110. David A. Butters, DC

111. Christopher Huson, LAc
Acupuncture Association of Washington

QUESTIONS FROM COMMISSIONERS

112. ERICA OBERG - STUDENT

1:15 p.m. - 2:00 p.m. 113. KAYCIE ROSEN - STUDENT

114. JOHN BRIGANTI - MAHARISHI VEDIC APPROACH TO HEALTH

Walk-in (On-site Registrants in the order received and at the discretion of the Chair)

20

2:00 p.m. ADJOURN

115. BRIAN FENNEN
AMER. ASSOC OF ORIENTAL MEDICINE

116. DONALD DOWNING STATE
WASHINGTON ~~STREET~~ PHARMACISTS ASSOC

- The White House Commission on Complementary and Alternative Medicine Policy thanks you for your participation in this Town Hall Meeting. In 3-4 weeks, a transcript of these proceedings will be available on our website:

117. RICHARD WARNER - CITIZENS COMMISSION ON HUMAN RIGHTS

http://www.whccamp.hhs.gov

118. JANE SAXTON - ~~STUDENT~~ Director, Library Services, Bastyr

20

- You are invited to submit written comments at these sessions, or to send them to us by logging onto our website. More information about our activities, including other Town Hall Meetings, also can be found on our website.

119. JUDY ZEIGLER - STUDENT

120. TUCKER MEAGER - STUDENT

121. DOUG NORDSTROM
AMERICAN CHIROPRACTIC ASSOCIATION

122. MERRILY MANTHEY (Video, Senior pamphlet)

15

+ Lori, Sheila, Pam Snider

*** Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.**

WHITE HOUSE COMMISSION TOWN HALL MEETING: EXECUTIVE/STEERING COMMITTEE AND STAFF RESPONSIBILITIES AND SCHEDULES

Management, Coordination with Commission, Speaker Identification:

Sheila Quinn
Pamela Snider

- Working with Michele Chang, Steve Groft, King County 2010 Executive/Steering Committee and staff speaker preparations – October 30-31 (all day)

Registration:

Judy Colchin
Susan Reiten

- Meet with Nancy Kasbeck (Commission Staff person)

Media:

Danielle Devine
Stephanie Marquis

- Report to Michele Chang (Executive Assistant, Commissioner staff) or Doris Kingsbury (Site staff) – October 30-31 (all day)

Speaker Placement (Leads):

KCIHC 2010 Executive Committee members
Sheila Quinn
Pamela Snider

- Report to Michele Chang (Commissioner staff) or Doris Kingsbury (Site staff)

Speaker Placement (Assistance):

KCIHC 2010 Executive and Steering Committee members

- Assist Sheila, Pamela and Doris with speaker identification and placement

Dignitaries:

Jim Metz (Lead)
Dick Lyons
Lori Bielinski

Attending the Town Hall Meeting:

King County Integrated Health Care 2010 Steering Committee members

Navigation Group:

Monday, October 30, 2000, Broadcast begins at 1:30PM
King County TV Broadcast – 516 Third Avenue, Seattle 98104

- Dr. Jim Gordon and Tom Chappel
- Departure from Town Hall at 1:00 PM
- Drs. Pizzorno and Shepherd will drive Dr. Gordon and Mr. Chappel to King County TV at the Metropolitan King County Council.
- Danielle Devine will meet the party at the 10th floor elevator and escort them into Council Chambers to meet Pete von Reichbauer, King County Council Chair, and the King County Council.

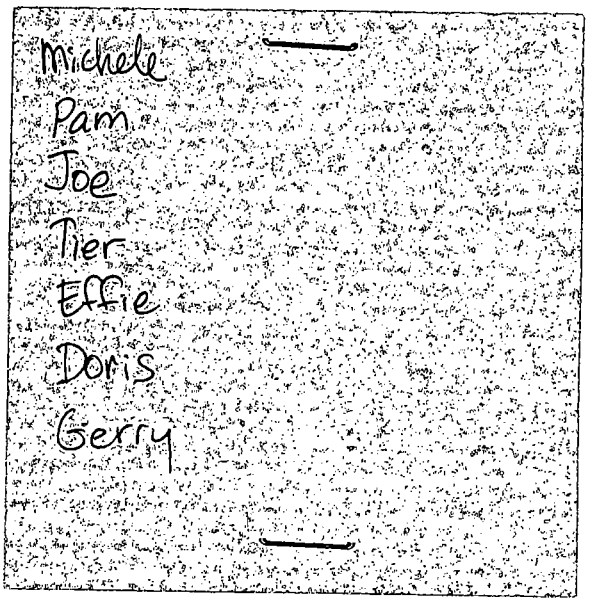
Monday, October 30, 6:00PM
Bastyr University Reception

- Car 1 – Lori Bielinski (Washington State Office of the Insurance Commissioner – Health Policy Division)
- Car 2 – Pamela Snider, ND / Terry Courtney
- Car 3 – David Matteson

Tuesday, October 31, 2:00PM
Integrated Clinics Tours

- Community Health Centers of King County – Tom Trompeter
- Bastyr University – Pamela Snider, ND / Terry Courtney
- Country Doctor Clinic – Bruce Milliman, ND / Lori Bielinski

*(Working with Michele Chang, Pamela Snider, or Sheila Quinn)


Michele
Pam
Joe
Tier
Effie
Doris
Gerry

The Coalition
For Natural Health

BOYD J. LANDRY
Executive Director

1-800-586-4CNH (4264) • Fax 1-800-598-4CNH (4264)
1220 L Street, N.W. • Suite 100-408 • Washington, DC 20005
boydlandry@naturalhealth.org

org file

The Coalition For Natural Health

The Coalition For Natural Health (CNH) Position Paper
Submitted to:
The White House Commission for Complementary and Alternative Medicine (WHCCAM)

The Coalition for Natural Health:

CNH is a national trade organization for the practitioners of a wide variety of natural health modalities that fall beneath the umbrella of traditional naturopathy.

Scope of Membership:

CNH's members are practitioners and students of these natural health modalities, as well as, other concerned citizens who are dedicated to ensuring that the practice of naturopathy and its constituent natural therapies remain in the public domain, just as they have been for centuries. In fact, within many cultures there are numerous documented occasions where natural health therapies have been safely and effectively practiced for thousands of years.

Mission Statement:

The mission of **CNH** is to protect every citizen's right to natural health freedom of choice. This includes the practitioner's right to practice and the consumer's right to access natural health options. **CNH** actively opposes legislation that would restrict or revoke a naturopath's right to provide consultation and make recommendations aimed at educating the consumer about natural health-related techniques and choices that promote a healthier lifestyle. **CNH** actively supports legislation that protects rights of naturopaths and other practitioners of holistic health modalities to practice. **CNH** also diligently attempts to educate consumers and legislators alike, regarding the role of traditional naturopathy in promoting wellness.

Naturopathy Compared to Allopathic Medicine:

Traditional Naturopathy is an approach to healthcare that focuses on the body's intrinsic ability to heal itself. *Vis medicatrix naturae*, or the healing power of nature, is central to the naturopathic philosophy. Strengthening and cleansing the body to allow natural healing is the ultimate goal of a traditional naturopath. Naturopathy is considered a holistic approach to health due to the fact that it focuses on the whole person – body, mind and spirit. Because the objective of naturopathy is to optimize the body's self-healing ability, rather than to address symptoms of disease, such as infection, a naturopath would never perform any invasive procedure, perform surgery, or prescribe drugs or pharmaceuticals.

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Washington, DC 20005-4018
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http://www.naturalhealth.org

On the other hand, Allopathic Medicine, or conventional medicine, focuses more upon treating symptoms than promoting good health. A person who feels ill and visits an allopathic physician will likely be "diagnosed" with a "disease" and then "prescribed" a "medication," to kill the germs that cause the illness. The allopathic approach to healing is to locate and determine the agent of the disease – the specific virus or bacteria – and then kill it. This approach to health delivery has been described as reductive since it reduces the body into individual systems in an effort to locate a specific source of illness, and bases subsequent treatments on the isolated symptoms or diseased areas, alone. Allopathic physicians are well trained to diagnose and treat disease through the use of surgery, prescription medications, and other invasive and noninvasive procedures. However, due to the inherent limitations of an approach to healthcare that is not fundamentally concerned with the underpinnings of good health, many conventional physicians are adopting some of the tenets and practices of traditional naturopathy to provide expanded patient care.

A Brief History of Naturopathy:

The profession of naturopathy – and its name – originated in the late 19th century; its roots, however, may be traced back through Europe into Greece, to Hippocrates himself, and beyond. Its theorists widely maintained that all disease was the result of incorrect lifestyle, a poor diet, and improper care of the body. Germs are not the reason for disease (after all they're present in a healthy body). Rather, disease is produced by the weakened body's inability to rid itself, naturally, of these accumulated toxins.

Naturopathy in America was founded and named by Benedict Lust (pronounced Loost). German born, Lust moved to America in 1892. He returned to Germany shortly thereafter, dying of tuberculosis. Fortunately, there Lust encountered Father Kneipp, a practitioner of the water cure and received this therapy. In 1896, he returned to America, cured, and ready to share the reason why. Lust subsequently pioneered many aspects of natural health in America.

Lust opposed many activities deemed dangerous today: the processing of foods, the administration of drugs and narcotics, and legislation restricting personal choice of healthcare. In 1901 he founded Lust's American School of Naturopathy, offering degrees, through both classroom education and home study.

Traditional Naturopathy has been practiced in this country since the time of Lust following the principles he set down, although this practice, for a time, was largely overshadowed by the scientific breakthroughs that catapulted allopathic medicine into the forefront. Today's economic challenges facing the medical industry, combined with other evident limitations of the allopathic medical model (e.g. numerous strains of bacteria developing an immunity to a variety of antibiotics) have resulted in a renewed interest in traditional naturopathy and the variety of natural health modalities encompassed within it.

Natural Health Trends (the Emergence of a New Health Delivery Paradigm):

More and more consumers are "voting with their feet" where access to natural health modalities is concerned. A 1997 survey in the *Journal of the American Medical Association* (*JAMA*) reported that 42 percent of Americans used at least one of 16 alternative natural therapies during the previous year. Another major study on alternative medicine was published in a November 1998 issue of *JAMA* in which it was stated that conservative estimates placed consumer spending

on alternative therapies at $21.2 billion in 1997; this figure is up from $14.6 billion in 1990. The study further revealed that the majority of people who sought alternative therapy services paid all costs out-of-pocket. Most consumers apparently recognize that the prevention of disease and the maintenance of good health is always a more cost effective approach to their personal healthcare than the necessity to cure a disease. As figures like these are increasingly associated with what is already widely viewed as an emerging model for healthcare delivery, the field of "Complementary and Alternative Medicine" (CAM) is rapidly attracting the attention of both allopathic practitioners and pharmaceutical companies. It is interesting to note that until quite recently most natural health modalities were, by and large, ridiculed or shunned by parties to the allopathic medical model. The recent consumer interest and the vast amounts of dollars that this represents has caused the allopathic community to do an about face on this issue. The ensuing scramble by outsiders attempting to secure a lucrative placement for themselves within the natural health community has generated enormous activity, and as a byproduct has produced confusion surrounding even the most basic points of natural healing. Even the terminology most commonly associated with CAM (in fact, even that term itself) all possess the potential to bias or mislead consumers.

Understanding CAM Terminology (from the Naturopathic Perspective):

In his book, *Complementary and Alternative Medicine*, (Johns Hopkins University Press, 1998) Michael Cohen makes mention of terms such as *unconventional*, *nontraditional*, and *nonconforming* and notes that these terms connote deviance from generally accepted medical norms "permitting biomedical [i.e. allopathic] assumptions to judge the validity of healing." He further maintains that these terms are ethnocentric since therapies that vary from the conventions or traditions of biomedicine may well be conventional and traditional in other cultures where biomedicine is considered nontraditional. Cohen continues that the term *alternative* "suggests the use of the therapies as substitutes for biomedical care," while *complementary* "suggests the use of such therapies in combination with biomedicine." He acknowledges the useful nature of the term *holistic* since it describes an "orientation toward the whole being."

Most traditional naturopaths would take issue with the use of the word *medicine* in the context of the term *complementary and alternative medicine* because its conventional interpretation plays no role in the practice of naturopathy. Another term commonly used in CAM discussions is *integrated medicine.* This can also prove to be a misleading term because it leads the consumer to believe that there is a "blending" of two completely distinctive models of health delivery that are combining to produce a separate "hybrid" model. Additionally, allopathic medicine uses the term *integrated medicine* to suggest acceptance when, in fact, it is nothing more than assimilation. Undoubtedly, the most blatant example of misuse of common CAM terminology, from a traditional naturopath's perspective, is the erroneous interchangeability frequently applied to the terms *naturopathy* and *naturopathic medicine.* As **CNH** president, Jeffrey Goin pointed out in his testimony before the ***White House Commission on Complementary and Alternative Medicine***, "There is a material and very important difference between naturopathy and naturopathic medicine...the titles *naturopathic physician* and *naturopath* have been treated as though they're synonymous...[and it is] implied that "naturopathic physicians" comprise the entire universe of qualified naturopaths. This is most assuredly not the case." (See appendix I)

Naturopathy vs. "Naturopathic Medicine"

First, do no harm. Many practitioners of the natural health community and allopathic practitioners, alike, have adopted this credo. However, to actually implement this philosophy is a much more arduous undertaking for members of the allopathic medical model than it is for traditional naturopaths. Because the practice of all modalities that comprise traditional naturopathy inherently avoids performing surgeries or invasive procedures and the use of pharmaceuticals – the very actions that often lead to client harm –the risk factor for traditional naturopaths harming a consumer is exceptionally low.

In recent years, however, a small group has been attempting to usurp, exclusively, the distinction of practicing naturopathy, (creating an understandable confusion among the public), while simultaneously endeavoring to extend their scope of practice into the realm of allopathic medicine – in direct contradiction to the fundamental tenets of naturopathy. "Naturopathic physicians" claim to embrace the same core philosophy as traditional naturopaths (yet they use the term naturopath only when it suits their agenda). Meanwhile, they attempt to encroach into territory long held by allopathic physicians in an effort to secure third party insurance reimbursement (thus coining the term "naturopathic physician"). They pursue a scope of practice that would allow them to perform minor surgery (and other invasive procedures), prescribe pharmaceuticals, and function as "primary care physicians," while also claiming to be naturopaths, ignoring the fact that *these activities contradict the very essence of naturopathy.*

Furthermore, many practitioners of both natural health modalities and allopathic practices question whether or not "naturopathic physicians" receive adequate training to assume the role of a primary care physician. Another question of merit is: Why, when there are presently in existence allopathic physicians capable of delivering primary health care to patients, and naturopaths that are qualified to offer natural therapies, does a third party need to create an entirely new profession that represents itself as attempting to combine the two? If allopathic physicians, in the interest of offering safer and more cost effective patient care, wish to include some modalities of natural healing in their practice, this is perfectly acceptable. However, for a group to claim the title naturopath (particularly when this is intended as an exclusionary tactic aimed at restricting the traditional naturopath's right to practice), while systematically disregarding the fundamental concepts of naturopathy, is not acceptable. Fortunately, traditional naturopaths far outnumber this small, special interest group.

"Naturopathy is not the practice of medicine and surgery...naturopathic practice is educating the individual in self-control, right habits, prevention of disease, improving the constitutional health so that Nature comes into her functioning, and to the level of harmony where she carries on her own defense work against disease and does her own curing. Cure comes about spontaneously by natural living"

Benedict Lust

Appendix I

Testimony of CNH president, Jeff Goin before the White House Commission on Complementary and Alternative Medicine Seattle, WA Town Hall Meeting, October 31, 2000

Mr. Chairman and members of the Commission, my name is Jeff Goin. I am President of the Coalition for Natural Health, a grassroots organization that represents over 2,500 natural healers nationwide.

Over the last couple of days, I have noted a few points relating to the misuse of CAM terminology and philosophy. I'd like to use the bulk of my three minutes to clarify those points:

Throughout this town hall hearing, both speakers and members of the commission have been using the terms "naturopathic medicine" and "naturopathy" interchangeably. It's imperative for the members of the Commission to understand that traditional naturopathy involves natural, non-invasive modalities that serve to stimulate the body's own, intrinsic self-healing capacity without the use of drugs. "Naturopathic medicine" is a hybrid approach toward health that represents itself as combining traditional naturopathic modalities with allopathic procedures such as the prescription of drugs and surgery. There is a material and very important difference between "naturopathy" and "naturopathic medicine."

Similarly, throughout the two days of meeting, the titles "naturopathic physician" and "naturopath" have been treated as though they're synonymous. Furthermore, many speakers, some inadvertently, some not, have implied that "naturopathic physicians" comprise the entire universe of qualified naturopaths. This is most assuredly not the case.

I'll give you my organization's take on the naturopathic universe: there is a small group of "naturopathic physicians" and then there's everybody else. The "everybody else" in the field of naturopathy is my organization's constituency and "everybody else" is comprised of generational healers, Central and South American curanderos and curanderas; French treaters; English herbalists; Native American tribal healers; and, other traditional naturopaths, in this country, who use methods and remedies proven effective over thousands of years, which have been handed down from generation to generation, as well as naturopaths educated through distance learning. It is wrong to assume that traditional naturopaths are not properly educated and trained simply because they did not receive their training from a resident college or university. Traditional naturopathy has existed in the public domain since the 1600's without the necessity for naturopaths to attend four-year medical schools and without any evidence of harm to those who follow its principles. Training to become a naturopath may be obtained from several different sources including: apprenticeships, institutions that specialize in teaching a particular therapy, specific courses, seminars, workshops, and distance education programs that lead to an N.D. degree. And for the record, I consider distance learning to be a much more respectful term than the term "mail order diploma" which is the moniker that Daniel Labriola and the Bastyr students prefer when they attempt to unjustly belittle traditional naturopaths. But, lest I digress, please let

the point be clear: In the entire naturopathic universe, the "naturopathic physicians" are a tiny minority.

The distinction between titles and terms becomes very important when considered within the context of licensing and regulatory activity that this Commission may be considering.

As you may know, naturopathic medicine licensing laws exist in 11 U.S. States. Those laws, were championed by the American Association of Naturopathic Physicians and the AANP's state chapters, and exclude the vast majority of naturopaths, or *traditional naturopaths*, in the following way:

First, the laws use the scope of practice that comprises naturopathic medicine as being the definition of all forms of naturopathy. In other words, the prescription of drugs and surgery are included in the laws' definitions of naturopathy.

Second, the laws state that in order to be qualified to practice any form of naturopathy, one must be qualified to perform the types of surgery and prescribe the types of drugs encompassed in naturopathic medicine.

Third, the only way, according to these laws, that one can become qualified to perform the types of surgery included in naturopathic medicine is to attend one of only three schools in the country that are accredited to teach naturopathic medicine.

Fourth, the laws state that prospective licensees must pass the Naturopathic Physician Licensing Exam, and that only graduates of one of the aforementioned three naturopathic medical schools are eligible to sit for the exam.

Fifth, the laws state that only those qualified to practice naturopathic medicine can use titles involving the word "naturopath." The titles co-opted by these laws include Naturopathic Physician, Naturopath, Doctor of Naturopathy, Naturopathic Practitioner, Naturopathic Doctor – even the adjective "naturopathic."

The upshot of the foregoing is that in order to be able to offer ***any*** form of naturopathic service, traditional naturopaths – practitioners who don't even believe that drugs and invasive procedures should be part of naturopathy – are being asked to be qualified to perform surgery and prescribe pharmaceuticals. The intended effect of this licensing initiative has been to deliberately attempt to preclude traditional naturopaths – again, those who comprise the overwhelming majority of practitioners – from practicing their trade.

The question posed by the Coalition's members is clear: Why, when there are presently in existence allopathic physicians capable of delivering primary health care to patients, and naturopaths that are qualified to offer natural therapies, does a third party need to create an entirely new profession that represents itself as combining the two? This action can only dilute the potency of the benefits that are provided by each distinctive model from which they're drawn, thereby reducing the effectiveness of each component. If allopathic physicians, in the interest of offering safer and more cost effective patient care, attempt to include some modalities of natural healing in their practice, this is perfectly acceptable—provided that their knowledge about the subject is sufficient to allow for an effective application. But, it is absolutely and unequivocally unacceptable and unethical for the AANP to attempt to co-opt <u>*all*</u> naturopathic modalities and <u>*all*</u> titles using the word "naturopath" as part of it's "naturopathic medicine" licensing efforts.

To summarize, our recommendations to the Commission are:

(1) Distinguish between "Traditional Naturopathy" and "Naturopathic Medicine."
(2) Differentiate between "Naturopaths" and "Naturopathic Physicians."
(3) Should the Commission concern itself with the matter of regulation and licensing – something that I'm not at all convinced is wise or appropriate – please try to develop an approach that serves the needs of consumers and practitioners, not one that is exclusionary.

Thank you for your time.

White House Commission on Complementary and Alternative Medicine Policy

An Open Letter of Welcome

We are pleased to welcome you to this Town Hall Meeting of the **White House Commission on Complementary and Alternative Medicine Policy**. The Commission, established by Executive Order on March 7, 2000, has been charged to submit a report to the President and Congress by March 2002, providing policy recommendations to help guide the nation's use of complementary and alternative medicine (CAM) practices and interventions.

We are glad you are here today. Your participation in this important process is critical.

The President's Executive Order outlined four broad topic areas for consideration by the Commission: (1) coordinated research to increase knowledge about CAM practices and products; (2) the provision to health care professionals of reliable and useful information about CAM that can be made readily accessible and understandable to the general public; (3) guidance for appropriate access to and delivery of CAM; and (4) the education and training of health care practitioners in CAM. A copy of Executive Order 13147 is included in this information packet.

To maximize the opportunity to receive public input, the Commission will hold a series of Town Hall Meetings throughout the country over the next several months. A proposed schedule is included in this information packet. Although the sites and dates of the Town Hall Meetings may change, there will be ample opportunity for interested individuals throughout the country to provide their input. Additionally, the public will be invited to present comments during Commission meetings held in Washington, D.C. throughout the coming year.

Because of the diversity and scope of issues related to CAM practices and products, we have developed a list of questions to help guide and focus discussion. We encourage you to review these questions and use them when you prepare your oral or written statements. A copy of these questions are included in your packet as part of the "Federal Register Notice" for this meeting.

Registration has now begun for the next Commission Town Hall Meeting. An announcement of the meeting is included in this information packet, and may be copied and distributed freely. To attend Town Hall Meetings, please register by calling 1-800-953-3298 or logon through our website: http://whccamp.hhs.gov If you have general questions, or need to contact us, please call Ms. Michele Chang, at 301-435-7592, or send us an e-mail at WHCCAMP@od.nih.gov.

We invite you to inform others about our work and hope that you will encourage your colleagues and constituents to participate in this critical process, particularly by attending our Town Hall Meetings.

James S. Gordon, M.D.
Chair

Stephen C. Groft, Pharm.D.
Executive Director

White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, MD 20817-7707
tel. 301-435-7592, fax 301-480-1691, e-mail: whccamp@od.nih.gov, website: www.whccamp.hhs.gov

Fact Sheet

The White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) was established by Executive Order 13147 on March 7, 2000, to develop a set of legislative and administrative policy recommendations that will maximize the benefits of complementary and alternative medicine (CAM) practices and products for the general public. The Commission has been charged to submit a report to the President and Congress by March 2002.

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3. guidance for appropriate access to and delivery of CAM; and
4. the education and training of health care practitioners in CAM.

Commission Membership

Currently 19 Commissioners have been appointed by the President, representing a diverse range of expertise in medical, scientific and CAM fields. The Commissioners include the Chair, James S. Gordon, M.D., and George M. Bernier, Jr., M.D.; David E. Bresler, Ph.D.; Thomas M. Chappell; Effie Poy Yew Chow, Ph.D.; George T. DeVries, III; William R. Fair, M.D.; Joseph J. Fins, M.D.; Veronica Gutierrez, D.C.; Wayne B. Jonas, M.D.; Charlotte R. Kerr, R.S.M.; Linnea S. Larson, LCSW; Tieraona Low Dog, M.D., A.H.G.; Dean Ornish, M.D.; Conchita M. Paz, M.D.; Buford L. Rolin; Julia Scott; Xiaoming Tian, M.D.; and Donald W. Warren, D.D.S. Eventually, the Commission will comprise a total of 20 members.

Full Commission Meetings

The Commission will focus on one or more of the four major topic areas during each of its full group meetings. The October 5-6- meeting focused on Coordinated CAM Research; December 4-5 on Access and Delivery of CAM Services and Products; February 2001 on Education, Training and Credentialing for CAM Practices; and March 5-6, 2001 on Dissemination of CAM Information to the Public. There may be additional meetings to revisit one or more of these topics. All meetings are open to the public and will be held in Washington, D.C.

Town Hall Meetings

To maximize the opportunity to receive public input, the Commission will hold a series of Town Hall Meetings throughout the country over the next several months. The first was held in San Francisco, California; others are planned for Seattle, New York City, Minneapolis, Albuquerque, and Atlanta. Additionally, the public will be invited to present comments during Commission meetings held in Washington, D.C. throughout the coming year. Written comments may be sent electronically, by fax or mail to the addresses below.

Contacting WHCCAMP:

Stephen C. Groft, Pharm.D.
Executive Director
OR
Michele M. Chang, CMT, MPH
Executive Secretary

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The White House Commission on Complementary and Alternative Medicine Policy

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Full Commission Meetings

In response to its mandate, the Commission will focus on one or more of the four major topic areas during each of its full group meetings. The meeting held on October 5-6 focused on Coordinated CAM Research; subsequent meetings include: December 4-5 on Access and Delivery of CAM Services and Products; February 19-20, 2001 on Education, Training and Credentialing for CAM Practices; and March 5-6, 2001 on Dissemination of CAM Information to the Public. There may be additional meetings to revisit one or more of these topics. All meetings are open to the public and will be held in Washington, D.C.

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Stephen C. Groft, Pharm.D.
Executive Director
OR
Michele M. Chang, CMT, MPH
Executive Secretary

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Suite 1010, MS-7707
Bethesda, MD 20817-7707

tel: 301-435-7592
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e-mail:WHCCAMP@od.nih.gov

WEBSITE: http://www.whccamp.hhs.gov

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release March 8, 2000

EXECUTIVE ORDER 13147

WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App.), and in order to establish the White House Commission on Complementary and Alternative Medicine Policy, it is hereby ordered as follows:

Section 1. Establishment. There is established in the Department of Health and Human Services (Department) the White House Commission on Complementary and Alternative Medicine Policy (Commission). The Commission shall be composed of not more than 15 members appointed by the President from knowledgeable representatives in health care practice and complementary and alternative medicine. The President shall designate a Chair from among the members of the Commission. The Secretary of Health and Human Services (Secretary) shall appoint an Executive Director for the Commission.

Sec. 2. Functions. The Commission shall provide a report, through the Secretary, to the President on legislative and administrative recommendations for assuring that public policy maximizes the benefits to Americans of complementary and alternative medicine. The recommendations shall address the following:

(a) the education and training of health care practitioners in complementary and alternative medicine;

(b) coordinated research to increase knowledge about complementary and alternative medicine practices and products;

(c) the provision to health care professionals of reliable and useful information about complementary and alternative medicine that can be made readily accessible and understandable to the general public; and

(d) guidance for appropriate access to and delivery of complementary and alternative medicine.

Sec. 3. Administration. (a) To the extent permitted by law, the heads of executive departments and agencies shall provide the Commission, upon request, with such information and

assistance as it may require for the purpose of carrying out its functions.

(b) Each member of the Commission shall receive compensation at a rate equal to the daily equivalent of the annual rate specified for Level IV of the Executive Schedule (5 U.S.C. 5315) for each day during which the member is engaged in the performance of the duties of the Commission. While away from their homes or regular places of business in the performance of the duties of the Commission, members shall be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in Government service (5 U.S.C. 5701-5707).

(c) The Department shall provide the Commission with funding and with administrative services, facilities, staff, and other support services necessary for the performance of the Commission's functions.

(d) In accordance with guidelines issued by the Administrator of General Services, the Secretary shall perform the functions of the President under the Federal Advisory Committee Act, as amended (5 U.S.C. App.), with respect to the Commission, except that of reporting to the Congress.

(e) The Commission shall terminate 2 years from the date of this order unless extended by the President prior to such date.

WILLIAM J. CLINTON

THE WHITE HOUSE,
March 7, 2000.

# # #

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release September 15, 2000

EXECUTIVE ORDER 13167

AMENDMENT TO EXECUTIVE ORDER 13147, INCREASING THE MEMBERSHIP OF THE WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App.), and in order to increase the membership of the White House Commission on Complementary and Alternative Medicine Policy from not more than 15 members to up to 20 members, it is hereby ordered that the second sentence of section 1 of Executive Order 13147 of May 7, 2000, is amended by deleting "not more than 15" and inserting "up to 20" in lieu thereof.

WILLIAM J. CLINTON

THE WHITE HOUSE
September 15, 2000.

# # #

Please visit our White House Commission on Complementary and Alternative Medicine Policy website at:

http://www.whccamp.hhs.gov

- White House Press Releases
- Commissioner's Biographies
- Future Meetings
- Register for Upcoming Meetings

And Much Much More!

ANNOUNCEMENT

White House Commission on Complementary and Alternative Medicine Policy
Town Hall Meeting
October 30-31st, 2000 in Seattle, WA

The **White House Commission on Complementary and Alternative Medicine Policy** is sponsoring a town meeting on complementary and alternative medicine (CAM) practices and products. Members of the community are invited to present comments and suggestions to the Commission about the coordination of CAM research, information dissemination, access to and delivery of CAM practices and products, and training and education of CAM practitioners and other health care providers.

NOTE: The event is free and space is limited on a first come, first serve basis. **Registration to speak must be received by October 23rd, 2000.**

WHEN AND WHERE:

Monday, October 30, 9:00 a.m. – 6:00 p.m.
Tuesday, October 31, 8:30 a.m. – 2:00 p.m. at the
Town Hall, Seattle, Seneca Room
1119 Eighth Avenue
Seattle, WA (206-652-4255)

COMMISSIONERS ATTENDING:

James Gordon, Chair of the White House Commission on Complementary and Alternative Medicine Policy, and Director of the Center for Mind-Body Medicine in Washington, D.C.

Tom Chappell, co-founder and CEO of Tom's of Maine, and founder and CEO of the Saltwater Institute, a learning institute of leaders seeking to integrate their values into their personal and professional lives.

Effie Poy Yew Chow, Qigong Grandmaster, founder of the East West Academy of Healing Arts in San Francisco in 1973 and, more recently, The EWAHA Qigong Institute, the American Qigong Association, and the World Qigong Federation.

Joseph Fins, Director of Medical Ethics at New York Weill Cornell Medical Center of New York - Presbyterian Hospital, who lectures extensively and has written widely in the field of Medical Ethics.

Tieraona Low Dog, Medical Director for the Tree House Center of Integrative Medicine in Albuquerque, and Chairperson for the Dietary Supplements and Botanicals Expert Panel for the United States Pharmacopoeia.

Linnea Larson, Associate Director of West Suburban Health Care, Center for Integrative Medicine in Oak Park, Illinois.

Veronica Gutierrez, Board member for the World Chiropractic Alliance, contributing editor to the Chiropractic Journal, and owner-practitioner at Gutierrez Family Chiropractic in Arlington, Washington.

Xiaoming Tian, Director of Wildwood Acupuncture Center in Bethesda, Maryland and Director of the Academy of Acupuncture and Chinese Medicine.

HOW TO REGISTER: (DEADLINE IS OCTOBER 23rd!)

Call 1-800-953-3298 or register on-line at http://www.whccamp.hhs.gov To contact the Commission, e-mail us at whccamp@od.nih.gov or call 301-435-7592.

White House Commission on Complementary and Alternative Medicine Policy

Fact Sheet
Complementary and Alternative Medicine

Complementary and Alternative Medicine (CAM) practices and products covers a broad range of healing philosophies (schools of thought), approaches, and therapies that mainstream Western (conventional) medicine does not commonly use, accept, study, understand, or make available. A few of the many CAM practices include the use of acupuncture, herbs, homeopathy, therapeutic massage, and traditional oriental medicine to promote well-being or treat health conditions.

People use CAM treatments and therapies in a variety of ways. Therapies may be used alone, as an alternative to conventional therapies, or in addition to conventional, mainstream therapies, in what is referred to as a "complementary" or an integrative approach.

Many CAM therapies are called holistic, which generally means they consider the whole person, including physical, mental, emotional, and spiritual aspects.

CAM's Growing Popularity in the United States

A published survey shows that the number of Americans using an alternative therapy rose from about 33 percent in 1990 to more than 42 percent in 1997.[1] People in this study reported using the following therapies most often: herbal medicine, massage, megavitamins, self-help groups, folk remedies, energy healing, and homeopathy.

In addition, Americans spent more than $27 billion on these therapies in 1997, exceeding out-of-pocket spending for all U.S. hospitalizations.

A survey published in 1994 reveals that more than 60 percent of doctors from a wide range of specialties recommended alternative therapies to their patients at least once. In addition, 47 percent of the doctors in this study reported using alternative therapies themselves.[2]

Indeed, 75 out of 117 U.S. medical schools offered elective courses in CAM or included CAM topics in required courses, according to an article published in 1998.[3]

Another survey found that people used CAM not only because they were dissatisfied with conventional medicine, but because these health care alternatives mirrored their own values, beliefs, and philosophical orientations toward health and life.[4]

Health care professionals and the public need policies to help coordinate and stimulate rigorous research of CAM practices and products, as well as the access and delivery of such services, education and training of practitioners and the provision of evidence-based information to the public.

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1 Eisenberg, D.M., Davis, R.B., Ettner, S.L., Appel, S., Wilkey, S., Van Rompay, M., Kessler, R.C. "Trends in Alternative Medicine Use in the United States, 1990-1997: Results of a Follow-Up National Survey." JAMA. November 11, 1998. 280(18):1569-75.

2 Borkan, J., Neher, J.O., Anson, O., Smoker, B. "Referrals for Alternative Therapies." Journal of Family Practice. 1994. 39(6):545-50.

3 Wetzel, M.S., Eisenberg, D.M., Kaptchuk, T.J. "Courses Involving Complementary and Alternative Medicine at U.S. Medical Schools." JAMA. September 2, 1998. 280(9):784-7.

4 Astin, J.A. "Why Patients Use Alternative Medicine: Results of a National Study." JAMA. May 20, 1998. 279(19):1548-53.

DK

White House Commission on Complementary and Alternative Medicine Policy

TOWN HALL MEETING
OCTOBER 30-31, 2000

SEATTLE TOWN HALL
1119 Eighth Avenue, Seattle, Washington

AGENDA* & LIST OF SPEAKERS

8:30 a.m. – 9:00 a.m. Pre-registrant Check-in and On-site Registration

9:00 a.m. **Welcome and Introductions**

Stephen C. Groft, Pharm.D.
Executive Director
White House Commission on Complementary and Alternative Medicine Policy

Commissioners:

The Honorable James Gordon
Chair and Moderator

The Honorable Tom Chappell
The Honorable Effie Poy Yew Chow
The Honorable Joseph Fins
The Honorable Tieraona Low Dog
The Honorable Linnea Larson
The Honorable Veronica Gutierrez
The Honorable Xiaoming Tian

9:15 a.m. **Opening Remarks**

Richard C. Kelley, PhD.
Regional Director, Department of Health and Human Services, Region X

Robert Harkins
Office of the Insurance Commissioner

King County Council
Greg Nickels, Maggi Fimia and Kent Pullen

Joseph Pizzorno, ND
Expert Health Systems

*** Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.**

9:40 a.m. – 11: 15 a.m. Speakers (in order of appearance; 3-minute statements)

1. Richard Lyons, MD, MPH
   Regional Health Administrator, US Public Health Service, Region X

2. Dorothy Wong
   International Community Health Centers

3. Gail Zimmerman
   Health Professions/Quality Assurance, WA Department of Health

4. Henry Ziegler, MD, MPH

5. Kathy Abascal, BS, JD
   Botanical Medicine Academy

QUESTIONS FROM COMMISSIONERS

6. Lori Bielinski, LMP
   Office of the Insurance Commissioner (WA)

7. Kent Pullen
   King County Council, District 9

8. Alonzo Plough, MD
   Seattle-King County Health Department

9. Maggi Fimia
   King County Council, District 1

QUESTIONS FROM COMMISSIONERS

10. Tom Trompeter
    Community Health Centers of King County

11. Judy Featherstone, MD
    Kent Community Health Center

12. Kathy Lynn Boulanger
    Washington Reflexology Association

13. Pamela Snider, ND
    Bastyr University

QUESTIONS FROM COMMISSIONERS

14. Leanna Standish, PhD
    Bastyr University

* Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.

15. Jeffrey Bland, PhD
Institute for Functional Medicine

16. Richard Hammerschlag, PhD
Oregon College of Oriental Medicine

17. William Dallas, DC
Western States Chiropractic College

QUESTIONS FROM COMMISSIONERS

BREAK: 15 minutes

11:30 a.m. – 12:15 p.m.

18. Robert D. Mootz, DC
Washington State Labor & Industries

19. Clyde Jensen, PhD
National College of Natural Medicine

20. Jim Taylor, MD
University of Washington

21. Karen Sherman, PhD
Northwest Institute of Acupuncture and Oriental Medicine

QUESTIONS FROM COMMISSIONERS

22. Suzzanne Myer, MS, RD
Bastyr University

23. Jacqueline Obando, DVM
MercyVet PLLC

24. William E. Lafferty, MD
University of Washington

25. Charles Simpson, DC
Complementary Healthcare Plans, Inc.

QUESTIONS FROM COMMISSIONERS

LUNCH BREAK: 12:15 p.m. – 1:15 p.m.

*** Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.**

1:15 p.m. – 3:45 p.m.

26. Arlene M. Darby
Citizens for Alternative Health Care

27. Nicole Ellis

28. Rose Eng-Lum, NMN
Dai Wai Association

29. Bruce Milliman, ND
WA Association of Naturopathic Physicians

QUESTIONS FROM COMMISSIONERS

30. Jayne Leet
Birdsong Ranch

31. Daniel J. Labriola, ND
WA State Department of Health (Consultant)

32. Gay Koopman

33. Kathy McVay
WA State Professional Loan Repayment & Scholarship Program

QUESTIONS FROM COMMISSIONERS

34. Fred Bomonti, DC
WA State Chiropractic Association

35. Laurence M. DeShields
Community Health Center (Board Member)

36. Tracy Turner

37. John Stephen Huber, DC
Highline Community College

QUESTIONS FROM COMMISSIONERS

38. M. Jacobson, MPH, MHRN, LLC

39. Laura Patton, MD
Group Health Cooperative of Puget Sound

40. Elizabeth Goldblatt, MPH/PA, PhD
Commission on Colleges, A/OM Accrediting Agency

*** Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.**

41. JoAnne Myers-Ciecko, MPH
Seattle Midwifery School

QUESTIONS FROM COMMISSIONERS

42. Susan Haeger
Citizens for Health (National)

43. Michelle Simon

44. Julie Chinnock

45. Chris LePisto

QUESTIONS FROM COMMISSIONERS

46. Don Taylor

47. Cindy Breed, ND
Community Health Centers of King County

48. Jane Guiltinan, ND
Natural Medicine Clinic, Bastyr University

49. Fernando Vega, MD
Seattle Healing Arts Clinic

QUESTIONS FROM COMMISSIONERS

50. Judith Aileen Kaufman
Emerald City Healing Arts

51. Stan Lippmann, PhD, JD
Natural Medicine Party

52. Valerie Sasson, LM
Puget Sound Birth Center

53. Scott Barnhart, MD, MPH
Harborview Medical Center, University of Washington

QUESTIONS FROM COMMISSIONERS

BREAK: 15 minutes

4:05 p.m. – 6:00 p.m.

54. Leah Kliger, MD
Evergreen Community Health Center

*** Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.**

55. Brenda Loew, MRP
Japanese Acupuncture Center

56. Robert A. May, ND
Alternare Health Services

57. Terry Courtney, LAc
Bastyr University

QUESTIONS FROM COMMISSIONERS

58. Sue Vlasuk, DC
DABCO

59. Diana Thompson, LMT

60. Houston LeBrun, LMT
American Massage Therapy Association-WA Chapter

61. Heike Doyle, LM
Puget Sound Midwives & Birth Center

QUESTIONS FROM COMMISSIONERS

62. Upledger Institute

63. Jerri Fredin
Citizens for Alternative Healthcare

64. Don Sloma

65. Robert Nicoloff
WA State Department of Health

QUESTIONS FROM COMMISSIONERS

66. Richard Whitten, MD
Washington Health Care Authority

67. Andrew John Brunskill, MD
Uniform Medical Plan, Health Care Authority

68. Karl D. Peterson, DC, ND
NW Naturopathic Physicians Convention

69. Pat Prinz, PhD
Department of Biobehavioral Nursing, U WA School of Nursing

QUESTIONS FROM COMMISSIONERS

* Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.

70. Kay Lahdenpera

71. Jane Bernice Nelson, MA
North Bend Elementary

72. Sheila Kennedy Rhodes
Mt. Baker Care Center

73. Vera Ridderbusch
Well Mind Association

QUESTIONS FROM COMMISSIONERS

74. Katherine R. Schmidt
Bellevue Massage School

75. Ronald Schneeweiss, MBChB
Department of Family Medicine, University of Washington

QUESTIONS FROM COMMISSIONERS

6:00 p.m. ADJOURN

- The White House Commission on Complementary and Alternative Medicine Policy thanks you for your participation in today's proceedings. We invite you to attend tomorrow's session, which is scheduled to begin at 8:30 a.m. and adjourn by 2:00 p.m.

- You are invited to submit written comments at these sessions, or to send them to us by logging onto our website:

http://www.whccamp.hhs.gov

* Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.

Seattle Town Hall Meeting
White House Commission on Complementary and Alternative Medicine Policy
Tuesday, October 31

7:00 a.m. – 8:30: a.m. Pre-registrant Check-in and On-site Registration

8:30 a.m. **Welcome and Opening Remarks**

Stephen C. Groft, Pharm.D.
Executive Director
White House Commission on Complementary and Alternative Medicine Policy

The Honorable James Gordon
Chair and Moderator

8:45 a.m. – 10:10 a.m. **Speakers Continued (in order of appearance)**

74 Katherine Schmidtz

76. Paul Saunders, ND, PhD
Office of Natural Health Products

77. Karta Purkh Khalsa, AHG, CN * hair

78. Jennifer Jacobs, MD, MPH
American Institute of Homeopathy

79. Emma Bezy, MA
Spirituality Program, Bastyr University

QUESTIONS FROM COMMISSIONERS

80. Tom Shepherd, DHA
Bastyr University

81. Robert Arthur Anderson, MD
American Board of Holistic Medicine

82. Charlotte Coon
Hellerwork International

83. Jeffrey Goin
Coalition for Natural Health

QUESTIONS FROM COMMISSIONERS

84. Barbara Mitchell, JD, LAc, MAc
Standards Management, Inc.

* Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.

85. Mark Tomski, MD
Washington Chapter of the AAMA

86. Christa Louise, MS, PhD
North American Board of Naturopathic Examiners

87. Todd L. Richards, Ph.D.
University of Washington

QUESTIONS FROM COMMISSIONERS

88. Lise Alschuler, ND
Bastyr University

89. Jeff Novack, PhD
Bastyr University

90. Sevak S. Kroesen, DC
Integrative Health Care Center, Inc. P.S.

91. Robert Shook
Northwest Institute for Acupuncture & Oriental Medicine

QUESTIONS FROM COMMISSIONERS

BREAK: 15 MINUTES

10:25 a.m. – 12:00 p.m.

92. Tommy Lewis
Northwest Indian College

93. Ralph Forquera, MPH
Seattle Indian Health Board

94. Graham Patrick, PhD
Seattle University School of Nursing

95. Wayne William Topping, PhD
Topping International Institute, Inc.

QUESTIONS FROM COMMISSIONERS

96. Wendy J. Weber

97. Heida Brenneke
Brenneke Massage School

* Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.

98. Paul Reilly, ND, MS, BS
WANP, AANP

99. John Daley, PhD

QUESTIONS FROM COMMISSIONERS

100. Eileen Stretch, ND
American Whole Health Network

101. Jennifer Booker, ND
American Association of Naturopathic Physicians

102. Victoria M. Taylor, LM
Quality Midwifery Associates

103. Austin McMillin, DC

104. Susan Rosen, LMT
American Massage Therapy Association-WA Chapter

QUESTIONS FROM COMMISSIONERS

105. Sheila Quinn
King County Integrated Health Care 2010

106. David Matteson
Pacific Solutions

107. James K. Rotchford
Medical Acupuncture Research Foundation

QUESTIONS FROM COMMISSIONERS

LUNCH BREAK : 12:00 – 12:45 p.m.

12:45 p.m. – 1:15 p.m.

108. Mitch Stargrove, ND
Integrated Body/Mind Information System

109. Bradford S. Weeks, MD
Well Mind Association

*** Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.**

110. David A. Butters, DC

111. Christopher Huson, LAc
Acupuncture Association of Washington

QUESTIONS FROM COMMISSIONERS

1:15 p.m. – 2:00 p.m.

Walk-in (On-site Registrants in the order received and at the discretion of the Chair)

2:00 p.m. ADJOURN

- The White House Commission on Complementary and Alternative Medicine Policy thanks you for your participation in this Town Hall Meeting. In 3-4 weeks, a transcript of these proceedings will be available on our website:

  http://www.whccamp.hhs.gov

- You are invited to submit written comments at these sessions, or to send them to us by logging onto our website. More information about our activities, including other Town Hall Meetings, also can be found on our website.

* Scheduled times listed here are estimated. Speakers are asked to be present in the Hall at least 20 minutes before their panel is called.

Kingsbury, Doris (NCCAM)

From: Michelle Simon [samichelle@earthlink.net]
Sent: Wednesday, November 29, 2000 9:03 PM
To: Whccamp (NCCAM)
Subject: Testimony submission from the Seattle Oct 30-31 meetings

White House commission on inte...

Hello,

I testifiied at the Seattle meetings in late October and would like to submit a copy of my testimony for the record. If this is not the appropriate address, please let me know the correct one.

Sincerely,

Michelle Simon, PhD

Testimony for White House Commission on Integration of CAM Policy
Michelle Simon, PhD, Bastyr University

My name is Michelle Simon. I am a third year student at Bastyr University in the naturopathic medicine program. I am here to address issues concerning the health needs of underserved and rural communities which might be best served by integrated health care clinics.

There is a great deal of interest among my classmates to meet this challenge, to work in underserved and rural areas, and help educate communities on good health practices which will raise the overall level of understanding, responsibility, and ultimately health of the community at large. We are a **ready, willing and able** workforce.

Naturopathic medicine is, in my opinion, an extremely well suited modality to serve these populations. Alternative medicine in general and naturopathic medicine in particular holds **as a basic tenant** the importance of preventative measures rather than costly end term solutions. This economic benefit addresses one of the issues which limits the care communities in need receive as the current standard of medical care necessitates a high cost of delivery.

As naturopaths, we are trained to conduct a comprehensive initial intake evaluation of a patient that uncovers not only medical history, but extensive lifestyle data as well. With training in primary care medicine NDs have the background to assimilate the information, recognize and address significant risk factors. By educating their patients with regard to lifestyle choices and their consequences, NDs seek to avoid the costly interventions which may be necessary in later stages of disease. If necessary NDs can refer and co-manage cases with other providers of health care. This type of cross-referral is simplified if the practice is in an integrated clinic.

There are several clinics in our area that currently practice an integrated model of care. Providers included in this model of care are MD's, ND's, LPN's, DO's, PT's, RD's, massage therapists, chiropractors psychotherapists, and acupuncturists. At one integrated clinic, the Healing Arts Center in Colville, WA, strong patient demand has resulted in greater than expected growth of the patient base[1].

Patients **are** aware of the possibilities. A 1995 survey of Community Health Center of King County patients indicated that 60% of current patients were interested in receiving natural medicine services.[2]

Some Strengths of Integrated clinics:

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1 "Integrative Clinic Benchmarking Project Follow-up Report: Surprises, Breakthroughs, and Year 2000 Goals of 16 Leading Clinics." The Integrator, March 2000, p 5.
2 *King County Natural Medicine Clinic at the Kent Community Health Center Fact Sheet

- Rich synergy of treatment options for patients
- High patient satisfaction that focuses on benefit of integrated approach to care
- Case co-management provides overall perspective and decreased risk for patient health

Challenges:

- Financial backing (grants, investors, loan reimbursement)
- Team focused approach to management and long range planning requires commitment

My suggestions:

- To provide grants to community, rural, and underserved clinics for the expressed purpose of bringing aboard licensed CAM practitioners to work in an integrative capacity.
- To include reimbursement for licensed CAM services among Federally managed health care plans such as Medicare and Medicaid.
- To fund naturopathic education in the form of scholarships, loans, and national loan reimbursement programs for licensed disciplines .

In closing I would like to say that I have a PhD in Biomedical Engineering. When I was evaluating the option of pursuing a MD versus an ND one thing was strikingly evident. There was a great deal of scholarship and grant opportunity available to me for pursuit of a MD, none of which is available to students of naturopathic medicine. This is the most rigorous educational experience of my life, I am proud to have chosen this path in part because I believe that naturopathic medicine is an excellent solution for many public health concerns especially in the rural and underserved communities.

Thank you all for your dedication to the fair evaluation of this topic!

White House Commission on Complementary and Alternative Medicine Policy
Seattle Town Hall Meeting

Dear Sirs and Madams,

This e-mail is to provide additional testimony the Seattle Town Hall meeting. My apologies for not being able to present this in person at the Town Hall meeting. This e-mail is composed of three subsections: a briefly description of my background; a brief description of massage therapy and the Naturopathy professions; and recommendations how changes in Federal policy can profoundly benefit these professions.

I am a licensed massage practitioner for about 8 years, and a licensed Naturopathic Physician in practice for about 6 months. I have a degree in Naturopathic Medicine and a degree in Electrical Engineering. I am an independent, small business owner.

Washington State has a comprehensive law for for licensing Naturopathic physicians. Candidates are required to complete a long list of prerequisites, not limited to pre-med training, basic science training including cadaver anatomy, clinical didactic training and clinical competency training. Candidates must pass a Nationally recognized test. Physicians are required to keep chart notes and take ongoing continuing education training. Physicians are able to purchase liability insurance. The State created this profession with three main goals: consumer safety, efficacy of the service offered and accountability of the physician.

Naturopathy is licensed in the following states: AK, HI, OR, WA, AZ, MT, UT, CT, ME, VT, NE and Puerto Rico. Utah has the greatest scope of practice and allows Naturopaths full prescription rights.

Recommendations:

Require schools of Naturopathy to teach this healing art commensurate with the greatest scope of practice for each state where Naturopathy is licensed. Given that the federal government underwrites student loans, it is appropriate schools utilizing this support, teach to the maximum scope of practice, thereby allowing students to practice in any licensed state. Currently, the the greatest scope of practice for Naturopaths is a synthesis of the laws in Utah, Oregon and Arizona. Utah allows for prescriptive rights for all non-controlled FDA approved therapies, and requires a 2 year residency. Oregon allows prescriptive rights for certain controlled substances such as hydrocodone, and morphine and has extensive minor surgical procedure rights. Arizona allows for the use of schedule-1 substances such as medical marijuana. As confusing as this all may seem, the schools must raise their standards so that a graduate from any federally supported school shall be capable of practicing in any licensed state. Since federal support of student loans applies to students from any state, it only seems fair that students graduating from such a supported school receive training commensurate with the laws of all licensed states.

Federal policy shall apply only to licensed health care professionals. Non-licensed health care providers, while well intentioned, have no professional accountability and represent a potential danger to consumers. Federal funds should not support the efforts of unlicensed health care professionals.

Medicare and Medicaid shall apply the "every provider category" in its reimbursement plan, allowing for reimbursement for Naturopathic Physician and other professional services. It is a consumer's right to have the choice of health care provider, whether conventional or complementary, assuming that the complementary health care giver offers a service that is equivalent to the conventional. For example, Naturopaths are trained to treat hypothyroidism using prescription levo-thyroxin. Medicare will cover this treatment for ARNPs, MDs and DOs, but not Naturopaths. Medicare and Medicaid has

already set the president for covering some CAM providers. Medicare will cover chiropractic physicians for treating low back pain with manipulation, but not Naturopaths using manipulation. This is simply prejudice and inconsistent with American ideals.

The National Health Service Core shall accept Naturopathic Physicians, and develop a student loan reimbursement program. The United States has an enormous under served population, and Naturopathic Physicians can effectively serve this population. In return for this service, it is only fair to offer the same student loan reimbursement plan offered to conventional physicians.

The Military shall allow enlisted Naturopathic Physicians to practice on Military Bases. Currently, the Military has wellness officers. Wellness of enlisted personnel is a major stated goal. Naturopathic Physicians are well suited to this role and should be allowed to serve.

A patients bill-of-rights needs to be adopted, including the "every provider category" provision in all health care insurance plans. The "every provider category" works in Washington State and can work in every state.

The Federal Government shall somehow require that Naturopathic Physicians must complete a 2 year residency program and be given full prescriptive rights for all non-controlled FDA approved therapies. While licensing is a State issue, the Federal Government can help influence the advancement of Naturopathic Medicine in the licensed states. A two year residency and full prescriptive rights for non-controlled substances is the current law for Naturopaths in the State of Utah and should be the minimum law in all licensed states. A two year residency program will overcome objections to Naturopathic training and the full prescriptive rights will allow Naturopaths to treat many more conditions using FDA approved therapies.

Thank you for your consideration. If you have any questions, please feel free to call or correspond at the following.

Bruce Klein, ND
13896 NE 66th #589
Redmond, WA 98052

425.861.7746
425.867.3935 (fax)

email: klein_bruce@yahoo.com

Yours in health,

Bruce Klein, ND

#16

Presentation to the
White House Commission on Complementary and Alternative Medicine Policy
Town Hall Meeting, Seattle, WA, October 30, 2000

Richard Hammerschlag, Ph.D.
Research Director
Oregon College of Oriental Medicine
10525 SE Cherry Blossom Drive
Portland, OR 97216
503/253-3443, x156
rzhammer@compuserve.com

Members of the Commission: Good morning. I am Richard Hammerschlag, Research Director of the Oregon College of Oriental Medicine in Portland. I also serve as President of the national Society for Acupuncture Research and for 25 years, up to 1995, I was engaged in biomedical research in neurobiology. Research is my profession and my passion and it is a challenge to apply my training in biomedical research to CAM research in general and acupuncture research in particular. It is especially exciting to be part of the unique CAM research community in Portland, which is home to *two* of the 15 currently funded NIH NCCAM Centers.

I will focus my remarks on three questions essential to research:

- What kinds of CAM research are needed?
- How can CAM research findings be better disseminated to health care providers, policy-makers and insurers?
- What strategies can be developed to facilitate the incorporation of research-supported CAM therapies into conventional health care settings?

In talking about research, we should acknowledge that "evidence-based medicine", the current watchword at NIH, means research-based medicine.[1] It follows that CAM research, similar to conventional biomedical research, must be held to rigorous standards. But what kinds of CAM research should be encouraged?

I suggest that greater consideration *and funding* be given to research that compares real-world treatment options.[2] Just as models of Integrative *Medicine* are being created, we also need integrative research. When CAM therapies are tested side-by-side with conventional therapies, a richness of questions arise with major implications for clinical practice. These questions address how CAM and conventional treatments compare in terms of therapeutic effectiveness, long-term effectiveness, side effects, and cost-effectiveness. The Portland-based NCCAM Center at Kaiser's Center for Health Research is initiating such comparative

research in partnership with Portland-area CAM colleges of Oriental Medicine, Naturopathy, Chiropractic and Massage.

The CAM community also needs to be more proactive in ensuring that its research findings reach the wider health care community. One approach is to prepare informational packets that summarize research findings as well as educate health care administrators, providers and policy-makers in how to assess the quality of research articles. This would help to correct a major inconsistency in contemporary health care: We hear strong calls for evidence-based medicine, yet we have a health care community that is poorly trained to seek out, and assess the quality of, CAM research.

Lastly, we need to identify the obstacles that are slowing the incorporation of evidence-based CAM practices into mainstream medicine. Three approaches are: surveys to document attitudes to CAM; discussions on CAM at national meetings of hospital administrators; and demonstration hospitals where the integration of CAM practices can be evaluated.

In summary, I urge the Commission *first*, to call for research that compares real-world CAM and conventional treatments; *second*, to explore means of more widely disseminating CAM research findings; and *third*, to develop strategies to better ensure that CAM *research* benefits health care consumers.

Thank you.

[1] "There is no alternative medicine. There is only scientifically proven, evidence-based medicine supported by solid data or unproven medicine, for which scientific evidence is lacking. Whether a therapeutic practice is "Eastern" or "Western", is unconventional or mainstream, or involves mind-body techniques or molecular genetics, is largely irrelevant except for historical purposes and cultural interest."

Fontanarosa PB, Lundberg GD (1998) Alternative medicine meets science, *JAMA* 280:1618-1619.

[2] Hammerschlag R, Morris MM (1997) Clinical trials comparing acupuncture with biomedical standard care: a criteria-based evaluation of research design and reporting, *Complement Ther Med* 5:133-140.

#18

Comments on Appropriate Roles the Federal Government Can Play Concerning Complementary and Alternative Medicine

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Washington State Department of Labor and Industries

Presentation before the
White House Commission on Complementary and Alternative Medicine
Seattle, Washington
October 30, 2000

Ladies and Gentlemen, thank you for allowing me the honor to briefly present some of my observations regarding appropriate and constructive roles the Federal Government can play concerning complimentary and alternative medicine (CAM). First of all, I must applaud you for seeking information about this important and rapidly growing area of health care services. The perspectives I offer come from the following three vantage points: thirteen years in private practice as a doctor of chiropractic; eight years in academia and research; and six years as the first doctor of chiropractic to hold a full-time policy and research position within a government agency.

As you know, recent studies have shown that Americans make nearly twice as many visits to practitioners of alternative medicine than they do to practitioners of family medicine. They spend more money out-of-pocket for CAM services than they do for out-of-pocket hospital payments. Further, the past decade has seen an exponential growth in the use of alternative medicine. Chiropractic care and massage are the most utilized of all CAM approaches with nearly 15% of the US population visiting a chiropractor every year. This accounts for a third of all visits to CAM providers. Additionally, patient satisfaction data has also consistently demonstrated higher levels of satisfaction with many CAM approaches such as chiropractic care.

Obviously, the marketplace is already incorporating CAM approaches and providers into the "mainstream" in terms of preference, utilization, and expenditures. However, government and the health care system at large often proceed as though CAM merely represents some kind of "fringe" practice or a passing fad. From my perspective there are three key areas that the Federal government has both an interest and obligation in, as well as the ability to constructively influence the future of CAM and health care to meet needs for all Americans:

1. Provide meaningful federal support for CAM research and education

The CAM professions and their institutions need to develop and enhance their own educational and research missions, particularly research capacity and infrastructure development. Education and research are obviously the domain of the respective professions for they have the most knowledge and passion regarding it. Federal support need only be patterned after what exists currently for other disciplines.

Other than qualification for some federal student loan guarantee programs, government support of CAM educational institutions is nearly non-existent. This creates an incentive that fosters tuition dependence and focuses curriculum on basics that neglect important but costly residency and apprentice training, development of multidisciplinary exposure, collaboration with universities, and deters development of a culture of scholarship. This is important to federal policy makers in that this results in a loss of preparation for graduates of CAM professions to more seamlessly interface with the contemporary health care system and contributes to needlessly high default rates. Two distinct needs are related to this:

- Educational development grants, infrastructure grants, support for post graduate fellowships and advanced degree programs are examples of the kinds of support widely available for medicine, osteopathy, dentistry, and psychology programs but exclude CAM professions such as chiropractic, acupuncture or naturopathy.
- Level the playing field for students in legitimate CAM training programs in terms of student loan repayment options. Defaults need to be decreased though additional deferment options available to other health professions such as post-graduate residency and fellowship programs.

Barriers to research in CAM exist at many levels. Again these barriers have exceptional relevance to the federal government and to the American public at large. With out necessary research funding, the ability to delineate effective from ineffective procedures is reduced. Further, information necessary to the CAM professions themselves for their own quality improvement efforts is absent, placing these providers at a competitive disadvantage. This kind of policy reduces both choice and access for consumers, a key mission of many federal programs (eg, rural health care and caring for disadvantaged individuals and families). Key barriers include: inadequate scientific career training; limited science related career opportunities; bias, isolation from and ignorance of chiropractic with the wider science and health care communities; and inadequate representation in government research and policy circles. There are several distinct needs in this area:

- Post-doctoral training programs and incentives for CAM related scientists
- Establish incentives for dual degree training (e.g., MPH) for matriculates and graduates of CAM programs.
- Establish incentives for more partnerships, consortia, and collaborations between CAM institutions and universities. For example, joint conference sponsorships similar to the DHHS Health Resources and Services Administration (HRSA) funded geriatrics program (GRECC Symposium) with St. Louis University School of Medicine and Logan College of Chiropractic.
- Fund and establish more clinical research centers at CAM institutions.
- The National Library of Medicine indexes very few CAM journals and many of similar quality and content are rejected out of hand as irrelevant. This reduces retrievability of legitimate scientific and clinical information for policy makers and conventional scientists and practitioners. Relevant CAM subject index headings can be improved as well.

- Consider training support options in chiropractic and CAM disciplines to the same extent as supported in dentistry, medicine and other disciplines in order to reduce the climate of tuition and encourage development of widespread legitimate research cultures within CAM institutions.
- Consider the need for special support to "prime" scientific activity at CAM institutions, e.g., expansion of the Centers of Excellence programs being funded at HRSA.

2. Attain consistency in Federal programs with national trends and priorities

The Federal government is incredibly far behind the curve of social norms in its own health care programs. Chiropractic care for example, is a core benefit in personal injury protection coverage, most workers' compensation programs, and in health indemnity plans. Although managed care exclusions exist, meaningful chiropractic benefits can be found in a majority of insurance plans. On the other hand, Medicare, Medicaid, Veterans and Military Benefits, and Federal Workers' Compensation programs all have highly restricted coverage or exclude chiropractic care altogether. Even many managed care programs have not restricted or established the kinds of non-clinical, arbitrary and discriminatory policies on chiropractic care that exist in most Federal programs, although many are increasingly relying on these Federal programs as a template to justify such exclusions.

At the state level, patient's bill of rights legislation, court precedent and innovations such as Washington State's "every category of provider" laws are establishing that consumers and taxpayers want CAM services and they want their social institutions for health care to get along. On a social level, the potential for improvements in quality of life, satisfaction with care, and demonstrated cost efficiency in various circumstances have been documented in some situations. Chiropractic care for the people who have low back or neck problems, and headaches are just one example of how inclusion of CAM approaches (even within existing condition-oriented health plans) can offer direct tangible benefits to consumers and taxpayers alike.

CAM needs resources for quality improvement and CAM practitioners can improve their practices just like the rest of health care. The need for health services research and policy development that both explores CAM and includes CAM in government health policy circles is obvious. For example, there is only one DC employed within all of the federal government health care agencies and this only occurred within the past year or so at the National Center for Complementary and Alternative Medicine. Further, as far as I have been able to find out, my policy and research position within the Washington State Department of Labor and Industries is the only such position in existence at the state level. Many examples of benefits to both the state agency, the chiropractic profession and to the business and labor constituencies have accrued as a result. For example, the joint research between the Washington State Chiropractic Association, the Department, and the University of Washington led to the adoption of an evidence-based fee schedule for chiropractic services. This has provided more robust coverage for chiropractic care,

helped reduce administrative burden on doctors and department staff, and has made constructive progress in policy development without adversity, litigation, or excessive expenditure of resources by government or the community at the Legislature.

The precedent set by the absence of policy roles for CAM professions at the federal level permeates to state and local government as well. Although there is progress with DCs in ad hoc and advisory roles, more needs to be done, not only in chiropractic, but for many of the CAM professions. The value and contributions of such participation not only benefits respective CAM disciplines, it brings new perspective and insight to existing policy development efforts. I have seen this first hand in my work at the state agency level.

3. Promote collaboration and integration of CAM and expand the role of CAM within conventional health care delivery

One of the most important points to be made regarding integration of CAM within conventional delivery models is that a distinction must be made between the incorporation of certain *CAM procedures* into conventional medical practice and the integration of *CAM providers* into patient care pathways. An example from my discipline is the procedure of spinal manipulation compared to chiropractic care.

The procedure of manipulation has been used by many disciplines including medicine, osteopathy, and physical therapy for many years. In these settings it may be applied as an ancillary modality with the context of overall medical management, usually focusing on increasing joint range of motion and reducing pain. Although manipulation for specific conditions has a positive benefit, chiropractic management is truly distinctive, considering how body structure impacts physiology and function generally. Improved clinical outcomes and superior patient satisfaction with chiropractic care have been demonstrated repeatedly. Management approaches and non-specific effects of care are acknowledged as important variables in both clinical care and scientific research, yet these issues are often neglected in conventional delivery and research settings. However, for CAM providers, these issues are important basic elements of practice and research. CAM is a growing component of commonly used health care services in this country – not some separate, isolated, fringe element of society. The system might work better and towards everyone's advantage with a higher degree of support for and collaboration with individuals and institutions within the CAM disciplines.

Overall management perspectives, lifestyle approaches, and doctor-patient relationships are pivotal in health care. Tossing a few CAM modalities into general family practice is not the same as integrating practitioners in a constructive clinical environment who bring unique and extensive training, skills, and perspectives to the decision-making table. Consider the reverse: having a chiropractor incorporate suturing and NSAID medication into her or his practice seems unlikely to serve as a replacement for family practice medicine.

The federal government can play an extremely positive role through its policy leadership, better reflecting the social needs and trends of the American public, its direct impact on the marketplace via federal reimbursement in its own health care programs, and its substantial role as opinion leader and benchmark for the health care system, delivery settings, and health insurance plans.

Here in Washington State, provider choice is law, both in general health insurance and in workers compensation. Integration of CAM is not a medical profession issue, it is a social and marketplace issue. Exploring integration will require gradual exposure, training, and scientific research to accomplish. This exposure must involve all parties as the conventional science and medical communities have to move as far in their understanding of CAM approaches as CAM providers have to move in there understanding and skill in conventional methodologies and rationales. There are no simple "fixes." Rather, there is a need to continue to level the playing field, provide all interested parties with necessary tools for constructive engagement and bring reasoned appraisal both to discussions on integration and policy development at government levels.

Federal programs directed to these ends help stimulate economic advantages for consumers, tangible benefits in improving both patient choice, and improving the effectiveness of health care services. I urge you to recommend prioritizing only a small, but meaningfully proportional amount, of federal resources to this important, but long-neglected segment of the US health care system. The benefits accrued to the general public through better quality of care, innovations and improved effectiveness of treatment strategies, and realignment of priorities in prevention, lifestyle, and self-care so characteristic of CAM approaches will have yield beyond the small costs associated with it.

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#29

Testimony of Bruce Milliman, ND
White House Commission on CAM
Town Hall Meeting, Seattle, WA
October 30, 2000

I have been a naturopathic physician in private family practice for 18 years and have worked in an integrated setting since my graduation, first for three years with Chandra Sharma, MD, in London, UK and most recently with Fernando Vega, MD in Seattle. I am past president of the Washington Association of Naturopathic Physicians (WANP), 1995-1998 and have authored or been co-investigator on several peer-reviewed papers. (1) I was awarded "physician of the year" in 1996 by the American Association of Naturopathic Physicians (AANP) and continue to serve as an active member of the health insurance committee.

During my tenure as WANP president, the "All Category" Law came into force and mandated that all health insurance plans provide in all of their products sold in Washington State, unfettered access to all categories of licensed care for all conditions covered in the basic health plan; provided that said service is within the providers scope of practice. Naturopathic physicians have the third broadest scope of practice, next only to MD's and DO's. (2)

Prior to the January 1, 1996 implementation date of the "All category" mandate, I was invited to meet with the medical directors of several health plans to propose how our profession might be included into third party reimbursement. I stated that as we were qualified and trained in fully accredited naturopathic medical schools, that we were required to pass State administered naturopathic medical boards, that we were licensed and regulated by the State of Washington, that our educational curricula were at least as comprehensive and required at least as many contact hours as conventional medical (CM) schools, that for basic medical sciences we used the same texts used by CM schools, that we had overlapping administrators and instructors with CM schools, that we were covered by malpractice insurance to the same extent and by the same insurers as by our CM counterparts and that we were trained as primary care providers and designated as such by our State Secretary of Health, we should be incorporated into the various products marketed by the health plans on a "level playing field" with our CM counterparts. We recommended the following:

1) Direct access by patient choice to naturopathic medical services provided by licensed naturopathic physicians who function as PCP's, and
2) Reimbursement for those services equal to CM, based exclusively on CPT (procedure) codes, for all ICD-9-CM (diagnostic) codes, for all care provided within our licensed scope of practice.

We have attained direct access by patients to our services and comparable reimbursement from two of the largest health plans in the State of Washington. Other major health plans

have created obstacles for patients to naturopathic medical care and to equal reimbursement in four ways:

1) By limiting patient access to care to a restricted list of diagnoses; and
2) By limiting patient access to services rendered to an amount not to exceed a specified dollar cap (typically $500/year) of the combined value of services of all "CAM" providers; and
3) By limiting access to care by a requirement that the patient must be referred to a naturopathic physician primary care provider (PCP) by a CM PCP; and
4) By limiting patient access to a narrow panel (aka "network") of providers, in some instances administered without any discernible peer review oversight.

The naturopathic PCP and primary prevention model, in which as a licensed profession we have been schooled continuously for nearly a century, has been popular, efficacious and cost-effective here in the Northwest. It should be replicated throughout the United States. Additionally, it is recommended to the Commission that:

1) All licensed, accredited CAM services be reimbursable by all federally funded programs, and
2) CAM services be required to be delivered by providers degreed in accredited CAM programs, and
3) Funding be made available to form inter- and intra-disciplinary CAM peer-review committees, convened to advise insurers, regulators, hospitals and other entities. Such committees would then
    a) Make profession-specific recommendations and determinations regarding medical necessity, and
    b) Make profession-specific recommendations and determinations regarding utilization, and
    c) Orchestrate funded, profession-specific guideline writing.
4) Funding be made available to assure access to residency training for all CAM Professions.

I encourage the Commissioners to make these recommendations to the Congress and regulatory agencies at the national level, thereby helping all Americans enjoy the benefits residents of Region X enjoy: Reimbursable access to the licensed, credentialed, accountable health care providers of their choice.

Naturopathic physicians are educated to the same standards as CM providers in fully accredited naturopathic medical schools. Their health care services are an underutilized national treasure especially as our population is aging, and should be part of the solution set to heal an ailing national quality of health and an ailing national health care system. Thank you for the opportunity to submit testimony. Please feel free to contact me for clarification.

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Milliman testimony: Footnotes

(1) Milliman, W Bruce. Childhood immunity-review article. J. Naturopathic Med. 1994;5(1):44-50.

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(In press; to be submitted upon publication). Demographic, Training and Practice Characteristics of Licensed Acupuncturists, Chiropractors, Massage Therapists and Naturopathic Physicians in Four States.

(2) See Washington State RCW18.36A for scope of practice of naturopathic physicians; see "Issues in Coverage for Complementary and Alternative Medicine", January 2000, page 29 (published by the Washington State Office of the Insurance Commissioner) for the text of the "All Category" law, RCW 48.43.045.

#39

White House Commission on Complementary and Alternative Medicine Policy
October 30, 2000
Seattle, Washington

I am the clinical director of alternative services at Group Health Cooperative. Group Health is a consumer-governed HMO which was founded in 1947 and provides prepaid comprehensive, coordinated care to approximately 590,000 enrollees in the state of Washington. We are the largest consumer governed healthcare system in the nation. Since 1996 most of our consumers have had access to a program of covered CAM services, and my comments today reflect what we have learned in the last 4 years. I will briefly discuss 3 assertions and make several recommendations.

The first assertion is that consumers value CAM services and are looking to their conventional medical providers to guide them. That they value CAM does not need much elaboration, as it's the primary reason we are all gathered in this room today. But they are being bombarded with information that is often confusing, inaccurate or incomplete, and they want their conventional providers to be able to give them objective, reliable information. These providers need help in order to fulfill these expectations.

My second assertion is that health care systems and mainstream medical training facilities need to take primary responsibility for initiating the dialogue with CAM professions. In the face of an ageing population, marked increases in chronic conditions and rising dissatisfaction with conventional medical care it becomes obvious that no one system of care can provide all the answers. Taking the initiative will become easier once our experience in Washington has been thoroughly analyzed and broadly disseminated.

Assertion 3: collaboration precedes integration. There is far too much focus on the goal of integrated medicine without enough focus on how to get there. True integration requires major behavioral changes on the part of both CAM and conventional providers. This degree of change does not occur quickly and will require collaboration at multiple levels: At the most basic level patients and their conventional providers need to be comfortable talking to each other about CAM. Another level involves leaders of conventional and CAM professional organizations dialoguing with one another and being able to find common ground, such as the Clinician Workgroup on Integration and now the King County 2010 initiative. Most importantly, training institutions need to find ways to collaborate with each other. Within the greater Seattle metropolitan area are premiere training institutions for conventional medical professionals, naturopathic physicians, acupuncturists, massage therapists and licensed midwives. We have barely begun to mine this richness of resources.

Recommendations:

- Establish a clearinghouse for all CAM related articles published in peer reviewed scientific journals which would be easily accessible to all medical professionals (for example, an internet site with monthly updates)
- Work with the FDA or other appropriate agency to develop mandatory manufacturing standards for producers of herbal products
- Support efforts of CAM professions in guideline development, benchmarking and practice profiling
- Encourage conventional medical schools to require at least one course about CAM including observation of CAM practices and personal experience
- Encourage CAM training institutions to teach their students fundamental skills needed to work with health plans such as coding, billing and documentation standards.
- Fund analysis and dissemination of currently existing cost and utilization information to guide health plans contemplating CAM coverage
- Finally, involve consumers (including skeptics) at all levels of information gathering and decision making

Thank you for this opportunity to speak.

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