurate and up-to-date information about the benefits and risks of all procedures, drugs, and tests suggested for use during pregnancy, birth, and the postpartum period, with the rights to informed consent and informed refusal;
- Receive support for making informed choices about what is best for her and her baby based on her individual values and beliefs.

Do No Harm

- Interventions should not be applied routinely during pregnancy, birth, or the postpartum period. Many standard medical tests, procedures, technologies, and drugs carry risks to both mother and baby, and should be avoided in the absence of specific scientific indications for their use.
- If complications arise during pregnancy, birth, or the postpartum period, medical treatments should be evidence-based.

Responsibility

- Each caregiver is responsible for the quality of care she or he provides.
- Maternity care practice should be based not on the needs of the caregiver or provider, but solely on the needs of the mother and child.
- Each hospital and birth center is responsible for the periodic review and evaluation, according to current scientific evidence, of the effectiveness, risks, and rates of use of its medical procedures for mothers and babies.
- Society, through both its government and the public health establishment, is responsible for ensuring access to maternity services for all women, and for monitoring the quality of those services.
- Individuals are ultimately responsible for making informed choices about the health care they and their babies receive.

These principles give rise to the following ten steps which support, protect, and promote mother-friendly maternity services:

Glossary

Augmentation: Speeding up labor.
Birth Center: Free-standing maternity center.
Doula: A woman who gives continuous physical, emotional and informational support during labor and birth. Doulas may also provide postpartum care services in the home
Episiotomy: Surgically cutting to widen the vaginal opening for birth.
Induction: Artificially starting labor.
Morbidity: Disease or injury.
Oxytocin: Synthetic form of oxytocin (a naturally occurring hormone) given intravenously to start or speed up labor.
Perinatal: Around the time of birth.
Rupture of Membranes: Breaking the "bag of waters.

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Wagner M. Pursuing the Birth Machine: The Search for Appropriate Birth Technology. Australia: ACE Graphics, 1994. (Dr. Wagner's book has the "General Recommendations" of The WHO Fortaleza, Brazil, April, 1985 and the "Summary Report" of The WHO Consensus Conference on Appropriate Technology Following Birth Trieste, October, 1986.

Ten Steps of the Mother-Friendly Childbirth Initiative

for Mother-Friendly Hospitals, Birth Centers, and Home Birth Services

To receive CIMS designation as "mother-friendly," a hospital, birth center, or home birth service must carry out our philosophical principles by fulfilling the Ten Steps of Mother-Friendly Care:

A mother-friendly hospital, birth center, or home birth service:

1. Offers all birthing mothers:
   - Unrestricted access to the birth companions of her choice, including fathers, partners, children, family members, and friends;
   - Unrestricted access to continuous emotional and physical support from a skilled woman-for example, a doula, or labor-support professional;
   - Access to professional midwifery care.
2. Provides accurate descriptive and statistical information to the public about its practices and procedures for birth care, including measures of interventions and outcomes.
3. Provides culturally competent care-that is, care that is sensitive and responsive to the specific beliefs, values, and customs of the mother's ethnicity and religion.
4. Provides the birthing woman with the freedom to walk, move about, and assume the positions of her choice during labor and birth (unless restriction is specifically required to correct a complication), and discourages the use of the lithotomy (flat on back with legs elevated) position.
5. Has clearly defined policies and procedures for:
   - collaborating and consulting throughout the perinatal period with other maternity services, including communicating with the original caregiver when transfer from one birth site to another is necessary;
   - linking the mother and baby to appropriate community resources, including prenatal and post-discharge follow-up and breastfeeding support.
6. Does not routinely employ practices and procedures that are unsupported by scientific evidence, including but not limited to the following:
   - shaving;
   - enemas;
   - IVs (intravenous drip);
   - withholding nourishment;
   - early rupture of membranes;
   - electronic fetal monitoring;

   other interventions are limited as follows:
   - Has an oxytocin use rate of 10% or less for induction and augmentation;
   - Has an episiotomy rate of 20% or less, with a goal of 5% or less;
   - Has a total cesarean rate of 10% or less in community hospitals, and 15% or less in tertiary care (high-risk) hospitals;
   - Has a VBAC (vaginal birth after cesarean) rate of 60% or more with a goal of 75% or more.
7. Educates staff in non-drug methods of pain relief, and does not promote the use of analgesic or anesthetic drugs not specifically required to correct a complication.
8. Encourages all mothers and families, including those with sick or premature newborns or infants with congenital problems, to touch, hold, breastfeed, and care for their babies to the extent compatible with their conditions.
9. Discourages non-religious circumcision of the newborn.
10. Strives to achieve the WHO-UNICEF "Ten Steps of the Baby-Friendly Hospital Initiative" to promote successful breastfeeding:
    1. Have a written breastfeeding policy communicated to all health care staff;
    2. Train all health care staff in skills necessary to implement this policy;
    3. Inform all pregnant women about the benefits and management of breastfeeding;
    4. Help mothers initiate breastfeeding within a half-hour of birth;
    5. Show mothers how to breast feed and how to maintain lactation even if they should be separated from their infants;
    6. Give newborn infants no food or drink other than breast milk unless medically indicated;
    7. Practice rooming in: allow mothers and infants to remain together 24 hours a day;
    8. Encourage breastfeeding on demand;
    9. Give no artificial teat or pacifiers (also called dummies or soothers) to breastfeeding infants;
    10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospitals or clinics.

Does Not
Checked
do not have
Testimony

White House Commission on Complementary and Alternative Medicine Policy

Town Hall Meeting
September 8, 2000, San Francisco, CA

ROSTER & ORDER OF SPEAKERS

9:00 1. MARILYN SCHLITZ, PHD
Institute for Noetic Sciences & CA Pacific Medical Center
San Francisco, CA

9:10 2. ✓ BEVERLY RUBIK, PHD BIOPHYSICS
Institute for Frontier Science
Oakland, CA

9:20 3. ✓ CATHERINE DOWER, JD
UCSF Center for Health Professions
San Francisco, CA

9:30 4. ✓ MAY LOO, MD
Stanford Medical Center
San Jose, CA

9:40 5. DEBORAH KESTEN, MPH
CA Pacific Medical Center
San Francisco, CA

9:50 6. ✓ CORINNE GIANTONIO, PHD
Kaiser Permanente
Gold River, CA

10:00 7. SAVELY SAVVA
Monterey Institute for the Study of Alternative Healing
Carmel, CA

10:05 8. ADAM BURKE, PHD, MPH, LAC
San Francisco State University/IHHS
San Francisco, CA

10:10 9. ✓ DANA ULLMAN, MPH
Homeopathic Education Services
Berkeley, CA

10:15 10. ✓ CRAIG LITTLE, DC
American Chiropractic Association
Arlington, VA

10:20 11. MILLIE TSENG, BSN
Santa Clara County Employee Wellness
San Jose, CA

10:25 12. ✓ LIXIN HUANG
American College of Traditional Chinese Medicine
San Francisco, CA

10 30 13. ✓ BRUCE SHELTON, MD, MDH, DIHOM
AZ Board of Homeopathic Medical Examiners
Phoenix, AZ

10:40 14. ✓ KENNETH SANCIER
Qigong Institute
Menlo Park, CA

10:50 15. PEG JORDAN, RN, PHD (candidate)
Integrative Health Circles
Oakland, CA

11:00 16. ✓ MICHAEL MAYER, PHD
The Bodymind Healing Center
Berkeley, CA

11:05 17. ✓ LYNN MURPHY
Feingold Association of the US
San Jose, CA

11:10 18. ✓ KAREN SCOTT
Progress in Medicine
San Jose, CA

11:15 19. ✓ STEPHEN BENT, MD
OSHER Center for Integrative Medicine, University of CA
San Francisco, CA

11:20 20. ✓ BRADLEY JACOBS, MD, MPH
UCSF OSHER Center for Integrative Medicine, University of CA
San Francisco, CA

cancelled 21. SITA ANANTH, MPH
Health Forum/American Hospital Association
San Francisco, CA

11:25 22. JAN DEDERICK, BA, DC, CSI
East Bay Shen Center
El Cerrito, CA

11:30 23. ✓ BRIAN FENNEN, LAC, OBT, QME
Council of Acupuncturists & Oriental Medicine
Calistoga, CA

11:35 24. ✓ CAROL CERESA, MHSL, RD
California Dietetic Association
San Rafael, CA

11:40 25. ANNE KOLKER, MS (Nutritional Science)
SFVA
San Francisco, CA

11:45 26. ANDREA GAREN, BS (Dietetics)
California Dietetic Association
San Rafael, CA

12:00 p.m. – 12:45 p.m. ❖ OPEN SESSION ❖

12:45 p.m. – 1:45 p.m. ❖ LUNCH BREAK ❖

1:45 p.m. ❖ AFTERNOON SESSION ❖

2:00 27. VENY ZAMORA
Administration on Aging
San Francisco, CA

2:10 28. ✓ CYNTHIA COPPLE, BS, CMP
Lotus Holistic Health
Capitola, CA

2:20 29. ✓ ALEX FENG, PHD, OMD, LAC
UCC AOM
Berkeley, CA

2:30 30. RICHARD PAVEK
Shen Therapy Institute
Sausalito, CA

2:35 31. ✓ NICOLA HENRIQUES
Institute of Classical Homeopathy
St Helena, CA

2:40 32. ADRIAN LOWE, GRANDMASTER
Lamas Qigong Association
Worksop Nottinghamshire, UK

2:45 33. ✓ GEORGE WEDEMEYER
National Council of Field Labor
San Francisco, CA

2:50 34. ✓ MICHAEL TRAUB, ND
American Association of Naturopathic Physicians
Kailua Kona, HI

3:00 35. JAY AZAROW, MD
Stanford University School of Medicine
Stanford, CA

3:10 36. ANTONIO MARTINEZ, JD
American Specialty Health, Inc.
Washington, DC

3:20 37. ✓ DEANE HILLSMAN, MD
Union of American Phyicians & Dentists
Sacramento, CA

3:40 38. ✓ SALLY LAMONT, ND, L.Ac.
CA Association of Naturopathic Physicians
San Rafael, CA

3:50 39. EVELYN LEE, EDD, LSCW
Richmond Area Multi-services
San Francisco, CA

4:00 40. JENNIFER BOLEN, BA
JURIMED
Novato, CA

4:05 41. ✓ RICHARD HANSEN, DMD
Advanced Health Research Institute
Fullerton, CA

4:10 42. ✓ RICKI POLLYCOBE, MD
CA Pacific Medical Center
San Francisco, CA

4:15 43. ✓ ROY UPTON
American Herbal Pharmacopoeia
Santa Cruz, CA

4:25 44. ✓ JAMES UNDERDOWN, BA
Center for Inquiry - West
Los Angeles, CA

4:30 45. ✓ MARC HALPERN, DC
California College of Ayurveda
Grass Valley, CA

4:35 46. CARLA WILSON, L.Ac.
Quan Yin Healing Arts Center
San Francisco, CA

4:40 47. HOWARD MOFFET, MPH
American College of Traditional Chinese Medicine
San Francisco, CA

4:45 48. PERFECTO MUNOZ, MA, PHD
Health Plan of San Joaquin
Stockton, CA

4:50

49. LEN SAPUTO, MD
Health Medicine Forum
Walnut Creek, CA

4:55

50. BURTON GOLDBERG
Alternative Medicine.com

5:00

51. ✓ KAREN EHRLICH, CPM, LM
CA Association of Midwives
Santa Cruz, CA

5:05

5:00 p.m. – 6:00 p.m. ❖ OPEN SESSION ❖

6:00 p.m. ❖ CLOSING ❖

STATEMENT PREPARED FOR
THE WHITE HOUSE COMMISSION ON CAM POLICY

Sept. 8, 2000
San Francisco Town Hall Meeting

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I'm delighted to be here, and I would like to congratulate my colleagues for being selected to serve on this distinguished Presidential Commission. This is a most welcome format to examine the larger issues and take us beyond what NIH has achieved thus far into the next stages. Thank you for coming to San Francisco to hear from us. I look forward to a productive relationship with you, and to following your continued fine work.

One of my areas of expertise is in bioelectromagnetic medical applications. I've traveled all over the world gathering information about this promising area of energy medicine. There are bioelectromagnetic medicine devices that provide therapy for various conditions and diseases through the application of very low level electric, magnetic, and electromagnetic energies to the body. When these treatments are repeated sequentially typically in a short course of medical treatments over a few weeks, they stimulate natural healing to occur, or they may accelerate it. In other words, they gently move the body into a healing state, which, of course, is one key characteristic of CAM modalities. Moreover, there is some evidence that specific electromagnetic frequencies may activate certain cell receptors and produce pharmaceutical-like effects, without the side effects of the chemical drugs themselves. With bioelectromagnetic medicine, we are at the dawn of a new medical frontier, in which devices that look much like those in Star Trek or other science fiction movies that are used to resuscitate, revive, and regenerate tissue, are becoming a reality. This whole area could someday transform medicine from its primary emphasis on pharmaceutical products to electronic medicine and even digital medicine that delivers subtle but potent, bio-information to the body that promotes bioregulation through computer interfaces. There areà, in fact,

significant developments in this area, largely outside of the US. One of my concerns is that we are lagging behind the rest of the developed world in bioelectromagnetic and other types of subtle energy medicine. Australia, Japan, Canada, Germany, France, and England are some of the countries that are considerably ahead of us in device development of this type, and in granting government approval to this type of energy medicine. Moreover, most of these device-related energy medical modalities are unavailable to the American people because they involve CAM devices unapproved by the FDA. In some cases, they are all lumped together with other, less worthy devices and labeled as quackery by certain so-called skeptics. This is of concern to me, too, because some of these therapies are inexpensive, safe, and yet simply unavailable on US soil. Only the wealthy can afford to go abroad to receive these therapies. Clearly, there is confusion in this area, and some excellent modalities are being discarded with the insubstantial. I would like to suggest that new programs in research and education tailored to sorting out the wheat from the chaff need to be developed.

Some of these energy medicine devices evaluate how the acupuncture meridians of the body conduct low level pulses of electricity, or, in other words, how the biofield reveals information about the energy reserves of the patient. There is, for example, the electrodermal testing according to Voll (EAV), Vega, AMI, Computron, BEST machine, and there are many other related practitioner products in the global marketplace. These devices have been proved safe and effective diagnostics in the developed world outside of the US. They give practitioners instant access to patient assessment that is very inexpensive and noninvasive compared to many conventional diagnostics. Although there are occasional continuing medical education programs, no standard curriculum exists to my knowledge in any university to teach health care practitioners about these devices. Moreover, there are serious obstacles to FDA approval of these devices.

Then there is laser therapy, which has been proven effective to heal skin wounds rapidly, even decubitus ulcers in bedridden patients and necrotic foot ulcers in advanced cases of diabetes. Not only lasers but light-emitting diodes (LEDs) are also used, which are inexpensive, safe, and effective. These are not powerful lasers as those used in laser surgery. Instead, they emit low level light that does not even heat tissues. There is a sad history underlying phototherapy in the US, whereby decades ago, mavericks in this area were imprisoned or removed from practice. Irradiation of blood used to be a successful, widely used treatment of

septicemia before antibiotics. Now it is unavailable in the US, although it could be a practical solution to to antibiotic-resistant infectious diseases. Today, most phototherapy devices are illegal in our country, relegated only to research, even though some of them have an impressive research database, safety record, and considerable clinical use abroad. Physical therapists traditionally use them in other developed countries for a variety of conditions, but there is little if anything on light therapy in the education of physical therapists in the US. Moreover, it is prohibitively costly to prove the safety and efficacy of these devices in our country. There may also be historical biases operating in FDA regulatory affairs, because of the long historical association of color therapy with quackery.

I would like to congratulate the NCCAM on the recently released RFA on "Frontier Medicine" that will fund up to 4 centers to study novel areas of CAM including subtle energies and bioelectromagnetic medicine. As a former member of the Program Advisory Council of the OAM, I advocated this type of a program for several years during my service at NIH. This Frontier Medicine Grant Program is a first step, and it is a wonderful start for the more maverick medical modalities. But we need much more attention and funding to a few areas of CAM that have been mostly neglected by NIH thus far. These are the frontier areas of medicine, particularly those in which the US has fallen behind the rest of the developed world. Whereas we have a giant pharmaceutical industry that can easily afford to conduct several stages of clinical trials demonstrating safety and efficacy, no large lobby, and no wealthy corporate counterpart exists in the CAM device arena. Just as the federal government has taken up orphan drugs because no private industry could do this profitably, it seems that federal aid would be well spent in assisting private enterprise in developing and testing devices and in moving them through the FDA approval process. I recently learned that NCCAM must spend 1% of its budget in SBIR grants. I would like to recommend that NCCAM make a special effort to fund frontier medicine applications in CAM therapeutic device and novel diagnostic industries. And since we are talking about extremely low level energies applied to the human body, in some cases even less than the electropollution from cell phones and other potential environmental hazards, safety issues with CAM subtle energy devices should be of little concern. I would also recommend some new policy making for FDA device regulatory affairs that will accelerate the clinical assessment of these devices and help the US achieve a leadership position in bioelectromagnetics and subtle energy medicine.

Moreover, it seems that the FDA is particularly difficult on foreign medical products. I also hear this from my colleagues in various parts of the developed world, as the foreign manufacturers of CAM medical products simply do not want to get entangled in US regulatory affairs problems. Let me tell you about a specific example in which I was involved. A Japanese firm for which I consulted encountered a conflict with FDA when we wanted to conduct a clinical trial on post-surgical patients using their new medical adhesive tape with semiconducting substances embedded in the adhesive, that reduce soft tissue inflammation and accelerated wound healing. Because the FDA said they did not know how to categorize this truly novel medical device, it was confiscated at the border and held there for over a year. The Japanese lawyers were not well prepared to deal with this difficult situation. As a result, the clinical trial that I wanted to set up could not be done. Therefore, some new policies facilitating FDA regulatory affairs on CAM devices would be helpful.

Conventional medical education in the US emphasizes biochemistry, physiology, pathology, and anatomy. But education in physics is lacking, and that means that a knowledge and application of subtle energies and subtle energy medicine is also lacking in our health care system. That may be, at least in part, the reason why, when bioelectromagnetic devices finally gain FDA approval, as did several bone healing devices for nonunion bone fractures, they are not utilized appropriately. For example, it is estimated that such bone healing devices are used in only 20% of the cases for which they are indicated, despite the fact that they are noninvasive and inexpensive. Instead, invasive and expensive orthopedic surgery with implantation of steel pins or plates is used. Lack of education, lack of dissemination of information to practitioners and other members of the health care community, and lack of knowledge by the public are the likely factors here. Perhaps there is also the problem of a lack of marketing of devices to physicians, since there is no large industry with "marketing muscle" producing these devices.

I am part of the last generation of biophysicists in the US. I was educated at the University of California at Berkeley in the 1970s, before the biotechnology revolution in DNA cloning. During the time I was engaged in my doctoral work, there were 27 different departments of biological science at UC Berkeley. It was a rich environment, with many perspectives on life, health, and healing. Ever since then, the emphasis throughout academia

shifted dramatically to a view of life that is predominantly biomolecular. Today, the life sciences at Berkeley is essentially one huge molecular biology department spread all over the campus. Other ways of looking at life, for example, posing questions about life energy flows, qi, prana, and the other ways life is regarded in other medical systems outside of conventional biomedicine have all but disappeared. This is not only true for academia, but for the most part, this is also the case at NIH. The dominant biomedical paradigm of molecular reductionism has grown stronger, and is also tied to big economic interests in biotechnology. With energy medicine, modalities such as homeopathy, bioelectromagnetics, qigong, and other subtle energies challenge this dominant paradigm and may not be fundamentally reducible to molecular mechanisms. They may, however, someday be explained in biophysical perspectives. Despite all the successes of the biomolecular paradigm in genetics and cloning, we desperately need some new programs to stimulate creative thinking beyond the biomolecular paradigm, both in education and in research. This is an issue where the federal government can take a leadership position and encourage new modes of education and research, through conferences, reports, new grant programs, and also new intramural research at NIH. We need to recover multiple ways of looking at life, posing new questions outside of the box, that give us fresh perspectives on how energy medicine and other types of CAM modalities may work. I understand that clinical research was the main mandate of the OAM and also the NCCAM. However, it's also important that research in the basic science underlying CAM modalities is funded, because if we understand how CAM works, we can better understand the appropriate delivery and limitations of CAM treatments. Much of NIH as a whole is funding basic research in molecular biology; it seems only natural to extend this to basic research underlying CAM.

Finally, we must also consider that the American people are using, not just single CAM modalities, but frequently multiple modalities, especially where they are suffering from chronic diseases and conditions for which there are no effective or noninvasive conventional treatments. The controlled clinical trial, which is the gold standard for testing conventional biomedicine, tests single modalities and discounts any results from placebo or self-healing. This, in my view, is not the best testing ground for CAM. We need to consider outcome trials when appropriate. We also need to consider in our research strategies how to test the interaction of multiple modalities used together, much the way they are being used by the American public. Biophysical theories of healing suggest that multiple modalities may

work together synergistically to accelerate healing. The combination may be greater than the sum of its parts, and in merely focusing solely on the components, we may be missing the best way to utilize CAM modalities to treat chronic disease.

I would be delighted to provide additional input on these suggestions for further consideration by the Commission. Here are a few published references. Most important ones to my arguments here are labeled with *.

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3

White House Commission on Complementary and Alternative Medicine Policy
Town Hall Meeting San Francisco September 8, 2000

Catherine Dower, JD
Associate Director – Health Law and Policy
UCSF Center for the Health Professions

The Center for the Health Professions at the University of California, San Francisco is a national, non-profit research and policy center addressing all 200+ health professions in the United States. The Center was established to assist health care professionals, health professions schools, care delivery organizations and public policy makers respond to the challenges of educating and managing a health care workforce capable of improving the health and well being of people and their communities. The Center is committed to the idea that the nation's health will be improved if the public is better informed about the work of health professionals.

Even if we focus just on the people who provide health care and leave aside the delivery and financing issues, we face numerous opportunities and challenges. These include technological advances and "telehealth"; workforce shortages, maldistribution and lack of racial and ethnic diversity; inadequate training for needed skills such as cultural competence and evidence-based practice; and an outdated regulatory system.

Emerging professions face these issues and more. The environment into which emerging professions seek to enter is not particularly embracing. This is not unique to complementary and alternative medicine; virtually every profession that has sought legal recognition over the past century has faced opposition. Some of the opposition is grounded in legitimate public protection concerns. Some of it has been based on economic or political concerns. The physicians oppose the nurse practitioners; the dentists oppose the dental hygienists; the ophthalmologists oppose the optometrists. The list goes on every day in every state legislature in the U.S.

Today, consumers have an array of choices of health care practitioners and diagnostic and treatment modalities and they are using these options. As consumers indicate their desire for these options, policy makers, insurers, researchers, educators and health care practitioners struggle to address essential issues of accessibility, safety, efficacy and cost-effectivenss. Pressing questions are "what are the qualifications of the providers and how can their qualifications be evaluated?"

The Center, with funding from the Arkay Foundation and the input from an interprofessional taskforce, is creating a model for evaluating developing professions, including those in the CAM world. The model will provide a template for practical information that policy makers, consumers, insurance companies, and others can use as they seek to understand and integrate emerging professions into health care. We expect the model to include criteria such as education and training pathways, profession description and parameters, professional oversight, and licensure and credentialing options.

After the model is complete, the Center will demonstrate its applicability by conducting a case study of naturopathic health care providers. Our timeline is to complete both the model and the case study by the end of 2000. We will publish our results in hard copy and online at our website.

Few would argue with the assertion that US health care is imperfect by almost any measure. It is outrageously expensive; not accessible by all; and offers outcomes that do not compare favorably to those of our peer countries. It is our hope that we thoughtfully expand health care to include promising new professions and treatments while limiting the risk of throwing energy and money at ineffective – or worse, unsafe – "care". We highlight the benefits of unbundling these two concepts: safety and efficacy and the need to address one or the other with more scrutiny depending on whether one is dealing with education, regulation, management or payment issues. We also highlight the importance of treating all professions fairly; we do not need one standard for evaluating an emerging "alternative" profession and another standard for an mid-level provider profession that is emerging within the biomedical model. We trust our work will provide much-needed guidance in this arena. Thank you for your time and attention.

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Complementary and Alternative Medicine in Pediatrics

May Loo, M.D.

White House Commission
Town Hall Meeting
San Francisco
September 8, 2000

Background of speaker

Behavioral and Developmental Pediatrics

Acupuncture and Traditional Chinese Medicine

Difficulties of CAM Research in Pediatrics

1. Informed Consent
2. Different Physiologic Maturation
3. CAM and preventive pediatrics
4. Problem with Scientific Methodology

Suggestions for facilitating CAM research in pediatrics

1. Educate the children about CAM
2. Flexible research methodology

My name is Corinne Giantonio PhD and for 20 years I have worked as a Psychologist for Kaiser Permanente. In the past 7 yr. I participated in the Development of a Health Plan Wide Program to provide Comprehensive and Integrated Care merging multiple alternative medicine treatments with traditional medicine, made available to all Health Plan Members covered by the basic insurance plan. For three years, I worked in the front line in Primary Care Medicine interfacing daily, directly and full time with patients, Physicians, Nursing staff, Yoga and Meditation Masters, Acupunturists, Psychiatry staff, Nutritionists, Exercise physiologists and Physical therapists as this Comprehensive Care program was implemented. I'd like to summarize for the Commission some of the major findings and some of the major obstacles faced as this effort at integrating Alternative Medicine Options with Primary Care Delivery of Services.

Four Main Interest Groups arose in the Administration of this Integrated Care Program

- **Patients**
- **Physicians—Primary Care and Specialty Medicine**
- **Alternative Medicine Specialists and Professionals**
- **The Insurance Plan**

Understanding the demographics of each of these interest groups is essential to any efforts the Commission for Alternative Medicine may make in achieving its Mission of generating a Consortium of Recommendations aimed at making alternative medicine modalities available to the Public. I'd like to highlight some of the results of our many formal studies over those seven years.

The Patient

- The educated, motivated patient will seek out alternative medicines and will generally have the financial resources to seek out Fee for Service options:
    - Yoga retreats, Meditation Groups, Massage Therapy, Aroma Therapy, Mind/Body Medicine Series and various noetic sciences NOT the population presenting itself to the insurance Dollar
- Most dramatically benefitting: Chronic Pain Patients (Pain persisting 3-6 months following trauma) Chronic Illness Sufferers: **38%-79% decrease in medical visits over period of two years following intervention of Integrated Medicine**
    - Muscular-Skeletal: e.g. Fibromyalgia
    - Arthritis
    - Digestive disorder: IBS chronic Nausea, diarrhea
    - Cardiovascular: Chest pain, High Blood Pressure, High Cholesterol, Heart Palpitations
    - Pulmonary: Shortness of Breath
    - Neurological: Headaches, dizziness, lightheadedness
    - Fatigue
    - Sleep Disorders
- Demographics of this under-served Population Presenting itself to Primary Care (Insurance Covered Option)
    - Uninformed re the nature and parameters of Chronic Illness in General
    - Unrealistic Expectations of Prognoses
    - Generally passive vs. active in his/her own participation in wellness practices
    - Life style usually one of excess:Physical Overextension, or Extreme Withdrawal vs. Pacing

- High incident **(62-76%) co-morbidity with psychological distress: Anxiety and/or Depressio**
- The "Worried Well", Stress-induced symptoms
- The Stable Elderly
- High incidence (90-98%)of Anger, Frustration, Distrust in the competency of Practitioners in Traditional Roles, Distrust in the competency of Practitioners in non Traditional roles

The Physician

- Predominant attitudes:
  - Helplessness: " I have nothing to offer this patient"
  - Powerlessness: " Limitations of traditional options: pharmaceuticals, surgery
  - Distrust: of the competency of practitioners in non-traditional medicine
  - Reluctance to refer to practitioners in non-traditional roles
    - Lack of education and information re the medical benefits **(78%)**
    - Perception of "relinquishment of the primary medical management of the patient when referring to non-traditional alternatives **(89%)**
    - Sense of "abandonment" when option of referral **(86%)**
    - Concern about the discontinuity between primary traditional management and the alternative medicine treatment intervention **(91%)**
- Resistance at considering the psychological and behavioral aspects of the presenting symptoms at first assessment **(self-reported perception – 24%) (as rated by independent assessment of initial MD eval – (98%)**
- Reluctance to approach treatment plan as a partnership with the patient **(self-reported 16%) (as rated by independent audit – 94%)**
- Designated (too many obstacles to getting pt. into alternative medicine option" as number 1 or 2 for reasons for NOT referring **(87%)**

The Alternative Medicine Practitioner:

- Characteristics of Professions regarded as "having established credibility" and most utilized as referral option:
  - Had licensure in place **(89%)**
  - Regulated own profession to point of med/legal censureship **(38%)**
  - Education Requirements: pre and post clearly articulated **(63%)**
  - Clear Proficiency exams **(89%)**
  - Able to generate specific symptom-reduction outcome studies that were measureable and repeatable and behavioral in nature **(76%)**
- Behavioral Characteristics of successful Alternative Medicine Practitioners
  - Able to provide clear written referral procedures **(63%)**
  - Referral procedures reflected the "Overall Treatment Plan" remained in the hands of the Primary Care MD **(76%)**
  - Alternative Medicine Treatment Plan was symptom specific in assessment language and behavioral specific in treatment recommendation and outcome goals **(89%)**
  - Patient was returned to the Primary Care Physician with Behavioral Outcomes and treatment plan for self-management clearly articulated. **(56%)**
  - Treatment plan was time-limited **(82%)**

- Found and identified patient within traditional medicine's purvue
- Conducted ongoing educational or grand round presentations to Primary Care **(66%)**
- Conducted ongoing educational opportunities for Chronic Pt. Population **(73%)**
- Demonstrated behaviorally measureable success with the "unmotivated, reluctant pt. population
- Available to Physician for consult and co-evaluation **(36%)**
- Demonstrated competence in either screening or assessing of co-morbid psychological overlays, specifically anxiety and depression disorders. **(43%)**

The Insurance Company:

- Covered benefits reflect adage that Illness rather than Health Care consumes the Insurance Dollar, Primary Budget reflects no <10% commitment to alternative Medicine Options
- Upstream, preventive intervention by way of patient education and motivational intervention will leverage the insurance dollar with greatest impact
- Fund research in alternative medicine that reflects evidence-based reduction in medical visits
- Seek government incentives for sponsoring such research

Challenges to the Commission for Alternative Medicine

Consider **all players** in consortium and collaboration: **Patient, Physician/Insurance, Alt.Med Practitioner** when making its recommendations

- The patient spectrum
  - Educated and motivated **(8-12% of the population)**
  - Uneducated, Unmotivated, **(90% of the population)**
  - Victims of Chronic Illness
  - Suffering from co-morbidity with anxiety/depression **(62-76%)**

- The existing medical structure: **The Physician, Insurance Industry** (Fee for Service, Medicare, Medicaid, HMO)
  - Primary Care responsible for overall Care Plan
  - PCP (Primary Care Physician) in need of education and research data
  - PCP most likely to overcome territorial issues when treatment options approached as Partnership with Pt. (Pt assumes co-responsibility for Tx Plan)
  - The role Fee for Service vs Insurance Covered Benefit for the Motivated, Educated pt. vs the Uninformed, unmotivated pt. suffering from Chronic Illness

- **The Alternative Medicine Practitioner**
  - Assumes Responsibility for the Integrity of its respective Profession:
    - Monitors itself with clearly stated educational requirements, proficiency exams, and legal censureship
  - Demonstrated ability to liason with traditional Medicine: Physicians and Insurance
  - Can generate cooperative treatment plans that are **behavioral** and **measureable** in nature and produce outcome goals that are

behavioral and measureable.

Homeopathic Educational Services

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Presentation by DANA ULLMAN, MPH to the WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE, September 8th, 2000.

According to a report from the *British Medical Journal* (Fisher & Ward, 1994), homeopathic medicine is presently utilized by approximately 40% of French physicians and 20% of German physicians. Over 40% of British physicians refer patients to homeopathic physicians and 45% of Dutch physicians consider homeopathic medicines to be effective. Based on these statistics, homeopathic medicines should not be considered "alternative" medicine in Europe.

Despite its stature in Europe, homeopathy is the "Rodney Dangerfield of alternative medicine" in the United States. It simply does not get the respect it deserves. I believe that the primary reason for this is that physicians, scientists, and the media are inadequately informed about the body of clinical and laboratory research that has been conducted on homeopathic medicines. I do not wish to say or imply that all of this research has shown homeopathy to be effective; it hasn't. Still, the body of scientific investigations shows that homeopathic medicines provide a therapeutic benefit beyond the placebo effect.

As recent as August 19, 2000, the *British Medical Journal* published a study on the homeopathic treatment of allergic rhinitis (Taylor, Reilly, Llewellyn-Jones, et al, 2000). This study was the fourth trial by a group of researchers at the University of Glasgow. This study confirms the previous three studies and showed substantially significant results from homeopathic medicines. After reviewing all four studies together, the researchers found that the mean symptom reduction was 28% for those given a homeopathic medicine as compared with only 3% for those given a placebo (P=0.0007).

If a conventional drug was found to have this degree of therapeutic benefit along with the high degree of safety found in homeopathic medicines, these natural medicines should be recommended by most primary care providers and would be in the medicine cabinets of most allergy sufferers. Sadly, this is not the case, and this is little to do with scientific evidence and more to do with medical prejudice, medical chauvinism, and simply ignorance.

I. ***What can be done to expand the current research environment for homeopathy***?

• Make research funds available for specific frontier medicine therapies, like homeopathy (frontier therapies are those in which most conventional physicians and scientists doubt therapeutic benefits but for which there is a body of scientific or empirical evidence that suggests otherwise).

• Because of the stature of this White House Commission (WHC), it should fund the development and publication of white papers on the present status of laboratory and clinical studies in homeopathy, as well as on the body of empirical evidence that presently exists.
• While it is certainly possible to conduct good double-blind, placebo-controlled randomized studies using homeopathic medicines, such studies also have their limitations for all types of healing modalities. With the stature of the WHC, a white paper should be developed and published that describes the benefits and the limitations of this "gold standard" of scientific inquiry.

II. ***Guide for Access to, Delivery of, and Reimbursement***...

The medical community and the general public are inadequately informed about the significant cost-effectiveness studies that have evaluated homeopathic care.

One study conducted by the French government in 1991 showed a significantly reduced cost from homeopathic care versus conventional medical care (Social Security Statistics, 1991). The totality of costs associated with homeopathic care per physician was approximately one-half of the totality of care provided by conventional primary care physicians. However, because homeopathic physicians, on average, saw significantly fewer patients due to the more labor intensive tendency of homeopathic care, the overall cost per patient under homeopathic care was still a significant 15% less. It is also interesting to note that these savings appear to increase the longer a physician has been using homeopathy. A follow-up study in 1996 confirmed these results (Caisse Nationale de l'Assurance Maladie des Travailleurs Salaris, 1996).

This survey also noted that the number of paid sick leave days by patients under the care of homeopathic physicians were 3.5 times less (598 days/year) than patients under the care of general practitioners (2,017 days/year). These figures suggest further benefit and savings to the homeopathic approach to care.

Homeopathic medicines are reimbursable under the French health care system, in part because they cost considerably less than conventional drugs (on average, the cost of a homeopathic medicine is 7 French francs versus 23.00 French francs for conventional drugs). Although homeopathic medicines in France represent 5% of all medicines prescribed by physicians, they represent only 1.2% of all drug reimbursements due to their lower cost per prescription.

Because of present ignorance and prejudice against homeopathic medicine...
• The WHC should develop and publish a white paper on the status of cost-effectiveness studies in homeopathic medicine.
• The WHC should explore which licensed health professionals and which individuals who have been specifically certified in homeopathic medicine would be appropriate in providing reimbursable services through federal programs and other health care coverage systems.

III. ***Training, Education, Certification, Licensure and Accountability***

We cannot and should not seek uniform standards of education, training, certification, and licensure for all alternative health care practitioners, no more than medical doctors, nurses, physical therapists, and psychologists should have uniform

standards. Each modality will benefit from uniform standards, but I believe that certification should be the standard, not licensure. In other words, those who pass certain tests and/or clinical evaluations should then be able to call themselves a "homeopath," or an "acupuncturist," or the like, but that doesn't mean that only "homeopaths" could use homeopathic medicines. Just as anyone can legally do accounting or architecture without being an accountant or an architect (as long as one doesn't hold themselves out as an accountant or an architect), one can and should be allowed to recommend and use homeopathic medicines without being certified as a "homeopath."

There are already certifying agencies established to provide certification of homeopaths, though, at present, there is one certifying agency for medical doctors and osteopaths, another for naturopaths, another for various licensed health professionals, and another for unlicensed individuals. Despite the various certifying bodies, I predict that it would not be difficult to get them to work together to create one certifying agency.

IV. ***Delivery of Reliable and Useful Information***

The WHC should form a proactive and reactive press office that works with the diversity of media outlets so that accurate information is provided to media sources. Because the media provides significant amplifying of information, the WHC should provide adequate funding for such operations.

Besides providing proactive information on alternative medicine based on WHC reports, the WHC should also respond reactively to incorrect information that gets transmitted through major media sources.

I strongly urge the WHC to provide significant resources to its press relations.

References:

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Testimony
Of the
American Chiropractic Association
Before the
White House Commission on Complementary and Alternative Medicine Policy
Town Hall Meeting
September 8, 2000
San Francisco, California

Good Afternoon, my name is Craig Little, I am a doctor of chiropractic practicing in Hanford, California. I am representing the views of the American Chiropractic Association and will address three of the four focus areas of today's town hall meeting; Coordinated Research and Development to Increase Knowledge of Complementary and Alternative Medicine Practices and Interventions; Guidance for Access to, Deliver of, and Reimbursement for Complementary and Alternative Medicine Practices and Interventions; and Training, Education, Certification, Licensure, and Accountability of Health Care Practitioners in Complementary and Alternative Medicine.

Before I address these issues, I would like to express my disappointment at the lack of representation on this commission from the complementary and alternative health care community. Although I respect the experience each of you has in the area of complimentary and alternative health, the ACA questions how any meaningful dialog and recommendations can be developed without adequate input from the CAM community. I would appreciate any discussion on the rationale behind the decision to limit the representation of non-MD CAM providers on this prestigious committee.

Coordinated Research and Development To Increase Knowledge of Complementary and Alternative Medicine Practices and Interventions.

Everyone will agree that research on the efficacy on complementary and alternative medicine practices must continue. In addition, as CAM research continues to gain importance, it is imperative that the CAM practitioners be involved in all phases of research. The ACA would like to highlight four key areas that the Commission needs to address/discuss in the area of CAM research:

1) *Support the National Institute of Health National Center for Complimentary and Alternative Medicine (NIH NCCAM) Information Clearinghouse.*

This commission should not attempt to reinvent the wheel. There is a host of research currently being conducted which are both publicly or privately sponsored that need to be collected and reviewed to reveal where additional research is needed. It is my understanding that the NIH NCCAM Information Clearinghouse provides information to the public on various CAM research. The Commission should utilize this clearinghouse as the central repository of CAM research and encourage all researchers to submit their findings to the NIH NCCAM Information Clearinghouse.

2. Relax federal statutory requirements that impede the use of CAM's in federal health care programs.

Currently, many federal programs do not reimburse for complimentary and alternative treatments. These statutory limitations may be impeding research. By not being recognized as providers under these programs, doctors of chiropractic as well as other CAM providers are not provided the opportunity to prove the cost-effectiveness and efficacy of their services. Statutes must be changed to allow for all CAM providers to participate in all federal programs.

3. Coordinate research with the National Institute of Health's National Center for Complementary and Alternative Medicine.

The ACA is pleased to see the increases and support of the NIH NCCAM, and supports the need for continued and increased funding of this worthwhile Center.

4. Provide incentives for private industry to invest in CAM research.

The Commission should invite all groups involved in CAM research to identify the types of incentives they need to continue CAM research. The ACA would be happy to supply the Commission with a list of those companies that have contacted the association on research issues.

Guidance for Access To, Delivery of, and Reimbursement for Complementary and Alternative Medicine Practices and Interventions.

Patients should be afforded the availability to seek treatment by proven complimentary and alternative providers without the referral of a medical gatekeeper. In addition, both private and federal insurance programs should not limit a practitioners' scope of practice. Proven CAM practitioners must be recognized and reimbursed for all reasonable and necessary services provided to their patients. CAM providers should not be reimbursed at a lower rate or be discriminated against in any fashion based on their training or licensure.

Direct access must be provided to those CAM providers who possess diagnostic skills to differentiate health conditions that are amenable to their management from those conditions that require referral or co-management with other professionals. Doctors of Chiropractic recognize the value of working in cooperation with other health care practitioners, and acknowledge their responsibility to do so when it is in the best interest of the patient.

As mentioned above, Doctors of Chiropractic are currently excluded from participating in federal health care plans and are extremely limited in the scope of reimbursable services they can provide to Medicare beneficiaries. In its formal recommendations, the Commission must address these impediments to chiropractic so that all consumers have appropriate access to chiropractic treatment.

Training, Education, Certification, Licensure, and Accountability of Health Care Practitioners in Complementary and Alternative Medicine

Providers of complementary and alternative medicine must be trained and educated at an accredited institution. In addition, state licensure should be considered to ensure that only trained and educated providers are treating the public. To create a better awareness of effective CAM practices, medical school students must be required to take a course on complementary and alternative treatments so that they are familiar with the alternatives available to their patients. Medical students should also be encouraged throughout their schooling to refer their patients to complementary and alternative care providers when pursuing the overall care of their patients.

The Council on Chiropractic Education, through the U.S. Department of Education, accredits all chiropractic colleges. A chiropractic college curriculum consists of a minimum of four academic years of professional education averaging a total of 4822 hours. There are five curricular areas that are emphasized in chiropractic education; adjustive technique/spinal analysis, averaging 555 hours of the clinical program, principles/practices of chiropractic, averaging 245 hours, and biomechanics, averaging 65 hours. Under the auspices of all chiropractic colleges, students are required to pass a practical examination on their manipulation skills and a clinical competency exam prior to internship. In addition, the chiropractic profession is held to rigorous skill testing for licensure. The principle-testing agency for the chiropractic profession is the National Board of Chiropractic Examiners. There are four parts to this examination: basic science, clinical subjects exam, written clinical competency examination, and special purposes examination for chiropractic. In addition, all states require a practical examination prior to licensure. This state licensing skill testing includes, diagnostic imaging, differential diagnosis, chiropractic technique and case management.

As mentioned above, currently there are very limited funds available to fund chiropractic/CAM educations. For example, the Public Health Service Act does not recognize Doctors of Chiropractic or other CAM providers to participate in this federal student loan repayment program. The Commission, in its formal recommendations must ensure that CAM students have access to federal funds, and federal repayment programs to assist in the repayment of their student loans.

Conclusion

Thank you for the opportunity to express the view of the American Chiropractic Association. I would be happy to answer any of your questions, and would also

encourage you to contact the American Chiropractic Association on any chiropractic specific issues debated by this Commission.

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12

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To: White House Commission on Complementary and Alternative Medicine Policy
From: Lixin Huang, American College of Traditional Chinese Medicine
Re: Support Traditional Chinese Medicine
Date: September 8, 2000

My name is Lixin Huang, President of American College of Traditional Chinese Medicine (ACTCM).

The American College of Traditional Chinese Medicine was established in 1980. In 1987, ACTCM successfully established the first 4-year graduate program in traditional Chinese medicine in the United States, improved the quality of health care by providing graduate education and patient care, enabled thousands of people to integrate traditional Chinese medicine into their lives. We have served both national and international community of students, patients, health care professionals and the public. Our graduates practice acupuncture, herbal medicine, Taiji and Qigong in many states of US, and in other countries -- Germany, Israel, Japan, Switzerland, Australia, Canada, Russia, and Finland. The College has provided health care services to seniors, men, women and children, stroke patients, HIV+/AIDS patients, and cancer patients. Our work is recognized and supported by the San Francisco Department of Public Health, the California Pacific Medical Center, and several city community health care clinics. We dedicate ourselves to education, research, and patient care, continuously improve standards of professionalism in practice and excellence in traditional Chinese medicine education. The American College of Traditional Chinese Medicine has taken a leadership role in defining and advancing the use of traditional Chinese medicine in American health care.

Traditional Chinese Medicine is an ancient medical system based on the philosophical Chinese concept that when a human body is kept in a harmonious balance, health and well being are naturally maintained. Chinese classical texts refer to the superior physician who prevent disease and the inferior physician who treats disease, thus emphasizing the vital importance of health maintenance. Traditional Chinese Medicine encompasses a wide variety of perspectives such as internal medicine, pediatrics, dermatology, ophthalmology, mental dysfunction, gerontology, immune deficiency, and musculo-skeletal. The validity of this medicine has been developed over the past 3000 years. Since the early 1970s, traditional Chinese medicine has been adopted rapidly in the United States. 38 states passed the legislation for licensed acupuncturists to practice the ancient healing arts, 6,000 students are currently studying acupuncture and herbal medicine at 40 graduate schools recognized by the Accreditation Commission for Acupuncture and Oriental Medicine and by the US Department of Education. Among the students, some are medical doctors, physical therapists, nurse practitioners, nurses, psychologists and pharmacists. Many students and their family members received benefits of Chinese medicine, decided to make career changes to provide the healing arts to help more people. There are over 20,000 practitioners currently practicing acupuncture and herbal

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medicine. People need the ancient healing arts since they are low cost, effective, remarkably safe, with fewer side effects.

With the rapidly increased aging population in US, our health care system has some crises. Traditional Chinese medicine has many effective ways to contribute to the health care needs of seniors. While many people in this country cannot afford the high cost health care, traditional Chinese medicine is able to provide low cost health care to these people. However, the health insurance industry, HMOs, hospitals, and the government have not recognized nor provided support to make traditional Chinese medicine available to the US people despite the fact that 20% of the people in the world are using this medicine effectively. Unless the government gives strong support in the policy, many people in this country cannot receive the benefits of Chinese medicine. I hope the Commission's report will bring some recommendations to the President and the Congress to support traditional Chinese medicine, and support other complementary and alternative medicine.

Thank you very much!

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Bruce
Shelton

Homeopathic

STATE OF ARIZONA
Department Of State

PROCLAMATION

WHEREAS, the State of Arizona has a legally empowered Board of Homeopathic Medical Examiners; and

WHEREAS, it is the responsibility of the Board to regulate MDs and DOs who practice Integrative Medicine in the Great State of Arizona; and

WHEREAS, agencies such as CLIA, The Office of Inspector General; and The White House itself are requesting public input on the subjects related to this vital and important field of Medicine; and

WHEREAS, the President of The United States has established the White House Commission on Complementary and Alternative Medicine to evaluate this subject; and

WHEREAS, the Board is sending representatives to participate in the Commission's work;

NOW THEREFORE, I, Secretary of State Betsey Bayless, proclaim that the State of Arizona supports the work of the Commission and encourages cooperation with the members of The Arizona Board of Homeopathic Medical Examiners.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of the State of Arizona. Done at the Capitol in Phoenix on the 1st day of September, 2000.

Betsey Bayless

Betsey Bayless
Secretary of State

VALLEY INTEGRATIVE PHYSICIANS PLLC

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HOMEOPATHIC INTEGRATIVE MEDICINE

Preventive Healthcare, ONE PATIENT AT A TIME

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Good Morning
Mr. Chairman and members of the commission. My name is Doctor Bruce Shelton. It is an honor to appear before you.
I am a Board Certified MD Homeopathic Family Physician licensed in Arizona as both a Medical Physician and a Homeopathic Medical Physician.

I am the President of The Arizona Board of Homeopathic Medical Examiners and bring you official greetings on behalf of the State of Arizona.

I have brought to you today a Proclamation from the Secretary of State of Arizona showing our states commitment to Integrative Medicine as one of only three states having a separate Board of Homeopathic Medical Examiners open to graduate MDs and DOs that qualify in the fields of Classical Homeopathy, Acupuncture, Orthomolecular Medicine, Chelation Therapy, Neuromuscular Integration, Nutrition AND Pharmaceutical Medicine

I am a graduate of New York Medical College, and the British Institute of Homeopathy.

In January I will become the National Medical Director of Heel Inc. of Albuquerque New Mexico and Baden Baden Germany. HEEL is one of the largest manufacturers of Combination Homeopathic Remedies and my comments made today are also made on their behalf.

I call to your attention that Homeopathic Medicines were and are legally part of the United States Pharmacopoeia and has been EVER SINCE IT WAS ESTABLISHED IN 1938. This is the same law that established the FDA.

Homeopathics of course have been on the scene since 1797 when this school of medicine was established by Dr. Samuel Hahneman MD A MEDICAL DOCTOR as he developed both the words Homeopathy AND Allopathy to differentiate himself from his non believing peers. Homeopathics being a "similar pathos or suffering" and Allopathics being an "opposite pathos or suffering. Similars being a permanent cure and opposites only temporary for as long as the patient is on the remedy.

To quote the Bible-give a man a fish and you feed him for a day, teach him how to fish and you feed him for the rest of his life.

EVEN though Homeopathy is legal in this country as the remedies themselves, it has been unfairly discriminated against by third party insurers, hospitals, governments and the Drug companies who realize that lesser priced homeopathics represent COMPETITION for higher cost pharmaceuticals. Not only does Homeopathy and Integrative Medicine work in a kinder more gentler manner and more completely but it saves money in large amounts.

What should be done to bring this to the fore and move our work forward?

1. Seeing that its legal already, mandate that discriminating against it is improper. Allow third party payers to pay for its legal use.
   Create the several hundred missing procedure codes to add to the already existing tens of thousand of codes that will allow for its coverage.

Allow HCFA and Medicare to tell properly licensed physicians to deliver services to patients that want and need them.

2. Seeing that its legal as it is in Arizona and several other states, allow Hospitals to use Integrative Medicine after full disclosure and full consent between doctor and patient. Make sure that patients know of its legal existence and give them the freedom of choice that they deserve.

3. Seeing that everyone is literally crying for reduction in the high cost of healthcare, commission the studies and data collection through large patient populations based upon outcome studies and the tenets of quantum physics to give our political and business leaders the data we all need to make informed decisions.

4. Allow states such as Arizona who have a Board of Qualified Medical Examiners to judge procedures such as Darkfield Blood Evaluation, Bio-Terrain Analysis and other valuable Complementary Lab tests to go forward by empowering CLIA with new regulations that they need that will allow this type of work to proceed under proper regulations

5. TAKE THE STIGMA OF VOODOO MEDICINE out of this important subject by allowing science to proceed unhampered. The Scientific Method itself demands that observations be proved or disproved methodically. The anecdotal observations involving literally tens if not hundreds of millions of patients have been around for hundreds of years. The current method of verification is anti-competitively structured to keep the truth from the light. Most of us in this room already knows that it works. All that we are missing is the correct political and legal courage to bring it about even if that means an addition to the Sherman Act.

We applaud the work of this commission and pledge the support of those we represent to move our important work forward as quickly and efficiently as possible. The Health of our Society depends upon our success.