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**White House Commission on**
**Complementary and Alternative Medicine Policy**

**Town Hall Meeting**
**October 30-31, 2000**
**9:05-10:40 am**
**Seattle Town Hall**

## Welcome and Introductions

**GROFT:** I can't believe how many speakers we have arranged. It's going to be very very busy. I'm Steve Groft and I'm the Executive Director of the White House Commission and I can't welcome you to Seattle, but thank you for hosting us. It is truly our pleasure to be here. We started talking about this right before the Commission had its first meeting back in July and I really would like to thank the people here in Seattle and the King County 2010 Planning Committee and their council that have been working with us these many months.

We started virtually from not having anything scheduled for Seattle to what you see today. And I think you all have received an agenda and all the speakers, you can see the amount of time that has gone into trying to arrange a number of presentations. All subjects that are particularly important to the Commission as we formulate our recommendations and prepare them for the President, whoever it may be, in an interim report next July, and then by March 7th of 2002 we will submit our final report to the President and to Congress for their action.

At today's meeting, before we have introductions we expanded the Commission or the President did by amending the initial executive order for the Commission by adding five new members. And three of those are here today. Veronica Gutierrez, and we'll get back to all the people in just a minute; Linnea Larson; Dr. Ming Tian; and there are two others who are not present today, Dr. Donald Warren from Arkansas and Dr. David Bressler from Los Angeles, California. So they'll be joining us at future meetings.

I would encourage you to visit our Web site. I believe we have information in the package of information. Everything that we do will be up on the Web site, so the transcript from this meeting, is the transcriber here by any chance? We're missing a transcriber. We will do something, whatever we can, to get the information up. We may scan the written reports that we receive from you and put into the Web site. But please check out our Web site on a regular basis. You can keep up with what's going on as well as write us and let us know your feelings toward the different issues. We will also put up the interim report for you to comment on and we will revise the report per your comments at that point.

We do have a limited number of slots for individuals to speak. I don't think there are a lot, but if you're not scheduled to speak and you would like to have about three minutes I think it is at the most, please register at the desk and we'll fit you in one of these two days, a very short period of time, so take advantage of that if you're not scheduled.

We will do the same tomorrow, except tomorrow we start at 8:30 and end at 2:00 so that there will be slots available at that point also.

At this point I just would again like to thank you for coming to make our trip successful. We can come here and nothing can happen, but it's only through your participation and your efforts to give us information that we can learn the tremendous strides in activities that have been going on here within Seattle, Washington, and Oregon, really has been tremendous. And I think that was one of the reasons that led us to come out here. It just has been tremendous. I want to just thank Sheila Quinn in particular for all the work that she has done. She has been really outstanding. Pam Snider and Lori Bielinski, three of the people who worked on very very early to help us get started. And there are several other people who you will hear from later today.

So at this point I'd like to turn it over to Dr. Jim Gordon, our Chair, and he'll take us through the next two and a half days, or two days. Thank you.

**GORDON:** Good morning everybody. Before we begin, let's just sit for a moment quietly. Thank you.

Our work here is about being present to you, with you, with ourselves. And so we begin the Commission meetings sitting quietly so that we can truly be here, letting go of the outside and being here for each person who is going to come be with us.

It's really been wonderful so far these last few months with the Commission. We've had an extraordinarily interesting time. And what we're finding as we reach out to people all over the country and ask them to come, people, like those of you who are here, are saying yes. It's time to really take a look at what so many of us have been doing for the last 30 years or 20 years or 10 years. Let's see where we are and let's see where we need to be going. And our work, as you heard from Steve, our work is really to take what we will learn here today, tomorrow, what we have been learning, what we will learn over the next year and some, and to digest it, assimilate it and then to offer it back to all of you for your thoughts, critique, and then hopefully to offer it as well, not hopefully, to offer it as well to the President and to Congress as concrete recommendations for the directions that we should move in to make a kind of comprehensive health care. One that is informed, not only by specific complementary and alternative medical practices, but by the world view and the philosophy that is embodied in those practices. To make that kind of health care available to everyone in the United States. So we have a large and really very joyous mission, and it's great to be working with you on it.

It's wonderful to be here in Seattle. I've worked in Seattle now for 25 years. I used to come out here and work with youth advocates, with runaway and homeless kids on the streets of Seattle. So all kinds of memories come back and it's fun for all of us. We had to limit the number of commissioners who could come, partly because people wanted to come to Seattle and partly because everybody was so, to use a technical term, blown away, by the response and by the response of your community and of leaders in your community to the Commission coming here. There is a sense of tremendous excitement that we have, that all the Commissioners have.

Because there has been such a great response, we are going to have to be a little tough minded up here and ask you to be tough minded too in presenting, those of you who are going to be presenting to us. And we're going to stick very carefully to the time limits here. On my right I have Michelle Chang who used to work as a bone breaker back east and she is going to be, she may look very gentle and nice, but underneath. And she's going to be making sure we all stick to the time limits. So what we really passionately want to hear from you is what's the essence of the message. And as we ask questions, we've said we've learned from previous meetings it's

important for us to have time to ask you the questions and for you to give the answers that will help to guide us as we move ahead.

We'll have panels of four or five people and after each, we won't ask questions after each speaker. We'll ask questions at the end of the panel. And we'll have about eight minutes. And all of the Commissioners will have an opportunity to ask questions.

I'd like to introduce my fellow, that's not quite right, my brother and sister panelists. And each one from the right will just say a word or so of greeting. First, Tom Chappell.

**CHAPPELL:** Good morning. I'm Tom Chappell, the co-founder of Tom's of Main. I'm very interested in being with you this day and a half to hear the content of your stories, your experience and your real convictions about this topic. So what you have to share will be very meaningful to what we can take back.

**GORDON:** Thank you, Tom. Tieraona Low Dog.

**LOW DOG:** I'm Tieraona Low Dog. I'm from Albuquerque, New Mexico. And I love Seattle and I've been fascinated with what's going on up here in your state of Washington and how you're addressing the issues around complementary and alternative medicine. So I think you have a lot to teach us today. And we certainly are here to learn and share in what your experiences are. So we want to thank you for letting us come to your community and coming out to help us.

**GORDON:** Effie Chow.

**CHOW:** I'm Effie Poy Yew Chow, President of East West Academy of Healing Arts in San Francisco. And Seattle is kind of my second home and so your comments and your creative thinking will be very essential for us, and thank you for having us here.

**GORDON:** Veronica Gutierrez.

**GUTIERREZ:** I'm Veronica and my husband and I have been chiropractors in Washington state for 37 years. We've seen a great shift in consciousness over those years towards complementary and alternative medicine and I'm just excited about being a part of taking it even one step further.

**GORDON:** This is Michelle Chang who is our Executive Secretary, and Steve Groft is our Executive Director. Linnea Larson.

**LARSON:** My name is Linnea Larson and I have been working as a social worker. I'm very pleased to be here. My particular interest is in really hearing with discernment what you have to bring to us, specifically with reference to doing anything with the underserved.

**GORDON:** And Xiaoming Tian.

**TIAN:** My name is, everybody call me Ming, it will be very easy. I was trained as a sports medicine orthopedic and a bone pathologist and I am interested in Chinese medicine and I was trained as an acupuncturist and herbalist in China and practice in Bethesda and I am the director of the Academy of Acupuncture and Chinese Medicine. And ten years ago set up the first

acupuncture clinic for acupuncture. So besides our clinic and we handle about 10,000 patients every year, visits. And also we serve acupuncture for NH patients starting in 1991. We have a grant of research for fibromyalgia so we treat fibromyalgia patients. And also we have done the study of Chinese herb to treat arthritis, fibromyalgia and osteoporosis post-injury. Thank you.

**GORDON:** And Joe Fins.

**FINS:** Good morning. I'm Joe Fins. I'm a general internist and medical emphasis from New York and just want to add my thanks and my great delight in being here with you today. I think we're going to learn a lot, and this is really in many ways the epicenter of this kind of practices in the entire country, so we're really thrilled to be here. So thank you.

**GORDON:** Thank you all very much. And I guess I'm Jim Gordon. I'm the Chair. Aside from being a frequent visitor to Seattle, I'm a physician in Washington, D.C., a psychiatrist, and I work with Chinese medicine, nutrition, meditation, herbalism, western herbalism, manipulation, many things. So I feel very at home in nature and at home in the natural climate in the Northwest.

We're going to begin by introducing four speakers who are going to set the stage for us today. Richard C. Kelly, Robert Harkins, actually it's more than four, four groups of people, and from the King County Council, is it Maggi Fimia, Kent Pullen and Greg Nickels, and Joseph Pizzorno. They're all each going to come up there? Okay. So maybe they can sit at the table and then come up one by one.

## Opening Remarks

**KELLY:** Good morning ladies and gentlemen. On behalf of the United States Department of Health and Human Services I'd like to welcome you all to this White House Commission on Complementary and Alternative Medicine Policy town hall meeting. I would like to extend a special welcome to Region X to our White House Commissioners. We'll be spending two days in Seattle. They still have a little bit of cultural adjustment to make. Dr. Fins, a place that has as many earthquakes as we do doesn't really like to be called the epicenter.

**FINS:** Thank you. I was just trying to be nice.

**KELLY:** I particularly want to welcome all the individuals that have come here today to testify. Your comments and testimony are very important to the success of this venture, as the Commission will ultimately be making recommendations for national policy. I regret that some of our Washington state legislators and other officials who are interested in being here could not be due to their required attendance at the Washington State legislative conference and I bring their apologies.

As you all know, the task of the Commission is to provide to the Secretary of Health and Human Services, Donna Shalala, my boss, recommendations that can be transmitted to the President for appropriate administrative and legislative initiatives to improve the health care and wellness of all segments of the United States population. By signing the Executive Order 13147,

President Clinton lifted the issues related to complementary and alternative medicine, CAM, to the highest levels of consideration in the federal government. Today we all have a very interesting and important opportunity through the partnership inherent in this Commission's structure to fulfill the purpose and spirit of the executive order. I look forward to hearing the testimony today on how we can assure that public policy maximizes the benefits to Americans of complementary and alternative medicine. Issues such as increased research on CAM practices, delivery, and access to CAM services, dissemination of information to both providers and consumers, licensing, education, and training of providers, and reimbursement for CAM provider services will all be addressed in these hearings.

The Northwest is a unique environment for the integration of conventional and complementary and alternative medicine. The confluence of cultures which enriches our region has also contributed to the cross fertilization of health traditions. In the next two days you'll be hearing testimony about our unique history and partnerships. And I would urge the Commission to carefully consider the testimony of a region that has taken a real leadership role in the integration of conventional and complementary and alternative medicine.

I am very proud of the contribution that HHS Region X Regional Health Administrator Dr. Richard Lyons and Deputy Regional Health Administrator Karen Matsuta have made to this work.

It is also my hope that the Commission will work in concert with the goals and objectives of Healthy People 2010. This is our department's blueprint for our nation's public health. Healthy People 2010 seeks to increase life expectancy and quality of life as well as to eliminate health disparities among different segments of our population. These differences occur by gender, race or ethnicity, education or income, disability, living in rural localities and sexual orientation. Our department is dedicated to bring equal access to comprehensive, culturally competent, community based and integrated health care to every person in every community across the nation, especially those who are now uninsured and undeserved.

Health traditions individually have roots which go thousands of years deep. But our journey together is just beginning. I thank you all for coming to participate and I thank the White House Commissioners for contributing their time and energy to this effort to create a more integrated health care system for all Americans in the first decade of the twenty-first century.

**BIELINSKI:** Good morning. On behalf of Washington State Insurance Commissioner Debra Seen and Chief Deputy Robert Harking who is home ill, I want to express thanks to the White House Commission on Complementary and Alternative Policy for selecting our state as a site for one of your town hall meetings. Washington State's Office of the Insurance Commissioner has played a founding role in the efforts to integrate health care. But we should also give credit where credit is due. Washington's health care consumers are among the nation's effective advocates for access to complementary and alternative health care. Credit them for providing the support to policymakers that led to the passage of the nation's first law that guarantees access to CAM providers within health insurance plans. That law faced a long and determined challenge from the insurance industry, but Commissioner Sean's strong advocacy for this legislation never wavered and ultimately the U.S. Supreme Court upheld its implementation. In addition to its landmark access law, Washington has the greatest number of regulated CAM professions: acupuncture, doctors of chiropractic, dieticians, massage therapy, naturopathic physicians, and licensed midwives. But even in our state we are still only at the threshold of a new health care

era. For that reason the White House Commission's work is timely and important, developing recommendations for practitioner education and training, coordination of research, getting research data to health care professionals, and finally, providing guidance for appropriate access to the delivery of CAM medicine.

What we see here in Washington is the public's continued call to insurers and providers to end what they see as increasingly irrelevant decisions in the health care system. We see our mission as one that listens to that call, and we are pleased that the White House has heard it as well. Each day brings new discoveries and treatments. Our opportunity as public officials and policy makers is just to facilitate access to that care and for the benefit of America's consumers. Thank you for listening.

**NICKELS:** Good morning Mr. Chair, Commissioners, ladies and gentlemen. My name is Greg Nickels. I'm an elected member of the Metropolitan King County Council and I chair the King County Board of Health. My role today is simply to welcome you to our region, to our fair city here, and thank you for honoring us with your presence. I was very pleased in looking through the schedule that you have set out for the next several months at the number of stops that you are going to make throughout our great country.

I am a local politician. I believe in action at the local level. And I believe that by taking action at the local level we make it safe for our states and our national government to take a look at innovative and new policies. We've done that here in King County. Our Board of Health has existed since 1996 and I've had the honor to be Chair of the Board since that time. We were one of the first, we think perhaps the first, Board of Health in the United States to have a naturopathic physician as a member of our Board of Health. We're very proud of that and you're going to hear from him in just a moment.

But we also, as a King County Council, are very proud of some of the investments that we have made to explore natural medicine, alternative medicine, complementary medicine, and to find ways to integrate traditional medical practices known in this country with those alternative and complementary medicines. And you're going to hear about that today.

Our Council has heard from the 1.6 million people that we represent that our constituents want to make informed choices about how to have a healthy lifestyle and a long and healthy life. Two of the leaders on our Council are going to be here and participate with you today and tomorrow. And I'm very pleased to introduce one of those, Council member Kent Pullen. Thank you.

**PULLEN:** Thank you. Again, I'd like to echo Council member Nickels' comments and welcome you, Mr. Chairman and members of the Commission. My job this morning is to welcome you and everyone else here today. I want to thank all the attendees, I want to thank our wonderful staff who worked so hard to make this a successful event, and particularly the Commissioners who have come such a long way to be here. I am a panelist down as item number seven, so I'll be making some of my technical remarks at that time.

But for now I want to reemphasize the fact that the Seattle area has been a beacon that has lit the way for the rest of the country with regard to health care reform, improving health and reducing the cost of health care. We hope that we'll be able to provide you with information on what we've accomplished and that you'll take that knowledge back with you.

All of you are very powerful and influential commissioners. The recommendations that you will be making will have a profound effect on health care in our country for years and years to come. So your presence is very much welcome, and I, too, would like to thank my colleagues, Council member Greg Nickels, Council member Maggi Fimia, who have been such wonderful leaders at the local level. Again, thank you all, and if any of you Commissioners need any help from us in any way, please let us know. We're here to help. Again, thank you very much, and welcome.

**PIZZORNO:** Good morning Dr. Chair and Commission members. Welcome to the Northwest. We're honored and excited to have you visit with us these two days. Many organizations in the Northwest have worked very hard together the past two months to prepare for you what we hope will be an interesting and informative two days. And I would particularly recognize the organizations that provided the funding and personnel. King County 2010, King County Council, Region X Public Health, Bastyr University, The American Massage Therapist's Association Washington Branch, The Washington State Chiropractic Association, and the Washington Association of Naturopathic Physicians.

We worked very hard to facilitate all the invited speakers making their presentations in the context of the four categories that you've been mandated by Congress to cover. And through this presentation of information we hope that you will hear fourteen key things that we think are important for you to develop recommendations for. Now before I mention those fourteen things, I would also like to mention that we also hope that you will see here the importance of broad collaboration in making something of this nature possible. You will see collaboration at the local, state, and regional levels of governmental bodies, regulatory agencies, academic institutions, practitioners, public health officials at organizations and payer organizations. We've all been working together for what we hope you will find of interest.

So those fourteen things:

1. CAM is about systems of healing, not isolated therapies. Natural medicine is defined by its philosophy, not by modalities, or by the substitution of green drugs for synthetic drugs. These systems change what we think about and provide health care.

2. Disintegration movement in the Northwest is not only about . . . CAM, it is about mutual collaboration to create a true health care system. Not about limited disease oriented system that today dominates health care thinking and resource allocation.

3. We urge you to do everything you can to facilitate collaboration. And this collaboration is not just about conventional practitioners and CAM practitioners working together, it is also about full integration of public health officials, regulatory bodies, payers and governmental agencies.

4. Research. Research outcomes first, not isolated therapies. CAM is multifactorial. Patient satisfaction quality of life are critical measures. Just as we as a society have reaped tremendous benefit by a huge investment in conventional medicine research, similar benefits will be found by investment in CAM research. Again, the CAM research must be about outcomes, not about single therapies.

5. Level the playing field. Disparity between CAM and conventional medicine education research maturity are directly due to the disparity in federal funding for those activities.

6. Strengthen accountability. Accountability and standards are critical for public safety. Support activities that communicate and respect existing standards in emerging professions and

fund activities to improve and further develop those standards. Those standards need to be strengthening the accreditation, practice guidelines, education, not only of CAM professionals providing CAM therapies and CAM interventions, but also conventional practitioners who want to use CAM therapies or CAM systems of healing, they need to have appropriate education. We would have national certification boards with credible testing and credentialing processes.

7. Although this may sound somewhat like number six, it is a key issue here, and that is, we have a great need for appropriate nationwide regulatory standards. We need to have uniform licensure, regulation, and public safety. We need to have national board exams. We need to collect and disseminate information about state regulatory models that are working so that other states can adopt those same kinds of regulatory models. As you are aware, the Constitution delegates to the states authority for the regulation of the practice of medicine. We need to provide advice to those states about how best to do that. We need to develop federal guidelines so that the natural lifestyle of emerging professions can be accommodated and facilitated. Although chiropractic medicine, acupuncture and naturopathic medicine and massage are well developed in this country, there are other natural healing arts that are trying to emerge in this country, such as aervada. We need to provide methodology by which they can develop. Right now the environment is hostile for new professions.

8. We need to help the CAM professions mature. We need to facilitate the development of practice guidelines, credentialing systems, peer review processes, inclusion in federal programs, infrastructure of CAM institutions. A huge challenge here. And if this body of knowledge is to provide health care opportunities that it can, we need to facilitate these processes.

9. We need to deeply engage CAM professionals at all levels of evaluation and decision making. CAM professionals have considerable and sophisticated expertise. They need to be utilized. All health related committees and advisory boards should include CAM regulators or CAM practitioners or researchers as expert advisors, consultants and/or researchers.

10. True integration and collaboration require joint training programs in clinical properties. Practitioners who train together practice together. It's been well demonstrated in conventional medicine where practitioners train together they will practice together. We need to do the same thing to include CAM professionals. We need to support strategies for expanding integrated care settings in which conventional and CAM providers practice side by side, learning from each other and being jointly committed to improve the quality of the care they provide.

11. Include special needs populations. Right now too much of the access to these forms of medicine is limited to those who can provide for it out-of-pocket. That means the underserved, the poor and uninsured, those with special health problems, like HIV and AIDS, the elderly and such, do not have access to the services which can be of benefit to them.

12. The reimbursement system needs careful reconsideration. The problem is right now the reimbursement system pays for disease treatment and yet we need to develop a system that pays for health promotion. Right now even when health promotion is covered, if you look at the codes you get paid less per minute of time to provide prevention services than for diagnostic and therapeutic services. This is ridiculous, we need to change that. We also, as we go through the reimbursement system we must fully engage the payers net process. We can't simply impose a process on it from the outside.

13. There is a critical need for accurate information for the public and professionals. We need to develop content databases that validate intervention and ethicacy and safety of interventions, systems of healing and particular therapies. We have a good process for adverse

events reporting and monitoring and we need to establish systems to disseminate information about these therapies so that practitioners and the public will know what is safe and what is appropriate.

14. We have a critical need for natural product quality assurance programs, either public or private. While most of the products out there are safe, reliable, and effective, too many are not safe, reliable, and effective. And we need to develop methodologies to ensure both practitioners and the public have good quality products that are safe for the public.

So finally, ultimately good health comes from personal decisions which means it's absolutely imperative that public health be fully engaged in the new health care . . . as we develop it. As you know, we spend 98 percent of our health care dollars on interventions and only two percent on public health. And yet the benefits derived from public health far exceed those of interventions. We must engage public health fully.

So at the end of these two days I think you will see the value of collaboration, recognize the importance of standards and accountability, and see that this remarkable phenomenon in the Northwest is not only about integration or leveling the playing field, it is about a shared vision to create a true health care system and not be limited by our current disease stricken system. Thank you.

**GORDON:** Maggi Fimia. Maggi is it? Sorry, please.

**FIMIA:** Good morning Commissioners, members of the audience, my name is Maggi Fimia. I'm one of the County Council members from the King County Council and am delighted, absolutely delighted and honored that you are all here this morning. One of my favorite expressions in the whole world is "believe everything or doubt everything, there's two ways to slide through life. Believe everything or doubt everything, both ways keep us from thinking." We are at a point in this world, I believe, in this region and this country where we are recognizing that we can no longer just believe everything or doubt everything. That the decrease in the quality of life and the escalating costs of criminal justice, transportation, environment, and health care are forcing us to start looking and listening and sharing with each other as to what is best and not to continue to doubt everything or believe everything. We need to let go of some of our beliefs and we need to hold on and adopt new ones. And through that deliberation that you are engaging in at a national level and that we are engaging in at a local level of sharing with each other we will come to recognize all those grey areas of great wisdom that we have collectively so that we can deliver better health care, more sustainable health care at a much lower cost, now and in the future. And I think that's what this exercise is going to be all about.

I got a phone call a few weeks ago from the appointee that I appointed to the Harborview Board of Trustees. Harborview is our regional hospital here, emergency trauma hospital, that we're very very proud of. And we just approved a ballot measure to be able to do retrofitting for seismic retrofitting and to increase the number of beds. I got a phone call from my appointee on that Harborview Trustee Board asking me to please support putting this on the ballot, which of course I did. My appointee is a naturopathic physician. That never would have happened five years ago, ten years ago, twenty years ago. And here this naturopathic physician was calling me to ask me to please support this incredibly important traditionally medical establishment.

I also got a call from a physician, a medical doctor, who is engaged in doing research on the importance of activity and nutrition and social interaction for seniors. He's engaged in some

very significant research. He used to be the medical director at Harborview and now is doing this work with seniors in conjunction with senior centers to demonstrate that importance. Again, never would have happened five, ten, twenty years ago.

I'm a former registered nurse, former Lamaze teacher, formerly married to a naturopath who has now defected and become a medical doctor. And when we set up practice 25 years ago in Hood River, him as a naturopath, me as a child birth educator, no one knew what naturopathy was. The American Cancer Society and the medical societies were all absolutely discounting the importance of nutrition, for instance. They discounted that had anything to do with cancer, diabetes, heart disease. We were just shouting in the wind. Now that's established fact.

There is much work to be done. I think we need to celebrate during these next two days what has been accomplished and then outline what we can do together in the future. I welcome you and I welcome that discussion.

**GORDON:** Thank you all very much. We appreciate it. Will you be coming back to talk later, Joe?

I'm just curious, before, if anyone wants to ask Joe Pizzorno a question or two, especially the new Commissioners who didn't have a chance to speak with him in Washington. Any questions at this point? Okay, we'll catch you later. Thanks so much, Joe.

Would the next panel please come up. It will be Richard Lyons, Dorothy Wong, Gail Zimmerman, Henry Ziegler, and Kathy Abascal. If I mispronounce you can correct me. I'm always interested in how to say it right. And what we'll do is each person will speak in turn in the order that's listed in the program. I think that will make it easiest. So just keep of track of it for yourselves. And remember, we'll have a chance to ask questions after all of the panelists have spoken. Richard Lyons please.

## Speakers

**LYONS:** I'm Dick Lyons. I work for the Department of Health and Human Services as the Regional Health Administrator and my boss is Dr. Dick Kelley who just gave a greeting. It's a pleasure to be here. We're very excited to have all of you here and you're going to hear some exciting things from our colleagues in the next two days.

I'd like to give you just a little perspective of this region, which is the states of Alaska, Idaho, Oregon, and Washington. It comprises about 22 percent of the surface area of the whole country. In that surface area we have distributed about three percent of the U.S. population, so we are a rural state. We have tremendous examples of poverty and underserved communities in this region. It's a tremendous importance to us. Particularly the Native American population, which we have approximately 20 percent of the total Native American population in our region in almost half of the federally recognized tribes. So we're very interested in that particular underserved population. And also in the immigrant population, which is ever growing in our communities. And many of these populations are very interested in CAM services and indeed the general interest in CAM services has increased in our region very rapidly over the past few years. So I think we have a number of unique things about our region.

We also have a number of unique activities going on here which you are already aware of from hearing Dr. Pizzorno give you his long list of things. And many of those are going on right

here in this community. I'd like to make a couple comments about the training programs and give you an idea of the number of licensed individuals practicing CAM services in our region. I think it's fairly incredible that we have virtually all of the training programs for the CAM professions here in our region. One school for chiropractors in Portland and we have about 3,700 licensed chiropractors in our region. Two of the three naturopathic schools are here in our region. And we have approximately 900 practitioners licensed now. We have four licensed midwifery schools and approximately 140 current licensed practitioners. We have five acupuncture and Oriental medicine training programs which have provided a large part of the graduates that are now licensed approximately 1,100 in our region. And finally massage therapy training programs, we have about 12,000 licensed massage therapists in our region. So we have a lot of practitioners.

The reimbursement issue is very important. We have some incredibly important activities, both in the state of Washington, which Lori has already mentioned, a mandated program. We have a nonmandated but fairly successful program for reimbursement by the major insurers in Oregon. I think a really exciting thing in this state we have the first state that has designated service for CAM providers, particularly naturopaths and licensed midwives to practice in underserved communities and extend the loan repayment service to them. Which I think is a good model for us to consider for the rest of the nation.

The research components are strong here. Both our major allopathic medical centers in Portland and in Seattle have working relationships with the CAM schools in their communities. They need to be strengthened but they're there. They're embryonic and ready to grow. And of course Bastire has its own research program.

Washington's tremendous gains in dealing with issues relating to CAM providers has been amplified by Maggi and also by Joe Pizzorno and I think I don't need to mention that any more, but I think it's exciting that there are many involvements of CAM providers in this community.

I'd like to conclude with pointing out some of my feelings about what we need to do. I think we need to develop a list of critical community assets that support the development of CAM practices, and we have many of those in our community. Joe has mentioned a lot of them, and I've referred to a few of them. I think we need to perfect that list and then find ways to strengthen and develop those assets in communities so that CAM activities can proceed effectively.

And I mentioned extending the federal laws to include loan repayment for some of the CAM professions in underserved communities. I think that would do a lot of good, particularly for the younger practitioners coming out, of which we obviously have a lot in our region.

And finally I'd like . . . also support the notion that Dick Kelley gave about focusing activities in CAM on Healthy People 2010 because CAM providers often deal with lifestyle and behavioral issues which are the crux of Healthy People 2010. And I think we must learn how to reward and reimburse practitioners, both CAM and allopathic physicians, in the service of health and human behaviors and changing lifestyles. It's critical. It's the new wave of public health and it's something we have to do with great enthusiasm. Thanks a lot.

**GORDON:** Thank you very much.

**White House Commission On Complementary And Alternative Medicine Policy**

**October 30, 2000**
**10:40-11:40 am**

**WONG:** My name is Dorothy Wong and I'm the Executive Director of the International Community Health Services, a community health center that primarily serves the limited English speaking Asian and Pacific islander immigrant population in Seattle and King County. Alongside Allopathic Western Primary Medical and Dental Care we provide traditional Chinese medicine . . . services which include acupuncture . . . herbs and cupping. I have three main issues I would like to bring to the Commission's attention.

The first, complementary and alternative medicine is a very common practice among Asian and Pacific islander immigrants. Given the access failure to mainstream medical care, including lack of insurance, need for interpretation, limited knowledge about the medical care system, immigrants will often choose the more costly familiar ethnic health care practice such as acupuncture, herbs, massage, cupping, corn rubbing, traditional healers, etc. Research needs to be funded to accept the practice of these traditional methods, particularly looking at any interaction with concurrent allopathic medicine as well as the potential hazards and benefit of the traditional practices themselves.

Second, acupuncture and herbal medicine research cannot be taken out of context from their cultural background. Much of current research is done under the gold standard of randomized trial. This means that treatment must be standardized in order to compare treatment options. But traditional acupuncture and herbal treatment cannot be standardized for neck pain, for example. Since the treatment would be individualized according to specific imbalances in energy flow of the different body meridians, traditional Chinese medicine would involve a different treatment for each individual presented with the same problem. Unfortunately, much of current research being funded does not allow for these traditional means of diagnosis and treatment . . . standardize the therapy. Other research methodology will need to be developed to accept these therapies in their cultural context.

Finally, complementary and alternative medicines seem to be of benefit for the wide range of conditions that are not well treated by allopathic medicine. Chronic neck and back pain, neuropathic or nerve related pains, chronic tendinitis or irritation in tendons, such as tennis elbow, pregnancy related nausea and vomiting are some of these conditions. These conditions are not easily or successfully managed with medication or the side effects of medication have significant complications in themselves. Access to complementary and alternative medicine needs to be available and consistent. In California, for instance, work related injuries and Medicaid patients have coverage for complementary and alternative medicine. But in Washington state these same patients are not covered for these services.

Traditional Chinese medicine could be similarly covered from state to state. Practical guidelines for common ailments could include and integrate complementary and alternative medicine with allopathic medicine, particularly for these chronic conditions. Reimbursement for

these services could uniformly be covered following these practice guidelines. It would allow for provider and patient option in managing of these conditions. Thank you.

**GORDON:** Thank you very much. Gail Zimmerman, are you going to speak at this point or not? Okay. Henry Ziegler.

**ZIEGLER:** Good morning Commissioners. I'm Henry Ziegler, a public health and internal medicine physician. I'm proud to be here. My entire career has been underserved care and that's my passion. Internationally for many years and inner city Cleveland and in the last number of years as head of prevention at the Public Health Department here, Seattle, King County. I'm currently the Community Based Planner for the Lumi Indian Nation of which I am very proud. And I also teach at Bastyr in public health and do research there and do teaching at the University of Washington School of Public Health.

From that bases then, the following recommendations. In order to successfully address the health disparities and the needs of our poor and underserved we need all of the resources we can get. That includes our CAM professionals who are now not available in many cases. Showing of hands from my Bastyr medical students, over half were interested in underserved care. When I've done the same thing at University of Washington in previous, at Case Western, I run 20 to 30 percent. So there's more interest.

How do we get them involved? Well, first we have to make it feasible for them to do it. And that's called loan repayment so they can work in underserved areas. Second, we have to have Medicaid and Medicare coverage so they can continue to work there. Then we need to do research to look at their roles in primary care in underserved areas because if we don't know how they fit it's very difficult to get anybody to gamble to put them in the fit.

Shifting to the broader issues and what Joe was saying about collaboration, partnership is critical. We're very excited about a partnership we're developing with pulls together Northwest Indian College, Bastyr University, Region X HHS and other partners, nonconventional partners if you will, we're trying to break the bonds because we want the representatives of the underserved communities working with the CAM providers and with ourselves to make things work.

In addition to those kind of pieces we need to not simply train the conventional practitioners in CAM approaches, but use the CAM professionals with their whole paradigm shift, their whole looking at things from a different vantage point. We need to train our CAM providers in public health. They already have a holistic wellness approach. What they lack is the sense of the community as their patient, in addition to the individual and the family. As you do that they become fabulous public health practitioners. And finally, our minority communities are comfortable, as you're already hearing with CAM, because they partner well, and that partnership needs to be led by those committees themselves, not by us. Thank you very much.

**GORDON:** Thank you very much. Kathy Abascal.

**ABASCAL:** Hi, I'm Kathy Abascal, the Executive Director of the Botanical Medicine Academy. The BMA was formed on the premise that all health care professionals who use Western herbal medicines should work together. And the BMA is an umbrella organization that brings together all of the health care practitioners that use these botanicals, that is, M.D.s, N.D.s, osteopaths, midwives, pharmacists, nurse practitioners, herbalists and others.

Our mission is to enable consumers, governmental agencies, insurers, and other interested parties to be able to identify practitioners who are expert in the use of Western plant medicines. The BMA is urging this Commission to recommend a policy that supports and helps fund the creation of a voluntary national standard, perhaps through a national clearing house, for the practice of botanical medicine, a standard that cuts across professional categories and maintains the focus on identifying the quality of knowledge that practitioners offer the public.

Health care under our legal system is primarily the concern of the individual 50 states. However, this model presents unusual problems in CAM because so many different types of professionals use herbs. How can we accomplish reliability if standards differ, not only state to state, but from profession to profession? And how do we achieve a standard for Western herbal practice that also allows traditional healers to continue their practices? The BMA believes the public can achieve this reliable standard through a voluntary exam that measures only knowledge of the use of Western medicinal plants. After all, consumers should be able to assume that all practitioners prescribing herbs have the same degree of knowledge about the plants they use.

The BMA, working with the American Herbalist Guild, will this fall offer the first exam that measures that knowledge. The first exam will be directed to advanced clinical practitioners, but we will soon be offering a basic exam to practitioners entering the field. These exams will cover usage, dosage, side effects, interactions with other medications, quality of products and other such topics. The resulting certification will empower consumers to access quality information about the herbs they want to use. And it will set a bench mark that schools can model their educational programs to and give the government a single standard to monitor.

A policy decision to support and fund a single voluntary standard for all professionals will help the public enjoy the benefits that alternative medicine has to offer. Thank you.

**GORDON:** Thank you very much. I think the way we'll do questions is we'll start from one end and move on up. It's easier and then each in turn, if you'd like to ask questions please feel free.

**Questions from Commissioners**

**MAN:** I have a question for Dr. Lyons. Dr. Kelley spoke about health disparities and it has been a theme that has come up and Ms. Wong has some data here on utilization of services. Has your region access to any systematic look at utilization with a specific focus on health disparities regarding CAM therapies in the region?

**LYONS:** Yes, we have access to a lot of information about that through our associations with the CAM schools. And actually my office has funded two special projects to look into the health disparity issue in underserved populations. So those activities are at Bastyr so we're very closely connected to it. And one thing that I probably didn't mention in my testimony is that I think the crucial thing that we have in this community in terms of an asset is a close working relationship. We've met with each other for a number of years. Some of that is going to be brought out in future testimony, and we're connected. We talk together, we have fun together and we're becoming close associates just in the last few years. I think in like about three or four years. And so we exchange information a lot and we collect sources of information relevant to extending the services into the underserved communities.

**MAN:** Regarding you mentioned that massage therapies, you have 1,200 in this state. How do you get registration? For instance, what is training program to be registered if it's not a license?

**MAN:** I'm sorry, Doctor, I'm not the expert on that. I think Lori Bielinski would be because she's a massage therapist and works in the insurance commissioner's office so I really can't answer that question.

**WOMAN:** This is actually to Dr. Ziegler. The data that you have been collecting on utilization and poverty in the underinsured or underserved, how long have you been looking at that in a collaborative way? One year? Two years? Three years? Is this a recent phenomenon.

**ZIEGLER:** We've actually just started the process. And what we're doing is an apprec(sp?) inquiry survey of Bastyr and Northwest Indian College. If you're familiar with apprec(sp?) inquiry you look at what's working, why it's working, and a vision of the future. And it's much more powerful than looking at the problems and trying to build from there. And so we're doing that in terms of the public health activities within Bastyr, within Northwest Indian College and then looking at how we can create through that combination a stronger career ladder for our Indian community, as well as stronger public health entities within both Bastyr and Northwest Indian College.

**WOMAN:** Thank you.

**GUTIERREZ:** After 37 years I didn't know there was a Northwest Indian College, so that's helpful information.

**GORDON:** Effie.

**CHOW:** I appreciate all the deliveries very much. Being in Washington the Northwest is in a leading field of the development that we are looking for models in which we could perhaps look at and pattern and I would like to ask if it's possible for you, Dr. Lyons, and the others, to present a more detail of how to. How did you reach this progressive state and perhaps be helpful to us as Commissioners in a more detailed forum. I really appreciate the creativity that has happened here.

**LYONS:** I'm sure most of us would be very eager to do that. We enjoy having those kinds of discussions and sharing information and we would entertain that. I think that, I like the concept of assets which I mentioned, and I think there's probably a critical number and type of assets that need to be in a community to make a really good environment for the advancement of CAM issues. And I think we just happen to have a lot of them here. And we've enumerated some of those. And I think getting a good list and figuring out which ones are the most important assets is a real critical step. And we'd love to work with someone about that.

**CHOW:** Perhaps we share some of those secrets.

**WOMAN:** I appreciated all the comments as well. I have a question for Dr. Lyons and Dr. Ziegler. Coming from New Mexico, I'm also from a very large underserved state and as a physician have worked in those areas. I am curious that naturopathic physicians and licensed midwives are being considered now, or are going into underserved areas and are being able to extend loan repayment or having loan repayment done, which I think is fantastic and a real step forward. But those are models that actually work within more of a Western paradigm, so they're easier to adopt. But I didn't hear anything about chiropractors or acupuncturists which also could benefit from that. I just wondered where that was at or if that's something that is being considered for underserved areas as well?

**MAN:** I'm sure that it is, and there are experts here that are going to give testimony on that loan repayment program that can answer the question much better. So I think we have probably refer to that. But I think they stick the first categories of naturopathy and licensed midwifery just because those were easier for them to deal with at the time and to get malpractice coverage and things like that. I'm sure their intention is to expand that. And I think it would be a good model to use in other parts of the country.

**MAN:** I concur, that's what my understanding is as well. This is the beginning of the wave, not the whole thing.

**MAN:** On botanical medicines, may I ask, is the process of establishing authority within the academy of what dosages, what clinicals, all of that research? Is it possible for you to establish an authority of where that standard should be? And secondly, do you envision that we would be able to project that same model into a regulatory world?

**ABASCAL:** In the exam context it's a bit easier because where there are disputes sometimes it's enough for the practitioners to know the different points of view and to explain them to their clients. And it's easier to test within a more open ended context of what might be appropriate, what the risks are, the benefits are. So we can test a knowledge base I think much more easily than we can actually create a hard standard that comes about when you try and legislate. And I think that is part of the reason a voluntary peer created and peer maintained system certainly initially provides such great benefit. Because we have all of the various professionals coming together, the experts in the field, finally articulating very specifically what we know, what we need to know, how we should test it and how we should educate it. And we're finding that just creating the exam has provided us with substantial knowledge that we were lacking previously as we tried to design educational programs. So it's a very interesting process.

**GORDON:** I have a question for Dr. Ziegler. I'm wondering if the guidelines for training CAM practitioners in public health, if you have those guidelines now and if we could have a copy of them?

**ZIEGLER:** I don't with me, but I'm sure we can get you the guidelines. And they vary again, the comment earlier about variety of CAM professions, you have a variety of CAM professions and so you're going to have different guidelines and certainly.

**GORDON:** I think this would be very helpful. What you're raising is a whole issue that would be very helpful for us to learn more about and the wonderful thing, as we listen to you is that so many of you and so many, I'm sure, of the people who will be speaking to us today have already taken the kinds of steps locally, and we really need your experience to help us shape national recommendations. So I hope that we'll also have that detailed information about the loan repayment forgiveness plan as well. That will be very helpful to us. Thank you all very much.

**Speakers**

**GORDON:** Next panel is Lori Bielinski, Kent Pullen, Alonzo Plough, and I'm still going to say, is it Maggi or Maggi? Maggi. I have a friend named Maggo, so, is your last name Italian?

**FIMIA:** Right.

**GORDON:** Right. Okay. That's my confusion. I'll surrender. First will be Lori Bielinski please.

**BIELINSKI:** Good morning. My name is Lori Bielinski and I'm a licensed massage therapist and a senior health care policy analyst at the Office of the Insurance Commissioner. In 1993 health care reform legislation was enacted in Washington that assured consumers could buy health insurance even if they were sick or changed jobs. Simultaneously, provider groups pursued inclusion of all licensed health care providers for insurance reimbursement within their respective practice scopes. To preserve the insurer's ability to select competent providers, the final legislation settled on the term every category without mandating inclusion of every individual practitioner. Subsequent revisions preserved these reforms and the Office of the Insurance Commissioner promulgated rules to implement that intent. An unusual footnote is that of the many sections of these reforms, this is one of the few portions of the law that remains. It has stood challenges in both the democratic and republican legislative majority, it has generated the most controversy, and is the most popular, as well as having been upheld by the U.S. Supreme Court.

There are specific criteria that must be met. The CAM professions must be regulated by the Department of Health with licensure or certification. The scope of practice must allow the provider to treat the condition that the patient presents. The provider must be contracted to be eligible for reimbursement. And finally, the patient must have benefits covering a condition that is within the scope of practice of the chosen practitioner. This is not an any willing provider law, nor is it a mandated benefit law. It allows consumers access to a choice of the provider who will treat the condition in which they are seeking care. Carriers have the right to credential providers as long as the standards are consistent with those established by the Department of Health. Carriers must not set network adequacy requirements, excuse me, they must set network adequacy requirements based on the number of covered lives in a jurisdiction where they are responsible for providing coverage. Carriers have the right to set the coverage limits, including services of CAM providers. The OIC has established rules that state these limits may not be unreasonable and may not be set by provider type but can be set by covered services. And the

carrier may not exclude a particular category of provider altogether, nor can it cover certain provider types only by a separately priced optional benefit.

Thus, it became very important to clarify to insurers, providers, and the public that the law relates to all regulated health professions and not just those considered those alternative. Additionally, the law does not mandate a benefit for anyone. It allows patients access to the provider of their choice for covered conditions.

The initial environment impacted by the threat of ongoing litigation. After many discussions, parties agreed how to establish a joint work group and hire outside facilitation. It was agreed that the OIC would convene clinicians from the carriers and the professional associations to focus on clinical issues. The full work group agreed that all decisions would be made by a planning committee made up of a smaller group of the whole to assure that all parties were represented in the decision making process. Participants included outside facilitation, CAM professional association representatives from acupuncture, chiropractic, dietician, massage therapy, licensed midwives, and naturopathic physicians, medical directors from carriers and CAM provider networks also.

In the second and third year we expanded the work group to include primary care physician organizations, educational institutions that train the CAM professions and the State Department of Labor and Industry's Our Workers' Compensation Program. The group's '97 work was spent developing trust, building working relationships and establishing agenda. The '98 agenda was very aggressive, including coverage decisions, technology assessment, medical necessity, and most significant was the training of CAM practice guidelines. The 1999 clinician work group activities were focused on the known integrated clinics and additional training on practice guideline development.

The most important deliverables were the final report which you've been handed out, and draft seed algorithms for at least one condition for each profession. They are in appendix I of the report with the stipulation that they are drafts and have not yet been tested, implemented, refined, or subjected to peer review. Each profession has been encouraged to continue develop algorithms using the peer review process.

In this process we learned that developing trust and understanding of each other's language was critical to a positive outcome. Continuous representation assured participants that everyone was invested in the process and could build on those relationships. We believe that the next step should include research, not just of clinical efficacy, but of true utilization of CAM services in conjunction with or in replacement of normally covered conventional care. Case management considerations should be addressed, and education of all entities is the most important byproduct of such an effort.

Finally, a national forum of this caliber or multiple forums in several locations can break down barriers to trust and understanding of CAM services and eliminate divisive action by people or groups that are operating in a noneducated environment. This is a consumer demand and we as policymakers have the responsibility to move the decision making into well rounded, deliberate discussions about cost, access, and outcomes.

**GORDON:** Thank you very much. The next speaker will be Kent Pullen.

**PULLEN:** Since I will be talking about the role of King County in promoting natural medicine, I should begin by defining natural medicine. Natural medicine refers to healing through a better

lifestyle and with the help of natural substances. We seek to correct deficiencies by putting into the bodies substances that belong there, such as vitamins, minerals, amino acids, enzymes, hormones, and digestive aids. And we seek to take out of the body bad things that don't belong there, such as toxins and allergens. Natural healing begins with a good diet. It includes eating natural whole foods, not processed or refined. It includes avoiding chemically altered foods, such as trans fat and avoiding additives, such as food coloring and chemical preservatives. It includes the use of therapies like chiropractic, acupuncture, and homeopathy which help the body to heal itself.

In 1994 I was curious to see if the county could promote better health care. I began by getting advice from a number of local leaders, Merrily Manthey, Dr. Joe Pizzarno, Dr. Jeffrey Bland and Dr. Jonathan Wright. I think you'll be hearing from most of this talented group, although at the present Dr. Wright is in Asia. But he did leave a videotape for your viewing.

I then consulted with my fellow elected officials and found that 11 of the 13 members of the County Council were already using natural medicine and were quite happy with the results. Encouraged by this support, I introduced a motion calling for the creation of a natural medicine clinic. The motion was adopted unanimously and we began getting a lot of help from a variety of sources. We were able to secure funding to open the clinic. Tom Trompeter of the Community Health Centers of King County agreed to manage the clinic and did a superb job. Bastyr University provided support in many ways. The staff were wonderfully cooperative and proved that conventional and alternative practitioners could work side by side in harmony. But most important, the natural medicine clinic was a huge success and the patients loved it. We received testimonials from some patients who said they've been trying for 20 years to solve their medical problems without success, until they were made well at the natural medicine clinic.

I'll conclude by noting that we have since made additional progress by incorporating natural medicine into health benefits for employees and we've begun planning to integrate natural medicine with conventional medicine. Why have we been so successful? I think it's because the Seattle area is quite progressive and because we have so many outstanding leaders here, such as the people I previously mentioned. We look forward to further progress and greatly appreciate your interest. Thank you very much.

**GORDON:** Thank you. Alonzo Plough.

**PLOUGH:** Thank you. My name is Alonzo Plough. I am the director and health officer of the Seattle King County Department of Public Health, Associate Professor of Health Services in the School of Public Health University of Washington.

I am very very pleased here to talk about in general, but what have to be the local underpinnings of partnership in order to transform local health systems so that complementary medicine, public health, and primary care can develop integrated models. And I'll speak in particular about our role in the King County Natural Medicine Clinic that Mr. Pullen identified. But I want to particularly emphasize the importance of the integration of public health practice and complementary alternative medicine as a transformational principle for the U.S. health care system in general.

When I came to Seattle and King County from being Commissioner of Public Health in Boston and in my confirmation hearings with the King County Council, I was surprised by a persistent line of questioning from members who are sitting with me right now. And those

questions were about my proclivities around complementary and alternative medicine, how did I see this fitting into the role of the health department I would be taking over. An unusual set of questions speaking to an unusual practice environment. I was very fortunate, I never knew how fortunate it was, that I had played a role in developing the first acupuncture clinic in a teaching hospital in Boston at Boston City Hospital and used that example at least to say that I've had some experience and wanted to get more in doing that. I hope that played an important role in my being confirmed. But I realized immediately that I was in a very different practice environment with lots of different possibilities for the promotion of health and well being in the region. And the kinds of leadership and local leadership that the King County Council demonstrated through their natural medicine motion which Mr. Pullen just described and I will not, has really set the tone for the work that my department has been able to do over the last six years. And allowed us to develop a practical and grounded approach to, again, recognizing the real importance of public health in complementary and alternative medicine as the main catalytic partners in increasing prevention and well being focus for the entire U.S. health care system.

So again, a guiding local vision by elected officials was certainly key to the changes we've seen in our region and it was very exciting to me today that four members of the King County Board of Health are with you today.

Our King County Natural Medicine Clinic, of which you'll hear more about from some of the folks who are working with that on the ground later, was a partnership. We called it a three legged stool, between public health, community based primary care, and CAM. And I think those three legs are really what made this very exciting. It was a partnership between the Public Health Department, Bastyr University, Community Health Centers of King County, with some evaluation and statistical work done from the University of Washington. I think that the ability of these institutions to collaborate around this activity was really important, and I think it took particular strength that we have in our region with Bastyr, Northwest School of Acupuncture and Oriental Medicine, the International Foundation of Homeopathy, many strong partners in doing this. What makes this partnership work I think was the respect of each of us of our different traditions. And I think that was a hallmark of the startup of the King County Natural Medicine Clinic. And I'll just note a few things that I think were particularly important.

This clinic was the first publicly funded integrative clinic that integrated alternative medicine, public health, and primary care. It was the first clinic to partner with a local public health department.

**GORDON:** We're on such a tight schedule. Could you submit those to us.

**PLOUGH:** I will.

**GORDON:** Okay. Thank you. I'm sorry to interrupt.

**PLOUGH:** Submit the?

**GORDON:** The characteristics to us.

**PLOUGH:** Fine. Should I just go on?

**GORDON:** No. If you could do it in 30 seconds, yes.

**PLOUGH:** Then I'll just conclude then. Again, I think that what we've seen in the clinic is a focus on prevention, a focus on the integration of the two traditions, and I think that's really key to transforming health systems.

**GORDON:** Thank you. I'm sorry we have to be tough with the time. We very much want to review the written material as well. So if you can't get it all into a speech, know that we're going to be taking a look at it. Maggi Fimia please.

**FIMIA:** Maggi Fimia, King County Council and I spoke before. I just wanted to touch on the potential role of government here, both federal, state, regional, and local government and what I see as our role.

The public in this region, and I can't speak for the others, but my sense is probably other regions as well, are way ahead of their governments in the establishment, in recognizing that there is a continuum of health care, it's not an either or. They want access to all different forms of health care, but they want it to be health care that actually works and is effective. The need is tremendous for us to address this issue now. We are working on our King County budget, for instance, right now and have found out that in 1998 our per employee health care cost was $480 a month per employee. Two thousand and one, the budget that we're looking at now it's up to $654 per employee. That's a 36 percent increase over just those three years, and we have 13,000 employees. We're just one government. This is happening to businesses and all governments. Clearly we want to make sure that with these tremendous investments in health care we are getting an equivalent or greater benefit in seeing increased wellness, not just attacking illness, but increasing wellness.

So government's role I think is to provide the forum to allow the different modalities to come together with both providers and the consumers of health care to set the tone for those forums so that people are willing and able to listen to each other and we know personally that we don't listen very well or learn very well if somebody is yelling at us or telling us that we're wrong and that what we've been doing for the last 30 years is incorrect. It doesn't facilitate change and tolerance. So government's role, if we're going to take one, is to be the referees and to set the tone that this will be a forum for increasing tolerance and listening to each other and recognizing that there's great value to what everyone is bringing to the table.

And to that end, we have set out a process here in King County called King County 2010 Integrated Medicine. Our goal for that process is to create an actual strategic planning document at the end of the process which would do three things.

First, celebrate what we've all accomplished, all modalities and all disciplines, over the last 30 years in terms of integration and promotion of wellness. And then to map out where we are now. Take an inventory. The town hall meeting has sped that process up and we are just absolutely very amazed and proud of ourselves for the list of speakers that are coming today, which is basically the beginnings of that inventory of what's happening in the region. And third to collectively decide on five to six goals that we can accomplish much better if we pull together and put them in a strategic planning document, identify who should take the leads on those different goals so that by 2010 we can look back and say, look what we accomplished together so much better, so much more collaboratively and effectively than if we had tired to do these things by ourselves. And they would be in the areas of research, of teaching, of cross training, of actual

delivery of health care, and in insurance. Those seem to be the broad areas where people seem to think we need to have the most work together. Thank you.

**Questions from Commissioners**

**GORDON:** Thank you all very much. We'll begin with questions from the other end, with Tom Chappell. Come closer to the mike. Speaking of the mike, can people in the back hear all right? Yes? Okay, great.

**CHAPPELL:** Maggi, I think I may have missed the nature of the collaboration you were speaking of when you talked about the five or six goals, things, you have something working now.

**FIMIA:** Yes.

**CHAPPELL:** I was just wondering, did you plan on extending that collaboration?

**FIMIA:** We have been working for two and a half years. We started with a small group of people that we knew on our radar screen, pulled them together from all the different practitioners and insurance commissioners, from the government research education and implementation and said, first, do you want to do this? Is this a good idea? The answer was yes. The County has taken the lead to do the staffing for this, along with Bastyr and some other institutions. It's been great. And then we said, okay, who is the next circle of folks who should come to the table? Who else do you know about that should come to the table, look at what we've produced so far as far as accomplishments and potential goals. We've done that and had 50 people instead of 20 people. We are working on the next round of making that a 200 person, so that there are actually more consumers of health care at that table, bringing them the draft information and documentation that we have already and saying, are we getting this right? What else should be included in on recognizing the accomplishments, mapping out where we are, and are these goals ones that you could concur with and should they be more refined as far as goals? How do we measure our success? So yes.

And then to actually go after funding collectively so that we're not at cross purposes and that we have money to actually implement this strategic plan. And set up some sort of institutionalized or recognized body where all these different groups can be coming together on a regular basis and have something formalized as far as structure so that we can update the plan as necessary.

**GORDON:** What we'll do is just move down the line. If you don't have a question, just pass and we'll go through.

**WOMAN:** Sure. Dr. Plough, something that we hear over and over again is about research based medicine. And this is in some parts of the country the excuse that's been used not to have integrative centers because some of the modalities lack research or evidence based medicine. It seems that your clinic is an ideal place to do outcome studies, clinical audits, case series. Is that

being aggressively done at your clinic so that that research can become available so that we can actually look at therapies and if they save money, if they work for what, etc.?

**PLOUGH:** We've begun some of that in the initial evaluation of the clinic. But I think only just the tip of the iceberg of those kind of studies. I do agree that it is a site where, if those research funds could be acquired, those kinds of evidence based questions could be addressed.

**WOMAN:** Funding. Money.

**PLOUGH:** Funding. Exactly. Those are very expensive. To do the kind of evaluation we would have liked to have done, to look at those outcome measures would have been multiples of the money that we had invested from the County to start up the clinic. So we were very much in need of those research dollars.

**WOMAN:** Mine deals with money too. And regarding the insurance, we're always frustrated with treatments being paid and there is no effect. And then when there is treatment that is effective there is no payment and people have to pay out of their own pocket.

Is there any thought in the insurance field that you pay for what is effective and not for what is not effective? There is rumbles of choice, there's a freedom of choice.

**WOMAN:** Be careful what you wish for.

**WOMAN:** And how far out is that? Because funding CAM seems to be far out before, but any comment about that?

**BIELINSKI:** I think it would be remiss for me to answer on behalf of the insurers. And since we regulate them, but it is the ongoing question. There are several people here in the audience today from the insurance companies and will be available to answer that from their perspective. There is also a speaker that is going to address you today about a study that he is preparing to conduct on CAM research, add on versus replacement costs, with three of the insurers in the state. So I think it's just starting. And again, it's about funding and proprietary information.

**WOMAN:** I'd like to address my question to Councilman Pullen. As your natural health clinic expands, I'm wondering if there is what amounts to a consent for care for the patients so that they have an outcome expectation. And I would think that a document such as that might allow for more integration and public education both in the process.

**PULLEN:** Well, I agree. And I believe that some of that is now being done at the clinic. And you have representatives here today representing the community health centers of King County which has managed the Natural Medicine Clinic and is now integrating natural medicine into all their clinics. And I believe at the appropriate time they can expand on that. But I do believe they've done some of that already with patients.

**MAN:** My question is, you mentioned that so many programs, like CAM therapies can be reimbursed or can be covered and does the patient have choice, for instance, to try chiropractor massage, acupuncture and herbal medicine, everything at the same time? It will cost a lot. Is that necessary? And you have to have a guideline to let patients have some choice.

**BIELINSKI:** The law is based on already covered conditions, so the patient presents with a complaint and it has to be diagnosed. One of the models of coverage which is referenced in the report talks about the gatekeeper method where they would have to see a primary care provider. One of the insurers in our state does credential naturopathic physicians as primary care providers. So that's one level of entry. There are many levels of entry which require a referring doctor to diagnose. When they diagnose the condition then they work it out with the patient what their benefits cover and what kind of provider they want to treat that particular condition. The herbal therapies are not covered because there is no standard at all of what is actually in the herb. There was one insurer at one time that did cover up to $300 per year for some herbal medicines, but that's no longer available. So they still have to have benefits to cover the condition. It's a matter of choice of provider of who is going to treat an already covered condition.

**MAN:** It would cover massage therapist? He's licensed or registered?

**BIELINSKI:** It is licensed. We have a 500 hour education requirement. There are approximately thirty some schools in Washington. And yes there are . . . and again they must already have benefits for the condition they are diagnosed with.

**MAN:** Impressive, thank you.

**MAN:** A question for Dr. Plough. Just looking at the report from the State Insurance Commissioner there are a lot of feedback loops here. And it's very commendable how at sort of the policy level of the various CAMs that have come together to work collaboratively. But how do you operationalize this? Do you have any concrete recommendations to foster collegiality, communication, continuity versus discontinuity of care between the range of practitioners who are on paper working together here?

**PLOUGH:** You may hear more from this in the panel to follow, but we found in the startup of the clinic it was very important to spend time with the practitioners doing cross learning activities and fostering that and recognizing that that takes some time. In a system that separately trains practitioners it takes an investment to get that cross learning to happen. So I think that was very critical, that that time be given in an integration activity and that be reinforced and supported. I also think in the example that we had I think it's generalizable nationally, local public health departments and federally funded 330 primary health clinics are natural incubators for this kind of collaborative activity. And I think that the kinds of things that you see from our natural clinic model could be generalized as a kind of place to incubate these kind of integration practices.

**MAN:** If you could just make available to us any of the curricula that have been used for that cross learning it would be most helpful.

**PLOUGH:** And we have a large qualitative evaluation of just the cross learning phase of the intervention which we can also share with the . . .

**MAN:** That's what I was going to ask as well. Obviously I haven't had a chance to look through this. Do you have an assessment of how you're doing and how you're doing economically in terms of coverage issues? Maybe that's more addressed to you, Lori, than.

**BIELINSKI:** We don't have any of the studies done yet. As I mentioned, Dr. Bill Lafferty is in the audience and we'll talk about an NH grant that he has applied for to do some of that. We've been trying to get various projects to look at utilization costs. There are some cost benefit analysis done by . . . and Robertson for pricing various CAM services. But I haven't seen one that's unbiased yet. And I'm not an actuary.

**GORDON:** Let me just say that I think, I think I'm speaking for all the Commissioners, it what would be very useful is any data that you could give us about cost benefits of the new regulations. Or even a descriptive sense of what has happened with whatever approximate dollar amounts you can attach to it. That would be very very useful for us to consider.

**BIELINSKI:** That would be a very good collaborative project for me and the payers.

**GORDON:** Okay, sounds great. Thank you all very much.

**WOMAN:** Thank you. If the following speaker who I think missed her slot, Gail Zimmerman, if you want to come up now, and we'll also take the following eight people. Tom Trompeter, Judy Featherstone, Kathy Lynn Boulanger, Pam Snider, Leanna Standish, Jeffrey Bland, Richard Hammerschlag, and William Dallas.

**Speakers**

**GORDON:** While people are coming up, it's wonderful to see so many people who have been working in this area for so long and done such wonderful work all here together. That's great to be working with you. And I like the idea of those collaborative efforts. Let's begin with Gail Zimmerman then.

**ZIMMERMAN:** Good morning. My name is Gail Zimmerman. I am an Executive Director with the Washington State Department of Health Health Professions Quality Assurance. I have oversight and presently work with 16 health care professions. The Health Professions Quality Assurance Division in the Department of Health is responsible for promoting an effective partnership between the Department of Health, the professional licensing boards, commissions, committees and councils, the public and health care professions.

I have been asked to share with you the licensing, disciplinary, and regulatory activities relating to all health care providers in Washington state. The Department of Health is charged with protecting the public and safety by regulating the competency and quality of over 240,000 health care practitioners. We provide in Washington 52 different types of licenses, certificates or registrations, and we work with 26 boards, committees, councils, and commissions to regulate the health care professions and services in Washington.

In conjunction with the above groups, the Department sets standards for professional practice. We review applicant qualifications and backgrounds. We receive and process consumer complaints for all of the 52 different types of licensed health care professions. The number of active licensees in Washington has increased in 1991 from about 164,00 to 240,000 in 1999. That's about a 46 percent increase in the last ten years. We at the Department have several quality assurance mechanisms that we use to assist both the public and the health care practitioners to obtain the most up-to-date information and help available. Regulatory reform in Washington has provided an excellent opportunity for both public outreach and input into our regulatory framework. We have an automated verification service which allows hospitals, insurance providers, and managed health care organizations to obtain information on health care practitioners 24 hours a day. We have one standardized application and review process to credential all 52 of the health care professions. And all professions in Washington use regional or national exams except in those professions where they may not be available.

We in Washington also our public disclosure process allows the public access to information concerning health care practitioners. All credentialed health care providers in Washington fall under one disciplinary act with standardized procedures for the licensure of health care professions and the enforcement of the laws for the purpose of professional conduct. The

Department has adopted procedural rules for the disciplinary and adjudicative processes. These rules include provisions for setting time periods and establishing specific time lines for each of the steps in our adjudicative process. We also have threshold criteria that have been established in policy for all cases to decide up front whether a case should be closed rather than to expend the resources. We have developed case disposition criteria to apply to all cases requiring investigation to help determine the appropriate action, including both informal and formal disposition.

We have been able to achieve these results through a collaborative effort on the part of our legislature, the public, health care providers, associations, government agencies, and other stakeholders.

I have provided staff with a report that outlines in more detail the work of the state and it also will provide you with a list of all the health care providers we credential in Washington. Thank you.

**GORDON:** Thank you very much. Tom Trompeter, nice to see you.

**TROMPETER:** Welcome back.

**GORDON:** Thank you.

**TROMPETER:** My name is Tom Trompeter. I am the Executive Director of Community Health Centers of King County. We are a private nonprofit community health center which receives a variety of grants sources of support from the federal government to our local King County Council and the local health department. We have six medical and four dental clinics spread throughout suburban King County and we are providing integrative medicine actually in two of those medical clinics now. Our patients are diverse and economically disadvantages. Ninety-seven percent of our patients have family income under 200 percent of poverty. Forty percent plus now are uninsured.

Since 1996 we have been involved in establishment of an integrative medicine clinic known as the King County Natural Medicine Clinic which is housed at our Kent Community Health Center. And I would like to express my appreciation for Mr. Pullen's kind words, but there are many others who have been involved in bringing this to fruition, including my former boss at the Health Center, Jane Lee and Marty Ross, our former medical director. You'll be hearing later from our current medical director. All of the providers, all of our staff, and I think most importantly our patients. One of the primary impetuses for us to even get involved in providing integrative medicine was we surveyed our patients and sixty percent of them said that if these kinds of services were offered that they would take advantage of it. We are a community based organization. We try to meet the needs of our community. So we are fortunate enough to be able to take advantage of funding opportunities to be able to bring this to fruition.

Currently we have on staff naturopathic physicians, acupuncturist, we have one acupuncturist employed and we are also engaged in a teaching collaboration with Bastyr University to provide acupuncture services as well, as well as a licensed massage therapist. Massage and chiropractic are also available services via referral from the practitioners in our clinics.

I think it's fair to say that at this point in time we have a rather well-functioning integrated clinic, but there's always more work to do. But one of the things that really, or a couple of the things that really support this is constant peer cross training and cross referral. Another thing that

I would like to mention in terms of the operations of our clinic is despite the bashing that managed care takes in many circles, we provide care to Medicaid managed care patients and to another program that Washington state has called the Washington Basic Health Plan. And the services of our naturopathic physicians and acupuncturists are we consider them to be covered primary care services within our own corporation. We get our own capitation dollars to provide those services and it is up to us to decide how to use them. And this is a decision that we have made.

There are a couple of things that I would like to say. About the systems mechanisms that have been in place, without which I think it would have been much more difficult, if not impossible for us to do what we've been able to do. One I think is consonants between the principles of community oriented primary care and complementary and alternative medicine. I think this is not to be understated. Community oriented primary care is the principle by which most community health centers, if not all community health centers, operate, in terms of looking at the needs of their patients, looking at the needs of their communities, emphasizing prevention and wellness. I think that this helped create a foundation that allowed us to move in the direction that we've moved with less trouble than might have happened in other environments.

Another thing that is really really not to be underestimated is that we have state licensing for CAM professionals. We have any category of provider law. We have supportive educational institutions such as Bastyr University and, as you've heard, we have local political and financial support, especially through the King County Council and the local Health Department. If there are some things that I would like you to walk away with in your minds as things to be done, better reimbursement under Medicare and Medicaid, clinical training for CAM students in community-based settings. This has been spoken to before, we need to have practice incentives for people who are graduating from CAM schools to work in underserved communities. This is talking about scholarships and loan repayment, whether that's at the federal level or the state level. And finally, from the folks who work in my part of the world, we need funding. It is not enough to simply do the other things. We need funding to help finance the services for people who can't afford to pay. Thank you very much.

**GORDON:** Thank you, Tom. In the interest of full disclosure, I worked with Tom in the clinic just as it was beginning to open and it's incredibly exciting to be there and to work with you all and I'm looking forward to coming over tomorrow.

**TROMPETER:** We have a fabulous new home.

**GORDON:** All right.

The other thing I want to say that I want to thank you particularly for, and say to all the speakers, is that we want exactly these kinds of recommends. Tell us what you want us to do, please. That's the most important thing for everybody. Thank you.

Next is Judy Featherstone.

**FEATHERSTONE:** I'm Judy Featherstone. I'm now the Medical Director of the Community Health Centers of King County. At the time of the establishment of our Kent Natural Medicine Clinic I was a family practice physician, and still am, in our Auburn clinic.

The concept of integrating the conventional medicine and natural medicine was rather uncomfortable for many of us when it was first suggested. Most of our conventional medicine providers had a lot of concerns, and those were particularly around our liability risks and adverse patient outcomes. Several steps were taken to allow this integration to proceed as well as it did and to allow us to have the program we have now that benefits so many patients. First was education of our conventional medicine providers about these alternative medicine practices. Most of us had little understanding and these providers were able to explain to us their training, their interventions and improved our common knowledge.

Next, to address the concerns about liability, a decision was made to hire only licensed practitioners. And this was reassurance to many of us. Addressing the conventional providers' concerns about the patient care was a bigger job. Shortly before the clinic opened a group convened that was made up of providers from Bastyr University and the community health centers to develop protocols for management of patients with specific diseases. This group created a list of diseases or problems that should be first seen by our conventional medicine providers. And those were many of the things we consider as emergency things: heart attacks, strokes, fractures. Most of the other problems, the patients were given a choice when they came in of whether they would see the naturopaths or the conventional medicine providers. This gave a lot of reassurance to the conventional providers and gave the naturopaths freedom to practice.

Since the integration clinic has been open we've used various tools to continue to promote the common understanding. There is an integrated medical record, there are meetings of all the Kent providers to discuss the integration, and there are monthly didactics for providers from all of our sites. And several of the alternative medicine providers have gone to our different sites to see patients with our conventional providers and give them input on patient care. Some of these teachings we could include in our practices, and we certainly developed a better understanding of what was appropriate to refer to our naturopaths and other alternative providers. Conventional medicine clearly doesn't treat all illnesses optimally, and our patients have benefitted by having a broader range of options.

I'd encourage the expansion of this model throughout the country.

**GORDON:** Thank you very much. Kathy Lynn Boulanger.

**BOULANGER:** Actually my name is Candy Burke. Kathy is the President of the Washington Reflexology Association, but was unable to be here today. I am a co-founder of the Washington Reflexology Association and I guess what I'd like to say to you is that reflexology, if it's unknown to you, is an ancient healing science. It's consecutively been a body of work known all around the planet, used and relied on in every culture that, number one, does not access to medical care for its work in how it helps the body move into its own ability to heal itself. Science, by the way, has proven through time that it also can be a little flawed after statistics appear 30, 50 years later as new things evolve in the world and our understandings, we find that we have to kind of move the lines a little bit anyway. Reflexology is something that relies on very specific hand and finger techniques, working over hands, feet, and ears. It's a body of work that bridges all of medicine. It bridges all of CAM providers. It's a body of work that literally, because it's primarily done on

the feet, supports, and that word is used very purposefully. It supports all the work that everybody else wants to do in the realm of care for the body.

In the state of Washington the work of reflexology has been governed by the law of massage therapy, and Lori mentioned that Washington state has 12,000 practitioners that are massage therapists. However, within that number, because that's been the guide for a lot of body attendance to work from, what's happened recently, just for your edification, is that people that do Shiatsu, people that do Aston Patterning(sp?), Feldoncrist(sp?), Reike(sp?), things like that, have been set aside as an exception to that law so they could do their work. Reflexologists now are engaged in conversation with massage therapists to become a certified program. And that then makes availability to the public that much greater currently in the city of Seattle. If you look in the phone book reflexology lists two people. Because my name is one of them, I am the recipient of a lot of calls that say, it sure is hard to find a reflexologist in this town.

In regards to insurance reimbursement to my clients, I only deal with reflexology now in my practice. I've been licensed for over 13 years as a massage therapist. My clients cannot go to their insurance companies who do provide for insurance coverage and be covered for reflexology, simply because it's just not known. Thank you.

**GORDON:** Thank you very much. Pamela Snider.

**SNIDER:** Good morning. I am Associate Dean for Naturopathic Medicine at Bastyr University, a naturopathic physician and co-chair of the Building Bridges Group with Dr. Lyons who you heard from earlier. I will address a key element helping to produce such effective collaboration in our region, collaborative working groups and specifically the Building Bridges Between Provider Communities Group.

The group is a coalition of agencies and organizations in the region with a mutual interest in the integration of alternative care. The group is one of the three core CAM integration work groups in this area. Members have worked well together based on a genuine desire to improve community health. The group's name became its mission. And its main activities were information sharing, immunization discussions (very interesting to note), and bridge building. As the membership developed, joint conference on diabetes and best integrated practices was held with the American Association of Naturopathic Physicians. Our follow-up activities were collecting data on the conference, issuing a report, and working to develop the Northwest Center and King County 2010 initiatives. The group has completed its work and is preparing a final report. Its members are active in the Northwest Center and King County Integrated Health Care 2010 initiatives. These initiatives are venues for local integrated health planning and institutional and regional public health partnerships focused on serving the underserved.

We feel we accomplished our goal, establishing strong working relationships, and we've become a stepping stone for collaborative efforts in public health. Licensed CAM providers established a sense of credibility about competence and our proximity to one another and a sense of shared mission have developed strong communities of action.

The joint conference on diabetes brought together a wide range of stakeholders. Seven hundred participants attended. Seventy-three percent said that their diabetes care would improve if they had better working relationships with other providers, especially CAM providers. We found that type II diabetes is an urgent problem in the country and must be addressed by CAM and conventional medicine.

We have six recommendations.

1. To fund and initiate bridges type groups in other DHSS regions.
2. Establish an immunization CAM task force in Region X.
3. Support regional and public health partnerships with CAM and conventional medicine with an emphasis on serving the underserved.
4. Conduct regional conferences on integrated CAM and conventional practices to reduce preventable diseases.
5. Reimburse for behavioral change for CAM and conventional medicine providers.
6. Support local community demonstration projects and strategic planning to integrate CAM and conventional health services.

Thank you very much.

**GORDON:** Thank you very much. We're going to have a chance now to speak with, this is the first panel of five, so we'll start from this end this time. Joe.

**Questions form Commissioners**

**MAN:** We had a meeting in Washington a few weeks ago and we were talking about some of the research infrastructure, and this is for Dr. Snider. You were talking about demonstration projects. What kind of resources would you need locally to do the evaluation side of outcomes research?

**SNIDER:** I think you might want to ask the insurance commissioner's representative about outcomes research. But as far as community planning, we are very interested in applying for grants to further the kind of community planning and outcomes assessment of implementing those community goals. We haven't developed a figure. But I'm sure we could get back to you on that.

**WOMAN:** This is for Dr. Featherstone. I'm very curious about who set out the guidelines and what would be taught to the providers in your new clinic. You said you had educational providers, only licensed practitioners, and you develop protocols.

**FEATHERSTONE:** Right. The protocols were developed by a group of naturopaths and conventional medicine providers.

**GORDON:** One thing I'll say at this point, I think it would be really useful, having worked with other nascent clinics like yours, for you to make your experiences widely available as possible. Not just, we'll be able to do a little bit of that down the road, but I think in terms of spreading the information through national meetings of all different groups of providers will be extremely helpful. Go ahead, Tom.

**TROMPETER:** We have done that both through the National Association of Community Health Centers, as well as through our regional associations. And we've been visited by health centers from New York to California. And I will tell you one of the things that really gets to be a puzzlement for a lot of folks is when they lack state licensing.

**GORDON:** When they what?

**TROMPETER:** When they lack state licensing. When naturopathic physicians or acupuncturists are not licensed, it makes it very difficult for people to generalize the model.

**GORDON:** Could you provide us with the kind of information or the kind of packets that you're giving to people when they come to visit or that you present?

**TROMPETER:** Sure.

**GORDON:** Thank you. Veronica.

**GUTIERREZ:** My question is for Tom Trompeter, but first I'd like to say that I've worked with Gail Zimmerman and the health of Washington is in very good hands in the Department of Health. Mr. Trompeter, I was interested in your presentation. I'm wondering who, and even more importantly, what is the criteria for determining a referral to a chiropractor?

**TROMPETER:** Actually, that's a medical question and I'm just an administrator. But it's basically provider judgment. When benefit is to be gained in that provider's judgment to a referral. We don't try to hamstring people too much in this. But we do, particularly for us, because this is a cash out of our pocket expense. We have a referral relationship with providers in the community and we pay them to provide these services. And so it becomes a resource that needs to be managed somewhat carefully. Therefore, we give our providers the discretion to decide when they really need to send someone. And that's when it's out of house. When it's in house, it's a little easier for us to take care of. Does that answer your question?

**GUTIERREZ:** Yes.

**GORDON:** There will be someone, there will be a physician from the clinic, will be here later.

**TROMPETER:** Yes. Dr. Cindy Breed will be here later and Dr. Featherstone can also help answer some of those questions.

**GORDON:** Effie.

**CHOW:** I just have a simple question. Is Chi go(sp?) included in any of your practices or programs. Chi go(sp?), a Chinese energy exercise, self-help.

**MAN:** Not at this time. Again, it is a resource question, what we can afford to have on staff and what we can afford to pay for out of pocket which also goes to my last recommendation to you folks.

**GORDON:** Charlie.
**WOMAN:** I guess I have a hypothetical question that we've encountered at similar practices in New Mexico. If you, as a physician, you have a patient you diagnosed with breast cancer, and she

chooses that just really for her at this time, based on probably many beliefs, she just wants to do acupuncture and herbs. That's going to be her treatment for breast cancer. How is that addressed and handled within your clinic?

**MAN:** . . .

**WOMAN:** I thought you'd like that one.

**WOMAN:** I think because our providers work so closely together it allows much better melding and it's an area that many of the conventional providers aren't going to know a whole lot about, and so they can sit down with our naturopaths and the acupuncturist and learn more about it because they're right there in the same space. Then we always support the patients with their choices. And if they make a choice, no matter what it is, it's our job to support them and to allow them to have the life that they choose.

**MAN:** Tom Trompeter, the economic model I'm interested in, if there is one yet. And the practitioners are on staff. Is that correct?

**TROMPETER:** Correct.

**MAN:** Then could you give me some estimate of by percentage the various sources of funds that are sustaining the clinics.

**TROMPETER:** Sure. About 30 percent of our funds are grant funds, which is a combination of public health service grants and local grants. Some small amount of state grant money, the state of Washington actually is quite progressive in how it approaches health care, and there is a small state funded grant program for health centers, not unlike what is in California and a few other states. About 30 percent of our revenues come from patient fees, which is cash that our patients pay us on a sliding scale. And the remainder is a mix of fee for service as well as Medicaid managed care, as well as revenues from the other program that I spoke about, which is the Washington Basic Health Plan.

In terms of setting context, the community health centers in Washington state a number of years ago formed their own managed care contracting entity for purposes of being able to preserve our ability to provide services for Medicaid patients that had been coming to us before the advent of Medicaid managed care. And it is the vehicle which allows us to at least provide the professional services component of the naturopathic physicians and our acupuncturists on staff as part of covered primary care services within our own corporate walls.

**WOMAN:** Are they paid employees then, the naturopaths?

**TROMPETER:** Yes.

**WOMAN:** And are your Western trained physicians and naturopaths paid the same salary?
**TROMPETER:** No.

**GORDON:** Could you give us as much as possible an economic breakdown. I think we're all really interested, and as one of the longest running, and certainly the longest running public model.

**TROMPETER:** Sure.

**GORDON:** It would be very helpful. On paper.

**TROMPETER:** Yeah. I had intended to provide you all with some written testimony, but I wanted to wait to see what kind of questions came up as well. And certainly if after I provide you with information if you feel you need more we'd be happy to provide whatever you need.

**GORDON:** Terrific. Thank you. Thank you all very much. We'll go to the next panel now. We have a substitution. Leanna Standish is first. Please, go ahead, Leanna.

**Speakers**

**STANDISH:** Dr. Gordon, do I have five minutes or three minutes? It makes, wow. Oh, well, hello, and welcome to Seattle. It's nice to see your faces again and new commissioners. My name is Leanna Standish and I'm the Director of Research at Bastyr University.

I believe that the major obstacle to CAM research right now is lack of research infrastructure and training at CAM institutions that have true CAM expertise. Between 1992 and 1999 only seven CAM institutions received funding from either the OAM (Office of Alternative Medicine), or NCAM (the National Center for Complementary and Alternative Medicine), compared to 76 conventional universities. This means that only nine percent of CAM research grants have gone to CAM researchers who teach and do research at clinics and colleges that specialize in CAM and have for decades, not just this last year, because there is now research dollars available at the NIH. The reasons for this discrepancy include the fact that many CAM academic and clinical centers do not have research expertise or the infrastructure to produce high quality NIH grants. There is very little time for research. As you probably know, most CAM academic centers are tuition funded, and therefore, teaching loads are very heavy. There is a potential, and I think very serious risk of CAM experts not being actively involved in researching their own field. The risk is the potential and likely loss of the best ideas, the most significant concepts, and the most important CAM therapies.

If we are not careful as we move towards mainstreaming and integration we may lose the very best of the fringe ideas. The price of mainstreaming may be high indeed, camodification(sp?) and dilution of whole systems CAM practice. And a new green pharmacy that does little to improve either health or change the basic assumptions of medicine or science. And CAM's current, exciting; you know what I want to do? I want to go right to my eight recommendations, okay. And I will submit to you my testimony so you can see why I'm making these recommendations.

1. My first one is I recommend that NCAM fund planning grants to CAM academic centers in order to develop research agendas, clinical trials consortiums, and strategic plans. CAM research should be designed and executed by CAM experts with the help of experts from

conventional medicine. Thus far, the emphasis has been placed in the other direction, that is research designed and executed by conventional universities with grafted CAM expertise. And because of this bias we risk losing the best science.

2. I think we should request NCAM that an RFA be developed specifically for CAM institutions to help them develop research infrastructure and a cadre of CAM experts who are also trained in research methods.

3. We should request the FDA to establish a CAM task force to develop policies and procedures for investigational use of CAM therapies.

4. In order to increase sample size and power of exploratory CAM clinical studies, NCAM exploratory research grants that now fund most of the research in this area should not have a cap of $125,000 a year. Rather, I would suggest we remove that cap and ask principal investigators to develop budgets based on the scientific needs of the research question. We have actually a system now that is biased towards the risk of type 2 errors at the NIH.

5. Allocate funds and authority to NCAM and other appropriate federal regulatory agencies to provide education to IRBs so that they can provide more informed ethical oversight of CAM clinical research.

6. Request a federally funded RFP process to fund research on insurance company CAM databases. We have a rich supply in the state of Washington. We must have an answer to the question of whether CAM use has additive or substitutive cost to the U.S. health care system.

7. Request the NCI (National Cancer Institute) to provide funding to CAM cancer clinicians to do the difficult administrative and clinical work of producing a best case series, and finally,

8. Fund programs to support prospective practice based outcomes research using a case series and weight list control method.

Thank.

**GORDON:** Thank you, Leanna. I see that Bob Learman is here in Jeff Bland's place. Bob.

**LEARMAN:** Thank you, Jim. I'm going to give you a summary of what we've submitted. In the past it was assumed that proof of safety and effectiveness of any therapy was secure only when there were well controlled clinical, randomized trials performed by well-respected investigators and published in peer review journals. Because many CAM therapies were developed outside of the pharmacologically-based medicine, they have not been subjected to randomized clinical trials and therefore considered by many to be of unproven value. An example is the work of Killmer McCully that worked on homocystine(sp?) and associated that with cardiac disease. And it's estimated that over the past 30 years that nearly a million Americans might have been saved heart attacks had full AB12 and B6 been given in their homocystine looked into.

So what can we do? We can try to find other approaches for evaluating the CAM therapies. CAM therapies are often complex in nature, involve more than one parapeutic(sp?) component tailored to meet the need of the unique patient and their effect may come across more than one patient outcome variable.

Clinical trials based on other methodology, such as cohort analysis, pattern recognition, statistical evaluation and multi-varied analysis or cluster analysis would be ways of getting about this. We at the Functional Medicine Research Center have been studying the influence of nutritional and botanical medicine approaches to chronic conditions over the past ten years and

successfully applied multi-varied approaches to studying complex health issues such as chronic fatigue syndrome, fibromyalgia, veritable bowel, insulin resistance in hormone imbalances in women at our center.

I'll move directly to the recommendations that Jeff put together.

The first recommendation is to support studies that are designed with methodologies other than the placebo controlled trial to test CAM outcome safety and effectiveness. Second is to foster integrated conclaves of basic scientists, clinical scientists, and clinicians with varied backgrounds. Focus research on the core processes that are related to age-related diseases, and it's the end of the health span that we're most interested in, to foster a life without illness. Support research that moves from CAM versus drug approach to studies that evaluate health outcomes from broad based clinical perspective. Sponsor research that requires collaboration among medical school researchers, CAM providers, HMO providers, and CAM educational institutions. Support research that looks at the interrelationship among the biomedical, medical, economic, sociological, psychological, and spiritual components in the determining outcome. Provide educational grants to scientists who want to learn more about CAM therapies who are willing to add arms to their existing studies to evaluate the impact of CAM interventions in their work. And last, to fund basic science studies that evaluate the influence of CAM therapies on gene expression and functional genomics. Thank you.

**GORDON:** Richard Hammerschlag.

**HAMMERSCHLAG:** Members of the Commission, good morning. I am Richard Hammerschlag, Research Director at the Argon 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's a challenge to apply my training in biomedical research in neurobiology 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 and CAM centers. And for Tom Chappell I'll just reinforce that this is Portland, Oregon.

I will focus my remarks on three questions essential to research. First, what kinds of CAM research are needed? Second, how can CAM research findings be better disseminated to health care providers, policymakers and insurers? And three, 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. 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. 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 NCAM center at Kaiser

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 policymakers in how to assess the quality of research articles. This would help to correct the 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 possible administrators, and demonstration hospitals where the integration of CAM practices can be evaluated.

In summary, I urge the Commission to 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.

**GORDON:** Thank you very much. William Dallas.

**DALLAS:** Thank you very much Dr. Gordon. And thank you for allowing me to testify. May I complement all of you for the public service that you're rendering to the humanity at large and all the work that you're putting in, not only here, but behind the scenes. I hope I'll stay within three minutes, and I think that won't be a problem. My name is William Dallas and I'm President of Western States Chiropractic College in Portland, Oregon. Before that I practiced as a chiropractor in Lakewood, just south of Tacoma, for 27 years, and before that I graduated from the Palmer School of Chiropractic in Davenport, Iowa, in 1958.

I have three main points that I would like to share with you.

1. The chiropractic profession is in critical need of research to provide valid clinical outcomes data.

2. The chiropractic colleges need adequate funding to hire researchers and to provide adequate infrastructure for chiropractic research.

3. Chiropractic education and research need to interact and integrate their programs with other higher education environments that include all relevant disciplines in science and medicine.

Chiropractic is at the point where priorities for survival are changing from political action to pressing needs for data defining a clear clinical role based on demonstrated outcomes. The profession has a strong patient advocate population, and consequently, strong support from state and political leadership. Even so, those in decision making positions regarding reimbursement and patient access are responding enough to answer constituent pressure, but in most cases with obvious reluctance. This scenario will prevail until enough supporting data is provided to allow objectivity in the process.

Another facet of the same problem is the difficulty in establishing standards of practice and care for the profession. All state and provincial boards of examiners who are charged with protecting the public face a daunting challenge of identifying and codifying an almost chaotic array of opinions, all having limited supporting data. Currently, we have over 60,000 practicing

chiropractors with about the same number of interpretations as to what constitutes the best clinical answer for their patients. It's exciting but it's very very difficult to get much done. Until objective assessments under scientific conditions have been conducted, this frustration will persist and optimum patient health care compromised.

I'd like to digress just for a moment and talk about a project that we have worked at at our college for a number of years, and the difficulty that . . . we are under way with a program called Conservative Care Pathways, and all that is is a logical and seemingly simple process of bringing together chiropractic practitioners, along with medical practitioners, naturopathic physicians, and with osteopaths, to discuss what really is the best course of action for patients, out of time already. I took too long introducing. What I will do is submit the rest of the material in writing. I understand that has to be in by the end of the week, and I am perfectly willing to answer questions.

**GORDON:** Thank you all very much. This is a very rich panel. Joe, do you want to begin? Oh, Tom, go ahead.

### Questions from Commissioners

**MAN:** Dr. Bland, at the present time, natural substances are not patentable. Do you think research would be improved if the laws were changed to allow for discoveries of natural substances.

**LEARMAN:** First of all, my name is Bob Learman and I'm the . . .

**MAN:** I beg your pardon. The picture was right in front.

**LEARMAN:** Right, I know, this says Jeff Bland. I'm standing in for Jeff. I'm the Medical Director of the Institute for Functional Medicine in Gig Harbor. I think that your point is well taken, that if there were ways of patenting some of these approaches that that might foster more rationale for companies to go out to try to find the research that, to do the research that could define other CAM treatments based on them. I think that it's probably also going to be necessary for the government to support research in this area because most companies cannot afford to put in the kind of research money the pharmaceutical companies can for the kind of botanical research I think you're referring to.

**MAN:** Thank you.

**WOMAN:** This is for Dr. Hammerschlag. The issues around real world CAM research is very similar actually for real world conventional medicine. Because primary care doctors are always confronted with, how much does this evidence base really affect me in clinical trials where you just narrow down to this really small group of people. So that's not usually what represents our patients in our practice. Much of the critique, what we keep hearing is that we need more research. And what we keep hearing from many of the researchers is that we've got to take out the confounders, which are the healers. We're the confounders basically. And when you've got

diet and when you've got acupuncture and when you've got herbs and you've got this whole pathage(sp?), how do you figure out what's doing what for public dollars. If we're going to have reimbursement, who is going to pay for what and what actually is working. How would you begin to address somebody who said, we have limited dollars? What are we going to pay for? And what works? And how are you going to do this real world CAM research? Which I'm in support of, I just want to know how to do it.

**HAMMERSCHLAG:** This is a multi-level question. The ultimate goal, I think, in doing this kind of research is not to say the way conventional medicine, conventional research has the goal of saying, what treatment will work for all people with this condition. And what we want to get to is, what treatment will work for this person with this condition. And so the ultimate goal of comparative outcomes, and we do include an arm of conventional medicine in the comparative outcome studies, the ultimate goal is to determine what condition is best for which patient. And so we include a lot of quality of life issues, we include a lot of instruments that measure all kind of psychological profiles, belief systems. This is part of the research. We're not just looking at medical outcomes. And that, I think, needs to be the ultimate goal of this research, is to say when a person comes in to your clinic, how do we know which is the best approach for that person.

**CHOW:** My central . . . concern about the research methodology, etc., too, and most of you have mentioned something about that. Do you have other concrete recommendations that you can submit to us as guidelines of what this real world research is or other than clinical trials and so forth? I think we're really searching in that line.

**MAN:** I think between Dr. Standish and myself, we would be glad to develop a set of guidelines for you along these lines. I'm delighted that her recommendations overlap, but were really different from mine, and so I think the two of us together could do that for you.

**WOMAN:** Effie, thank you. You have been consistent in this concern of how to really do practice-based research. And I can only tell you this, that in my frustration, we are about to start a hepatitis C clinic. We've developed a science-based protocol. It's going to be a comprehensive protocol. We're going to enlist anybody who wishes to come and we're going to have very hard end point measurements every six weeks and we will see, from each case, whether there is a change in the kinds of measures that one expects to see, including quality of life measures. So what I would recommend is that in about a year we'll have some hard information about whether that approach really works or not.

**GUTIERREZ:** My question is for Dr. Dallas. Nice to see you again. I would like to know, in your role as an educator, how you see the role of chiropractic in the paradigm of wellness and quality of life versus treatment of disease or disorder.

**DALLAS:** Now I'll get my time. Basically we are, as you well know, Veronica, we are pretty much as a self-defined health care discipline that shows its interest or focuses on the biomechanical structure of the human body and its influence on various parts of the health system. Wellness is a part, and you might say that it's an adjunct, certainly an assist, to dealing with a patient. In other words, the patient isn't just treated from the standpoint of a biomechanical

dysfunction or a subluxation, as we use the term, there are a lot of other considerations that should be made. Diet, general nutrition, lifestyle, ergonomics in the workplace, physical condition. All of those are a part of the overview of a chiropractic responsibility for the patient. As far as getting into any other areas, to date there hasn't been much movement in that direction.

**GORDON:** I'd like to, before I pass on to my colleagues, to ask all of you, and this is an expansion of Effie's request, to give us models of the kinds of research, the kinds of protocols you would like us to recommend, with whatever information you have at whatever stage about how well it's working. And, Bob, I would also like for you to give the wonderful example of homocystine, and whatever you can produce in terms of data, if we had but looked, at a sort of natural treatment for heart disease what could have happened and what happened when we didn't look at it. I think what we're doing is we're creating a narrative in a drama, as well as collecting data, and we need both. We need the data, but we also need the drama from the past that's shaping our recommendations, and we need the potential scenarios for what needs to happen. So we really would ask you to do that and make it as clear and concise as possible, so that when we make recommendations for legislation we can make recommendations about specific kinds of research programs.

Linnea.

**LARSON:** Dr. Dallas, you said that you had some impediments to osteopaths, naturopaths, M.D.s and chiropractors working together. What I would actually like it is you could do like bullet points on the impediments to their working together.

**DALLAS:** I would be very happy to. By the way it did work out well. When we finally got over the initial barriers in communication.

**MAN:** Could I just mention something in terms of the working together, that we now have a course called Applying Functional Medicine and Clinical Practice where we have physicians, M.D.s, D.O.s, chiropractors, M.D.s, R.D.s, and basically all the health care practitioners that learn an approach to care of the ill and through an approach that is science-based and patient centered.

**GORDON:** I think everybody knows that we will be working on, later on there'll be specific sessions on professional education. So we're, again, interested in your thoughts and suggestions about that as well.

**MAN:** Quick question for, what is the functional medicine, what is definition please?

**MAN:** Functional medicine is a patient-centered, science-based approach to medical care that looks for underlying causes of medical conditions and relying on those underlying conditions, treats them to improve function, physiologic function and improve health. I'm not sure whether that answers your question. That's kind of our basic definition. I could go into more detail if you like.

**MAN:** Dr. Standish, it's good to see you again. Let me ask you a question, sort of anticipating the homocystine story five years out. You mentioned you're doing some hepatitis C research, and

I don't know what you're doing. But you're obviously going to assess quality of life, functional status. Do you feel that Bastyr and other settings like yours are hampered by a lack of a basic science infrastructure. In other words, can you do the viral load, can you do PCRs, can you look at pathology? In other words, are you only studying the things you can study? There are other things you'd like to study but you can't because you don't have the collaborations or you don't have the research infrastructure or you don't have the MRI machines to look at the impact of acupuncture. If you want to bring the research home, do you feel you have that basic science infrastructure to bring it home and do it in the places so that the ideas don't get lost in the way that you described earlier?

**STANDISH:** Happily my answer is no. I think that what we found at Bastyr is that collaboration with nearby University of Washington has been a beautiful relationship. Viral lodes, for example, are very high tech tests, and not even most hospitals don't do them. So we're relying on biopsies done at Harborview Hospital. We have a wonderful collaboration with Harborview and the University of Washington. So we're doing the standard kinds of tests, including the gold standard of liver biopsy, but also focusing on medical outcomes using, we're using the SF36 for functional status. So I guess my answer is, thank goodness we have the University of Washington. If that were not the case, then we would have to be shipping our blood by Fed X to another facility.

**MAN:** So the model that you think would be best to replicate would be, no pun intended . . . viral lode here, but the best case scenario would be collaborations of the sort that you described.

**STANDISH:** Yes, absolutely. But you know, Joe, just think about it. Any kind of research that requires laboratory testing requires a certified, valid, commercial lab, usually either in a hospital or associated with a hospital. And so this is not a constraint that's particular to CAM institutions.

**GORDON:** Thank you all very much. We're going to take a 15 minute break now. When the break ends, if the next panelists could come and sit, that would be wonderful. Thank you.

**Speakers**

**WOMAN:** Would the following speakers please come up to the table. Robert Mootz, Clyde Jensen, Jim Taylor, Karen Sherman, and also Suzzanne Myer, Jacqueline Obando, William Lafferty, and Charles Simpson, please.

**GORDON:** Thank you. We'll begin with Robert Mootz please.

**MOOTZ:** Hi. Ladies and gentlemen, thank you very much for allowing me the opportunity to address you today. I also must commend you on the hard work you're doing. The perspectives I'm going to offer come from three areas. Thirteen years in private chiropractic practice, eight years in academian research at a chiropractic college, and six years as the first doctor of chiropractic to hold a full-time health policy and health services research position within a state government agency.

When it comes to the integration of CAM, Americans have already voted in terms of their preferences, utilizations, and expenditures. Nearly 15 percent of the U.S. population visits a chiropractor every year. Extraordinarily high levels of satisfaction have been documented with such CAM services. It's not a passing fad, as you know. Yet government and the greater health care system often proceed as though all CAM services are only a fringe movement.

From my perspective, the federal government has both an interest and obligation to constructively influence the future of CAM and health care in the following three areas. Provide meaningful federal support for CAM research and education. And I want to reemphasize what we've heard earlier today. Attain consistency in federal programs with national trends and priorities, something I haven't heard mentioned yet today. And I'll go into that in a little more detail. Promote collaboration and integration and expand the role of CAM within conventional delivery. We've heard about that already.

Regarding research and education, I'll speed through those comments and emphasize that in the written testimony I've provided you, I've outlined some of the things, and there's overlap with what other speakers have said. One thing I haven't heard relative to dissemination of information that's very tactical for the federal government to do would be to focus on getting National Library of Medicine indexing of CAM journals. The research dissemination and clinical information dissemination is much more readily achieved in that indexing database than the others where they are currently available, although there's a few. CAM disciplines must develop their own research expertise and infrastructure as we've heard that. I want to reiterate that, that is essential. Further, information necessary to the CAM professions to implement their own quality improvement efforts is absent, and that needs to be emphasized.

My second point regarding consistency in federal programs with trends, I want to emphasize that the federal government is behind the general public in terms of its coverage for many of its own health care programs. For example, chiropractic care is a core benefit in most personal injury protection workers' compensation programs and in health indemnity plans. Yet extremely restrictive and arbitrary limits exist in the very few federal programs that cover chiropractic at all. And chiropractic is in fairly good shape in the federal coverage compared to other CAM professions.

As an example of a meaningful effort at collaboration and integration, let me talk about my experience with the Department of Labor and Industries. In 1992 our department established a full-time chiropractic policy and research position. Many examples of benefits to both the state agency, the chiropractic profession, and more importantly, to the business and labor constituencies of the state workers' compensation have accrued as a result. One example is joint research between the Washington State Chiropractic Association, the Department of the University of Washington, which 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 legislative level. Including a chiropractic policy maker has helped in this very important area. This is a template that could be templated around in other federal agencies and encouraged in other governmental agencies.

Another point that we need to make is that there is a distinction between incorporation of certain CAM procedures into conventional medical practice and the integration of CAM providers into patient care pathways. Overall management perspectives, lifestyle approaches, and

doctor/patient relationships are pivotal in health care, and tossing a few CAM modalities into general family practice is not the same as integrating practitioners into constructive clinic environments, bringing extensive training skills and perspectives to the decision-making table. To illustrate this, consider reversing the scenario of chiropractor incorporating suturing and enseds(sp?) as a substitute for family medical practice. It doesn't work. I guess I'll stop there. Thank you.

**GORDON:** What do they say? Brevity is the soul of whit?
Clyde Jensen. You're not Clyde Jensen.

**DOWNEY:** I'm not Clyde Jensen. No. I'm speaking for Clyde Jensen. My name is Katherine Downey. I'm the Associate Dean of Clinical Education at the National College of Naturopathic Medicine in Portland, Oregon, where we offer advanced degrees in naturopathic and classical Chinese medicine. I'm here to present the testimony of our President, Dr. Clyde B. Jensen, who is the only person to have ever served as an executive in colleges of allopathic, osteopathic, naturopathic, and Oriental medicine. A death in his family has prevented Dr. Jensen from delivering his testimony in person. The following are his comments.

My experience in conventional and complementary medical education has convinced me that the best health care is integrated health care. Today I will make three observations with recommendations to facilitate the delivery of integrated health care.

First, doctors that train together treat together. In the rigid and often insular programs with which we educate physicians, there is little opportunity for medical students, interns, and residents to interact in any way but with their own kind. The products of these programs are distrustful of those who were trained in programs that differ from their own. I recommend federal support for integrated clinical training sites in which students, interns, and residents from conventional and complementary medical schools gain clinical experience in each other's presence.

Second, medical education trains doctors. Graduate medical education prepares physicians. Before conventional and complementary physicians can fully trust each other and confidently integrate their health care practices, their clinical training must be comparable in scope and in depth. The internships and residencies of graduate medical education programs provides the scope and depth necessary to confidently diagnose and treat. While graduate medical education opportunities are abundantly available for conventional medical school graduates, such opportunities for complementary medical school graduates are rare. I recommend federal support for the development of graduate medical education programs to prepare complementary medicine physicians.

Third, research is the common language of conventional and complementary medicine. The skepticism between conventional and complementary medicine providers can only be overcome by mutually acceptable research. To be mutually acceptable, research must be a collaborative process among conventional and complementary investigators. The research machine of the NIH and the academic medical centers can accommodate this research need if it is enriched with complementary medical investigators. I recommend that federal support be used to foster collaborative research by developing post doctoral research fellowships for complementary medicine trainees and by encouraging faculty appointments for complementary medicine investigators at conventional academic medical centers. Thank you for hearing my opinions.

**GORDON:** Thank you very much. Jim Taylor.

**TAYLOR:** I'm Jim Taylor. I'm a pediatrician from the University of Washington. I rewrote my thing when I saw your signs because I figured I had to chop it down some, so please bear with me.

I actually think we are in a very unique position for CAM research here in Seattle because there are located two large institutions with different approaches to health care, the University of Washington with excellent schools of public health and medicine, and Bastyr University, with Bastyr University Research Institute. The chance for collaboration between these two institutions and other places where there are such dual institutions is really unlimited. I think collaborative studies like this, or efforts like these would have enormous, would be enormously attractive to potential funders. And in fact, we've already had success. The reason I'm here today is because I'm part of a group of researchers from the University of Washington and Bastyr and private pediatricians in Seattle who were awarded an NIH grant for randomized control trial for the use of echinacea for treatment of colds in children.

In addition to lots of researchers with different areas of expertise here in Seattle, there is a high level of interest in CAM. In planning our study, we surveyed 600 parents whose children were being seen by private pediatricians. One-third of these parents indicated that they had given their child echinacea for treatment of cold in the past, and 53 percent had used at least one of the following therapies. These include herbal remedies, zinc, homeopathy, chiropractic adjustment, acupuncture, or massage therapy.

This interest in CAM has really been translated into participation in the study. In the first seven weeks of enrollment, a hundred children had been recruited from private pediatricians' offices and 45 from Bastyr University clinics. So we have researchers from many disciplines, we have a population willing to participate, and there are monies available for studies. So why has the collaboration been limited so far. And I thought of four things.

1. First is the lack of familiarity of alternative research and investigators by allopathic researchers.

2. Second is a suspicion of CAM therapies by allopathic practitioners. In my field, pediatrics, most of the research in the past is focused on the rare life threatening illnesses. A lot of CAM therapies, as you know, are helpful in relieving symptoms, so there needs to be a change of focus by pediatric researchers.

3. And last and most important probably, is in the past there has been a mistrust of practitioners and researchers from different disciplines.

I don't think any of these obstacles are insurmountable at all. There are too many positives to collaboration for future studies. And I would suggest that collaboration between allopathic clinician and researchers and CAM clinicians and researchers that include lots of patients from different areas is likely to have the most significant impact. This collaboration will result in the highest qualities of studies on CAM therapies, and maybe more importantly, the participation of allopathic researchers and CAM studies will facilitate the incorporation of CAM therapies with demonstrated benefit into the clinical practice of allopathic physicians.

**GORDON:** Thank you very much. The final speaker on this panel will be Karen Sherman.

**SHERMAN:** I'm Karen Sherman. I am an epidemiologist and also the Research Director at the Northwest Institute of Acupuncture and Oriental Medicine. I'm not an acupuncturist. My comments will focus on two important issues for the Commission. How can we use our limited resources to stimulate research on CAM practices, and secondly, how can we encourage CAM and conventional researchers to work together for mutual benefit?

Since CAM therapies are already being used by substantial numbers of the public, I think we should place relatively more emphasis on pragmatic clinical studies that examine CAM therapies as they're actually practiced, rather than the efficacy studies that are typically done of medications. If these effectiveness studies show that a CAM therapy yields good patient outcomes, then further studies can be done to find out which components of the intervention were responsible for its success, because it is true that CAM practitioners don't necessarily do the same thing, even when they see the same patient.

In addition, in the context of pilot projects in integrated care, which I do think are important, we can collect data on the safety of CAM therapies about which relatively little information exists and on some important patient outcomes for common medical complaints.

Performing rigorous research on CAM therapies is actually quite an intellectual challenge, even when collaborating with CAM practitioners as I do. I have experience in this area. I have been funded off of four grants, looking at these items, and also I've been involved in a couple of other studies. Often CAM practitioners are not well versed in research methodology. They may lack even very basic information that it would be necessary to construct protocols, such as how long the intervention should last and how often they should be given, or at least what the bounds of the limits on that are. I recommend that funding be available to help develop a research culture among CAM providers that would include monies for the development of rigorous courses on research methods in CAM institutions. I've been teaching acupuncture students research design for five years, and more needs to be done in that area.

In addition, conventional researchers need a better appreciation of how CAM is actually practiced so that they can think creatively and appropriately about designing such studies. The development of researchers who specialize in CAM methodology, people who would be familiar with the unique issues is also important. CAM research should based on what practitioners actually do. If we don't know, we need to ask them or perform surveys to find out. Most funded CAM grants, with the possible exception of studies of single herbs, have CAM practitioners listed as coinvestigators or practitioners, but often they're not really true collaborators, and that needs to change.

In summary, I think we should shift our emphasis on CAM research towards: 1) performing pragmatic clinical trials from the realm of health services; 2) in cross educating CAM providers and conventional researchers about each other's disciplines so that they are capable of collaborating with each other; and 3) in requiring clear evidence of real collaboration in preparation of grant applications. Thank you.

**GORDON:** Thank you. And thank you all four for your grace with the time constraints. Joe, do you want to begin?

## Questions from Commissioners

**MAN:** Dr. Taylor, thank you for your comments. I wanted to ask you how this would play out at the University of Washington. We hear a lot about collaboration and the need to synergize between the traditional and the CAM providers to do the kind of research that you describe. How would it play out at your university if the federal government, say, suggested that for you to be eligible as an institution to get federal funding a certain percentage of your work would need to be done with CAM providers? In other words, here you and Bastyr have a wonderful relationship. But what about all the other institutions where that relationship hasn't developed? How do you think that would play out in the dean's office?

**TAYLOR:** You're asking someone who is so far down from the dean that I have no idea what the dean thinks about. And without trying to be cute, I think it depends on, I think that would be very controversial. But I think it comes down to how much money is available and how much they need the money. If they need the money enough they would sort of make accommodations for that. But I would think before that people would suggest alternative ways to try to do that other than say you have to meet some quota.

**MAN:** Or just to leverage. In other words, there are certain research arenas where it would make sense to collaborate, and ways to fiscally promote that collaboration seems to be something we might want to think about. Can I ask a real quick question of . . .

**MAN:** . . .

**MAN:** Thank you. I really want to ask Dr. Mootz a question about the National Library of Medicine database and indexing of journals. And they use generally index medicases(sp?) the criteria. Is there a comparable gold standard for quality journals, not all medical journals are in . . . what other CAM journals would reach that threshold?

**MOOTZ:** Well, actually there are many CAM journals that are of similar quality to conventional journals that are in there. But NLM has pretty much limited it to one chiropractic journal. There is a couple of alternative health care journals that are indexed now. So to be blunt, it's relatively biased. I'm an editor of a chiropractic journal and we applied for indexing and it was turned down as irrelevant to chiropractic practitioners, yet it's probably the most comprehensive description of clinical practice activity of chiropractors. And the same has happened with three other chiropractic journals I know of. There have been some acupuncture journals I'm aware of that similar sorts of things have happened. And it's because the reviewers have no idea of the relevance or what it means. Having chiropractors and other CAM providers on the organizations would help solve that. NIH has one chiropractor now.

**MAN:** I have a question for Dr. Sherman regarding research of acupuncture. You understand that NIH funding the clinical trial using double blind study to treat arthritis knee, treat fibromyalgia, and other conditions. Do you have a better idea to design a study which could be convincing scientists, and also satisfy CAM providers.

**SHERMAN:** Well, I actually think that we will probably need to do a couple of these efficacy studies. It's impossible to have a completely double blind acupuncture study, but they're doing as

well as they can. It's probably necessary to do that to satisfy the scientists. But from a pragmatic perspective, I'd like to see some of these pragmatic trials that use the designs from health services first. Then if we find something there, then we can start to take the intervention apart. But I do think there are probably a few special cases for acupuncture where it's perfectly reasonable to do that quasi double blind study.

**WOMAN:** . . . Question to Dr. Mootz . . . direction of the Department of Labor and Industry. I understand there have been discussions about incorporating an . . . old model for participating doctors and so with a concern about access to the public for chiropractic, I'm wondering what you have to say on the issue of the managed care organization model as opposed to open access to every licensed chiropractor in the state.

**MOOTZ:** I think with the Department of Labor and Industry's patient choice and open access is a given. There is nothing on the radar screen about limiting access in any way, shape, or form. Patient choice is key to all of our policy right now. The physicians who can treat as attending doctors in our system are delineated in in WAC(sp?), in regulatory laws. So that's not going to change.

**WOMAN:** I hear CAM being referred a lot to as CAM therapies. And our concern with CAM is on a quality of life and health promotion. A great deal of it is on. Can any of you say something to that? Do you have research on what makes good health, instead of focusing on disease? Or your research is based on what money is available, and there isn't money available for studying on what keeps you well. In China we say that the doctor keeps a client well, and otherwise they're not a good doctor. So could you.

**SHERMAN:** We were actually beginning a study where we're hoping to take a look at some of the outcome measures that CAM providers feel are particularly important and look more broadly. But among the published literature that I've looked at for general health related quality of life, you're not really talking about optimal health. There's one called a ceiling effect, and beyond that you're not really going to measuring anything. So your points are very well taken.

**LOW DOG:** Kathleen, I think, from NCM. I am very sensitive to the question about postgraduate training, because it's been raised actually in some of the states where naturopaths have applied for licensure that there isn't this postgraduate training, which even many of your own naturopaths feel has put you at a little bit of a disadvantage because you just don't get to see the volume of patients. But what would you see as the, what type of postgraduate training? Would you see it, like as a family, three months of surgery, six months of pedes, six months of obgy? Is that what you're looking for? What is your dream of postgraduate? And how does that best, how can that be done and what should it involve?

**DOWNEY:** National College has become certified, has a certified residency program, this past year, through the . . . and the requirements for that residency program is that we have 60 percent of it is involved with a naturopathic doctor and 40 percent of it can be rotations with other practitioners of allopathic, well, mostly allopathic. That's how it goes in hospitals and things like that. Our ideal is, we have 23 residencies right now that are certified through our school. I'm now the director of that program. I'd like to see that double this year. And we're looking at all

sorts of programs that would be collaborating with hospitals so that our residents can work in various rotations. In Portland we're doing that as well. We have all of our residents rotating in different disciplines. So it would be more of a broad-based discipline, like you say. It wouldn't really include a lot of surgery, since we don't do surgery, but minor surgery, gynecology, pediatrics, dermatology, cardiology; all those disciplines and have rotations in those.

**LOW DOG:** So right now is it primarily that they go out and like apprentice with a naturopathic physician? Which is a good way to do it too. Is that what you're talking about?

**DOWNEY:** We have distant rotations. We have one, we have a couple with the Cancer Treatment Centers of America, we have six of them that are with our school, in our clinics, we have 16 community clinics, so they work with our naturopathic doctors in our community clinics in Portland. We have them with private physicians. So there is a lot of difference. And there are some that are working, there is one that is working in a clinic in Bridgeport, Connecticut, that is also collaborating with a hospital there, Griffin Hospital there. So it's a broad mixture of different types of residency programs.

**GORDON:** Tieraona, thank you for your question. And could you give us both a description of the residency and also a description of what you would like it to grow into, in writing. So what I'm saying is a description of the options that are available now, the rationale, and then your sense of how it ought to expand. Because I think that's a really good question and it would be very helpful to us. Tom.

**MAN:** Dr. Taylor, we've been hearing a theme that alternative practitioners need help applying for research grants, research protocols and so on. I'm wondering how the collaboration was effective and successful with the pediatricians and the alternative practitioners in your case. What was each bringing to the party? Is there anything that we can learn from your experience in what each professional was bringing to the collaboration?

**TAYLOR:** Basically I think our collaboration went really easily because of our situation. I think what the private pediatricians who participated in the study, what they brought is a real world view of what it's like dealing with patients all the time, having people ask them about these therapies, and they have no idea of either the names or what they do. So they brought that kind of focus to the group. I think for me working with the people at Bastyr, it was really an understanding, sort of, the basic science research on something like echinacea, and I think what I really had to offer was just sort of a pragmatic approach to doing a research study in a clinical setting like that. So I don't know if I really answered your question or not, but it really was very easy. And I think, I don't know about the other people, but I've learned a fantastic amount in this, and I know the pediatricians have. I'm not so sure the people at Bastyr have learned as much as I have, but hopefully they learned a little bit.

**GORDON:** Thank you. One of the things that would be helpful, too, both from your side, maybe if there would be some kind of joint statement that Bastyr and U of W could make about what kind of research training you see is useful. Again, you have a good history of collaboration,

that's probably longer than most places, and the lessons you've learned spelled in writing for us would be very helpful as we think through some of these issues we come back to research.

Thank you very much. We'll move into the next panel now. And the first speaker will be Suzanne Myer.

**Speakers**

**MYER:** Hi. I am an Assistant Professor at Bastyr University. I am teaching in the largest nutrition program in the state of Washington. I am also I think the only registered dietician that will be speaking to you today or tomorrow. I had been trained as a clinician and as a teacher. I have not been trained as a researcher. I would like to be more involved in research as a clinician, but as previous speakers have talked about, there are limitations in my skills and knowledge, and then in resources to help with me being involved in research.

Also, as others have recommended, I echo the recommendation on more outcomes oriented research, especially in the field of nutrition. I think it's very difficult in the field of nutrition to tease out what is actually causing a benefit. Like we know the vegetarian diets decrease heart disease, but we really don't know why. So outcomes research is very very important.

And then also as has been previously discussed, funding is crucial, especially in the field of nutrition, when we're talking about real food, whole foods. And I'm often asked, what is a whole food. And if you can think of it growing, that's a whole food. Marshmallows, you can't kind of see a field of it growing. So if you can think of it growing, that's a whole food. And unfortunately whole foods don't have a lot of deep pocket funders and lobbyists to go after research funds.

But really what I wanted to do was give you a clinician's viewpoint on why research is important. I think food is incredibly powerful, and I particularly want to help my students help their patients prevent chronic disease, treat their symptoms, keep them from having to spend a lot of money on costly medications. We have a clinic in Wallingford, and where I supervise students, and a few years ago a twelve-year-old boy came in with his mother, and his mother wanted to not increase his asthma medication. So she said, well, let's try food and see if food has anything to do with your symptoms. So the boy came in a little reluctantly, but I have kids so I worked with him pretty well. He followed a ten day elimination diet that we used to test food sensitivities. He came back after ten days and told him mom and I that for the first time he ran after his dog without wheezing. And tears were in my eye. We figured out that he was sensitive to corn products, processed corn products, like in pop and candy. He changed his diet. He decreased the use of his costly medication and I think most importantly he figured out the connection between health and what he's putting into his food. I think diet is incredibly important and I would like to see more research put into nutrition. Thank you.

**GORDON:** Thank you very much. Is Jacqueline Obando in the audience? She has a place on this panel if she is. Okay. William Lafferty.

**LAFFERTY:** I am as Associate Professor at the University of Washington Health Services.

We look primarily at cost, access, and quality of health care in the United States. And I really think it's important to recognize that we have so many issues with health care in the U.S. right now. For example, the Health Care Financing Administration estimates we're going to be spending over 17 percent of the gross domestic product on health care by the year 2007. Forty-two percent of the worldwide health care dollar is spent in this country, and we still have over 15 percent of the people who have no health insurance. We have so many incredible gaps. The integration of CAM is merely one in a very long list of issues that the United States is grappling with right now.

I was thrilled by your question about what creates health. The School of Public Health and Community Medicine feels that the most important determinates of health probably aren't medical care, either alternative or complementary. It's income, it's equal access to jobs, it's good education, it's good food, the ability to buy the good food that you're talking about. And I just feel that whole social context is so important in all of these discussions.

With that said, I'd like to talk a little bit about money. The question was, for me, what do we need to get the private community to involve itself more in CAM research. And I believe it really is this whole area of cost effectiveness. Because if a private insurance company sees CAM as primarily an add-on being used by sick people with really no trade off as far as cost effectiveness, it's really not going to be very attractive for them to do anything more than just prove that. If, however, there are areas of medical care where CAM not only improves quality but lowers costs, I think there would be a tremendous amount of private excitement about it. And I think what you just heard is maybe one example, the ability to dump expensive medications, higher quality of life, and all of that. But the point being is, all of this research is truly in its infancy right now. And nobody knows what is what.

Well, in Washington state we do have a unique opportunity. We license CAM providers and we have mandated insurance funding for many CAM services. And at the end of this year all of that will have been in place for 12 months. And so I think we need to take a deep breath, look at what we've spent on CAM services with our state law, through our mandated insurance benefits, see what it looks like, and then thoughtfully try to make some decisions about where we go from there, were we sort of see the immediate results from what we've already done. And I think that will be very helpful. And I think there are lots of other areas when you're talking about cost, access, and quality that are so important to look at in the context of what are our overall health care priorities. But I think we need bigger data, more data, and better data upon which to make these decisions. So I just urge you all to speak for the voice of collecting very good scientific and economic data on these issues.

**GORDON:** Thank you very much. Charles Simpson.

**SIMPSON:** Hi. I'm Chuck Simpson. I'm the Chief Medical Officer of Complementary Healthcare Plans down in Portland, Oregon. I suspect that you all have had it up to here with collaboration and partnership and are thinking more about lunch at this point, but I would like to offer you my comments in writing and just basically skip to the bottom line about something that I haven't heard here yet this morning, and that is the potential for partnership and collaboration between the research community, the CAM professions and those who help pay the bills.

My company basically contracts with health plans in my area. And I would like to point out that there's a big difference between Oregon and Washington. We're not just the state that's

between Seattle and Northern California. We have little different approach to integration of CAM into health care. In Oregon it is entirely market driven. There are no mandates. There are no legislative issues that are pushing CAM integration. It is all being done as a result of people making business decisions. And so that kind of brings me to my point, which is, and you've heard this from other folks, we really need to be developing the kinds of information that helps folks who do make health care coverage decisions, and despite all of the comments about public health, a whole bunch of us get our health care through the folks that we work for. The people that make those kinds of coverage decisions need some very explicit and pragmatic kinds of information about CAM and any other kind of health care, incidentally, when they're deciding what they're going to offer their workers in the way of health insurance benefits.

So my message to you is we need to help worker on figuring ways to improve collaboration among the payers, the research community, and the professions. And I would offer you one example in the Building Bridges model of not the local Building Bridges, but the Building Bridges model that was developed by the American Association of Health Plans and AHRQ that does exactly that. I think that may be a model that may be useful for integrating companies like mine with the broader research community.

And just as a side note, my company has a research relationship with Center for Health Research, which is the Kaiser Foundation research entity in Portland, and we have begun doing some very interesting kinds of work to address the questions of, are we looking at an add on or are we looking at a replacement cost when it comes to using CAM services. And what we're finding is it isn't just necessarily a measure of looking at the dollars spent on CAM on the one hand and looking at the dollars spent on medical costs on the other and deciding that yes, in fact, these dollars offset those dollars. What we're finding is that a dollar spent here really does not equate to a dollar spent there, and the analysis needs to be much more sophisticated. And so we're going down the road at this point of using conjoint analysis which, I've got to tell you I know nothing about, but it's a different way of approaching that very problem.

**GORDON:** Thank you very much. I have a feeling there are going to be some questions here. Tom, do you want to begin?

**CHAPPELL:** Yes. Mr. Simpson, could you speak about the motivation that the private carriers have for understanding and incorporating CAM services. Where are we in that regard? That is, risk management decision based making versus wellness providing services.

**SIMPSON:** I would look at it in two ways. One is that the health plans are responding to the market in my community. Basically Kaiser was hearing over and over again from their customers, bring us, the were starting with chiropractic, and that's where they started. Turning around, however, the health plans didn't know where to go. Didn't know anything about CAM. They had to turn to organizations like mine to help them figure out how to integrate CAM with the typical medical kinds of models that they had already in their system. They're real comfortable integrating the medical side, they just don't know enough about CAM to do that.

**WOMAN:** For Dr. Simpson. Part of our real life here, I know that CHP is attempting to make inroads into Washington state with Regions Healthcare and as Regions providers, our office already got a letter saying it was their intent to reduce the participating providers by 80 percent.

So with access being my issue, I would like you to address how your third-party administration is going to improve access to chiropractic for Regions subscribers.

**SIMPSON:** I'm not quite sure what that has to do with my presentation here, but I'll have a swing at it. You heard about the issues of cost, access, and quality, and you also heard from the OIC that they will be holding the local health plans to access standards. The only thing I can say is we will meet those standards.

**WOMAN:** Thank you.

**GORDON:** I have a lot of questions. And my questions are really asking you, because what you've touched on in terms of the models of how you understand whether a dollar here equals a dollar there and how do you understand the integration of different kinds of therapies, I would like you, if you have or are in the process of developing those models, to make them available. If you're going slowly, please go a little faster. Because our charge is to present exactly this kind of information to Secretary Shalala, to whoever is going to be the Secretary of HHS, to the White House and to Congress. And the sooner we have your best understanding of how this financing could work or is working, and especially how it should work based on how it could and is working, the better, from our point of view. So this is really, in the nature of our collaboration with you, we need your help. We need you to do take a look at the natural experiments that are going on and to tell us what's going on and then to give us direction in how you think it should go. And as best you can, drawing on the different models that you have available, to give us a sense of what it's going to cost to provide what to people. Just to share with all of you, as we have had our hearings in Washington, as we've been in San Francisco and here, and as we look forward to the next hearing on access and delivery back in Washington, we're working toward that bottom line question. So please help us.

Maybe everybody is hungry. You have one question. Go ahead Linnea.

**LARSON:** Just a real quick question. You're Dr. Lafferty. You said, and correct me, that we need bigger, more, and better data both in economic and scientific information before we make decisions. Is that the implication? Or is that?

**LAFFERTY:** I think we need to look, in Washington state, for example, I think we need to look at the decisions we've already made and evaluate available data, for example, at the end of this year, with the very large samples that we've got from the private insurance companies. That's primarily what I was referring to. And you're talking about 12 million claims over per company per year that we've never looked at anything quite on that scale has been applied to this particular issue. So I think when you're trying to balance priorities, you ought to have everything in front of you that you possibly can. And that's really all my comment is speaking to.

**LARSON:** But in way by implication, it's let's look at the data that generated out of the Washington experiment, and thereby apply that model to whatever we're looking at federally?
**LAFFERTY:** Well, I don't know if it'll apply to the federal model. It may in some respects. For example, you know, because at the federal level, Congress is continually debating patient bill of rights and can you really expand a patient bill of rights without including CAM in all fairness?

That's what happened at our state level. How can you self-refer to every allopathic specialist and get that in law and not include this whole other segment of health care provides. So I think the issue does come up. And it's going to come up over and over and over again and really warrants some very in depth look. And I'm not wise enough to know how all of this is going to work out.

**GORDON:** I think the question we're really asking you is to use whatever wisdom you have to tell us how you think it should work out in a way that would be reasonable, coherent, and provide the kind of health care that people need. So we know it's a big challenge. We need all the help we can get.

Speaking of help we can get, we're going to adjourn now. We'll come back at 1:30. For the first session a couple of us have a, we're going to a cable TV, Council cable TV, so Dr. Joe Fins will be chairing the first session after we get back which will start at 1:30. So we'll see you all then and thank you very much.

**White House Commission On Complementary And Alternative Medicine Policy**

**October 30, 2000**
**1:35-3:00pm**

**WOMAN:** . . . Arlene Darby, Nicole Ellis, Rose Eng-Lum, Bruce Milliman, the first panel, please come up, as well as Jayne Leet, Daniel Labriola, Gay Koopman, and Kathy McVay. Could you all come up, please?

**WOMAN:** Welcome back. I hope you all had a good lunch. Dr. Gordon and several of our commissioners are doing a brief television spot right now. They'll be back and joining us shortly. But we would like to go ahead and get started so that we can finish on time. If we could please have Arlene Darby begin.

**Speakers**

**DARBY:** I'm Arlene Darby of Bellevue. I've been a participant, as well as an advocate for, CAM. When I say "complementary," I mean "conventional" is in with that.

Praise for each one, including President Clinton, plus all who inspired him, who were involved in any way to make the White House Commission on CAM possible. Praise for the professionals and all participants who are and will be a part of the paradigm shift called CAM.

When a paradigm shift occurs, it brings about the challenge of change, and often some chaos occurs before one can celebrate the change and paradigm shift. Some participants here today have found themselves not only working to bring about the greatest degree of health possible, or at least the best quality of life under the circumstances, but also are participating in the process of defending their practitioners. Protocol, standard of care, is often a problem. Updating protocol is a basic premise to the shift of the paradigm in health care. Pushes and pulls of political forces -- not just government, but other political forces -- is a reality. With pen in hand and paper -- legal documents, that is -- the power base in Olympia and other states, plus the political strategy, strength, and support of the power in Washington, D.C., CAM can become legal.

What potential is possible if practitioners and patients could only talk to each other about all possible facets of care! Pecuniary or money matters are very powerful, perhaps more powerful than political powers. Actually, pecuniary matters and political powers are intertwined. All participants for CAM will need miraculous negotiating skills, skills as awesome as those of people who have done the impossible in every field of endeavor throughout history. Planes -- Boeing, that is -- and Microsoft, along with the whole high-tech field, have given people, projects, programs, and products an opportunity to be all over the world. However, people, projects, programs, and products have also arrived here. Included are cultural differences in health care. CAM is a part of this.

Again, praise for all the leaders in the Puget Sound area and beyond for their vision, persistence, and perseverance in pursuing the challenge of the paradigm shift in healing and

health care so that safe and effective CAM therapy will be made legal. Please pursue all efforts on behalf of making CAM possible and legal.

May I hold up one other praise? Our natural medicine clinic in Kent was on *The Today Show* in 1997, the week they did a feature each day on alternative health care.

Thank you.

**WOMAN:** Thank you. Nicole Ellis? Is Nicole Ellis at the podium? Rose?

**ENG-LUM:** Thank you. We have all come back from lunch, and some of us may be a little sleepy. In Chinese medicine, we would call that spleen deficiency, wouldn't we?

My name is Rose Eng-Lum. I represent Dai Wai Association. I'm the founder and the president. We are a very unique organization in that we are trying to apply integrative medicine, a holistic approach -- that the mind and the body and the spirit absolutely must be integrated for people to have wellness. We focus this information in the area of a societal problem, and that is suicide for youth, and also for other sort of closed conditions in society that lead to disease. In those areas, we talk about domestic violence, sexual abuse, sexual orientation, in view of trying to help the community understand that when individuals are totally integrated, they do not then have a reason nor a will to do harm to themselves or to others.

A secondary issue I would like to address is that of, hopefully, alternative and complementary medicine will make its way into the public-health clinics and be available for migrant workers and for individuals whom we may call disadvantaged populations. Environmental studies have shown that people who are exposed to pesticides, herbicides -- some of this huge degradation of the earth for the sake of productivity has done great harm to people's health. In public testimony, individuals have stood up and talked about how only alternative medicine can help them.

Therefore, I feel we owe it to them to search our souls, to be able to implement this type of practice and make it available for those individuals who cannot be here today or have a voice.

Thank you.

**WOMAN:** Thank you. Bruce Milliman?

**MILLIMAN:** My name is Bruce Milliman. During my tenure as president of the Washington Association of Naturopathic Physicians, the all-category law came into force and mandated, as you've already heard, that all health-insurance plans provide relatively unfettered access to all categories of licensed care. In 1995 and 1996 of that year, I was invited to meet with the medical directors of several health plans in our state to propose how my profession might be included in third-party reimbursement. I stated that, as we were qualified and trained in fully accredited naturopathic medical schools, as we were required to pass state-administered naturopathic medical boards and were licensed and regulated the state of Washington and were accessible to malpractice insurance, and also that as we were designated as primary-care providers by our state secretary of health, we should be incorporated into the various reimbursement plans marketed by the health-insurance companies on a level playing field with conventional providers.

I further recommended specifically, number one, that we have direct access by patient choice to naturopathic medical services, and number two, that reimbursement for those services be equal to conventional medical reimbursement.

We have achieved these goals in the state of Washington with two of the largest health plans. However, other major health plans have created obstacles for patients to care and to equal reimbursement, in four ways: Number one, by limiting patient access to care to a restricted number or list of diagnoses; number two, by limiting patient access to services rendered to an amount not to exceed a specific dollar cap; number three, by limiting access to care by a requirement that the patient must be referred to care by a conventional medical provider; and number four, by limiting patient access to a narrow panel of providers.

The naturopathic primary-care physician 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, all licensed, accredited CAM services should be reimbursable by all federally funded programs. CAM services should be required to be delivered by providers degreed in said accredited CAM programs. Funding should be available to form CAM peer-review committees throughout the country. Funding should be made available to assure access to residency training and loan reimbursement for all CAM professions.

Naturopathic physicians are a national treasure, especially as our population is aging, and should be part of the solution set to heal an ailing nation and an ailing national health-care system.

Thank you.

**WOMAN:** Thank you. Jayne Leet?

**LEET:** Honorable Chair and Honorable Commission Members, my name is Jayne Leet. I have a degree in social work and an MBA in health-care management, with thirty-two years' experience in community health programs. I currently own and operate a licensed adult family home, providing twenty-four-hour care to frail elderly.

My remarks about access to CAM providers are the result of my experience as a CEO of the Community Health Centers of King County at the time of its implementation of the first publicly funded CAM program in the country, as well as my own experience as a consumer diagnosed with a very aggressive form of breast cancer in July of 1995, who decided not to undergo the usual standard of surgery, radiation, and chemotherapy.

Due to the lack of time, I will quickly list my recommendations for consideration for policy: One, require medical insurance carriers to offer access to licensed CAM providers within all coverage plans, and not just their most expensive. Two, require the same of federal Medicare programs and state Medicaid programs. Require medical insurance carriers to allow for consultations and second opinions by licensed CAM providers. Again, the same requirements for Medicare and Medicaid. Three, require insurance companies to allow for coverage for non-prescription substances prescribed by a licensed provider and certified by that provider as a primary required component of a treatment plan chosen by the consumer with informed consent. Again, the same for Medicare and Medicaid.

Examples in our community health center: We found good results with garlic-melon ear drops for otitis media. Low-income individuals on Medicaid would not choose this option due to lack of coverage under Medicaid. They would continue to choose covered antibiotics even when ineffective and a lesser choice.

My own example was, I elected not to go with radiation/chemotherapy, which would have cost tens of thousands of dollars, but instead went with a much lower-cost but totally out-

of-pocket cost, based on detox, pancreatic enzymes, and supplements. My comprehensive insurance program covered nothing except a basic doctor's office visit.

I see very few insurance companies represented on the speaking panels. I hope efforts will be made to ask them what it would take to get them interested in coverage in CAM, through some sort of survey or special programs. Perhaps government incentives should be offered to insurance companies for long-term studies regarding the cost and outcome of utilization of CAM providers and natural supplements. In addition, medical-coverage insurance companies could offer a partial cash-out of annual or maximum insurance coverage for those patients with catastrophic or terminal illnesses who choose, through written informed consent, other options. This is currently done with life-insurance companies.

I would like to see this Commission assess the regulations and means by which state boards of health and federal regulators can dismantle practices and remove licenses of providers practicing in the CAM realm. In many instances, two to four MDs, not even of the same specialty, have been able to strip MDs utilizing, quote, non-standards of care, unquote, of their licenses. It would be very beneficial to access if the Commission could be instrumental in revamping the narrow constraints dictated under the rubric, quote, standards of care, unquote; instead, promote the incorporation and integration of CAM treatment modalities through which wider use of informed consent could be utilized.

I would also like the Commission to support the integration of CAM providers within the community-health-center network across the country, to serve low-income, elderly, and ethnic minorities. It has proven a success in this region.

Thank you very much for this opportunity.

**WOMAN:** Thank you.

Before we start our questions, we would just like to let you know that insurance companies were asked to come and participate, but did decline. If any of you are present, we certainly would encourage you to submit your comments, since there has been a lot of reference to you.

Dr. Tian, start questions, please.

## Questions from Commissioners

**TIAN:** So how do we do a survey for the insurance coverage? You want to give a grant to insurance companies or some scientific people to do the job, or a CAM provider can do the job?

**LEET:** I guess I would hope that there could either be grants or some other form of incentives that would encourage them to do studies. When I have talked with insurance companies, the response I always get back is, if they incorporate CAM providers, then it will be a higher cost because people won't choose either/or; they'll choose both. My response to them has been, so what? I think, in the long run, you will find that the cost of coverage may be lower. That's a long, long run, in terms of preventive. Certainly in terms of cancer, where more and more people are seeking other alternatives, I think there could be studies that would show that the cost is lower. But they seem to be very fearful of opening that up because people would tend to choose both, and the cost would be higher.

**CHOW:** I'm also directing a question to you. Your decision to use CAM therapy instead of Western medical approaches -- was money the main factor?

**LEET:** Oh, no. It would have been far cheaper for me to have my insurance coverage pay for the traditional methods. I had a sister die of breast cancer who went through the chemotherapy and the mastectomy programs. It was purely a belief system on my own part. Being involved in the health-care system, I certainly had several MDs who came to me and told me I was making a terrible mistake. I will say that it was truly an integrated program. Before I made my decision, I did avail myself of a breast MRI to see how extensive it was, before I made a decision not even to have lymph nodes removed. I did do a lumpectomy, but I did not do the suggested mastectomy. I did seek out several providers, and I sought out MD providers and oncologists that would be supportive of my decision to see natural medicine.

But certainly the cost to me was far more than it would have been if I had had my insurance company cover the traditional method. If my insurance company had been willing to pay for what I chose to do, it would have been far cheaper to them than the cost of the chemotherapy and the surgery and the radiation.

**CHOW:** But you made an informed choice.

**LEET:** I made an informed choice.

**CHOW:** This is important.

**LEET:** It's very difficult to make that informed choice, however. I also had several MDs tell me they were afraid to support my efforts, especially with an oncologist who at the time was basically in the process of having his license removed from the board of health, and, though several of them said they wanted to come to that provider's support, refused to do so for fear of their own license.

**WOMAN:** I have a question for Dr. Milliman. There have been a lot of questions about whether Western medical providers sort of be co-opting many of the complementary therapies -- learn a little manipulation, learn a little acupuncture, learn a little herbs. There has been some critique that that's not really practicing within the paradigm that those systems often include, whole systems. Are there holes in your training that you think Western practitioners or Western-trained physicians -- because I'm hearing about limited diagnosis, referral by conventional medical doctors -- are there areas that you think Western providers may be better at addressing and certain areas that naturopathic physicians would be better at addressing? Sometimes I see that there's a little blurriness, because naturopathic training is very similar to Western medical training, in some regards, with basic medical science, but then treatment varies. Do you hear what I'm saying?

**MILLIMAN:** Yes. I think that if we look at the Western medical paradigm and think of the division of medical specialties into specialties and subspecialties, if a family practitioner were to come across a very complex cardiovascular problem, they would undoubtedly refer that person to a cardiologist, and so on; similarly in our arena, if some of the individual therapies can be applied, probably even in a not harmful and very helpful way by conventional medical

practitioners, who may have weekend seminars or other kinds of training in alternative therapies. But, ultimately, if somebody is going to be treated in a whole-person system, whether it's Chinese, Oriental, medicine, acupuncture, or herbal medicine, naturopathic medicine, et cetera, they would need to see somebody who, as I alluded to in my remarks, was actually qualified in a degreed program; their educational training had risen to a licensable level of qualification -- just as if, again, a general practitioner in the conventional arena were to perform brain surgery. Even though it's technically within their license to do surgery, it would be medically irresponsible and nobody would sit still for it; the disciplinary board would be down on it. It's exactly the same. It's a very clear model we have.

**WOMAN:** The other part of that question was, at least in my state, in New Mexico, part of the issue of primary care and naturopathic physicians has been the question, are naturopathic physicians trained to be able to make the diagnosis of a patient coming into the clinic. Have you seen enough patients to be able to recognize a complicated cardiac patient for referral? This is a question that comes up all the time. I'm just asking -- you've been through the training -- what do you feel the level of training is, and expertise? Are there areas that Western providers should be seeing, versus naturopaths?

**MILLIMAN:** If you're talking about in terms of triage, if a person comes to a primary-care setting, whether they come to a primary-care osteopathic physician, naturopathic physician, medical doctor, or ARMP, or midwife, if that person is trained, licensed in a qualified training setting, in a fully accredited school and is practicing -- they're actually in practice -- they're absolutely qualified to triage: Does this person need to go to a cardiologist or can I manage their level of hypertension or cardiovascular disease in-house? Any one of those licensed, and licensable and credential-able, provider groups could make that decision responsibly, safely, and, undoubtedly, effectively.

**MAN:** Ms. Leet, I apologize for missing your testimony. I did hear a little of it. I was wondering if you could perhaps comment on the relationship, if you've had any experience with hospice activities and CAM.

**LEET:** Only to the extent that, as now an owner of an adult family home, where we care for frail elderly, we have had the opportunity of taking care of hospice patients, as well as very frail stroke patients, diabetics, et cetera. I can tell you that our efforts to work with conventional MDs in terms of being willing to prescribe any kind of natural remedies to help these people is very difficult and very intensive. But it has worked, and we have seen remarkable results for reduction of pain, for having people totally removed from insulin for diabetes, for people that had been diagnosed, for example, with Parkinson's, losing their tremors. For people with arthritis, which we see every day, I can't believe the number of doctors that still are unwilling to try something as simple as glucosamine products in terms of at least attempting to relieve some of that pain. We have seen men that are incontinent -- the use of saw palmetto.

Once conventional docs say the usual -- "okay, I guess it will do no harm" -- they are totally amazed at the results, and at least are more willing to prescribe that for other patients.

**WOMAN:** Any other questions? Thank you.

Now we have Daniel Labriola.

**Speakers**

**LABRIOLA:** Thank you. When I first started this journey twenty years ago, the White House couldn't even spell "complementary" with an "e," so I have to tell you, I am really happy to see you all here.

I'm Dan Labriola. I'm a naturopathic physician. I practice in Washington -- well, maybe they could spell it. I didn't meet anybody who could.

What I'd like to do in the next 2.9 minutes is discuss how the delivery of CAM therapies in some jurisdictions, which are delivered in an inconsistent, if not incompetent, way, is affecting public safety, the public interest, and the hard work of this Commission. I'm also going to suggest some ways that the Commission can provide some leadership and guidance in this area, in my view.

Let me give you a little background, so you know where I form these positions. I'm a naturopathic doctor. I have been practicing for fifteen years. I'm a Bastyr graduate. I was one of the principal authors of the legislation that currently licenses naturopathic physicians in the state. I was the first ever special adviser to the Department of Health in the state for complementary and alternative medicine. I was the first chair of the governing body in this state within the Department of Health, called the Naturopathic Advisory Committee. I did that for almost ten years. I participated in other really exciting government initiatives, such as the health personnel resource plan, which you'll hear about. I currently direct the Northwest Natural Health Clinic. I am now also director of integrative care for a very large integrated cancer facility within the Yakima Valley Memorial Hospital System. It's called the North Star Cancer Center, which is a fully integrated, high-technology treatment center where naturopathic physicians and other CAM providers -- acupuncture, traditional Chinese medicine, et cetera -- will be coexisting and functioning in direct integration with conventional medical specialists -- a very exciting program. I've been doing this for a very long time. Actually, even as long as twelve or thirteen years ago, I was a consulting physician within the Fred Hutchinson Cancer Research Center, as a naturopathic physician.

In this time, and in the next fifty seconds, I can tell you that I've seen the best and I've seen the worst. I've seen outcomes that could never be accomplished by conventional medicine alone, because natural medicine was participating in a real and valuable way. I've also seen the very worst. I've seen morbidity, I've seen extreme side effects, and I've even seen deaths as a result of patients getting either bad advice from unlicensed or unlicensable providers, or just making simple mistakes on their own. I have seen enough to make you sick. I've seen teenagers, and others, just as a result of having done things incorrectly.

So there is a real need for this information to be provided in a real consistent and competent way.

My request is that the Commission consider developing basic policy and encouraging jurisdictional licensure and enforcement and regulation to protect the public interest and take advantage of the leadership opportunity that you have to have this freedom of choice available throughout the United States and various jurisdictions where this licensure occurs. Washington State is an excellent model for people to look at. You are going to have a really great speaker later today, Bob Nicoloff, who's the executive director from the Department of Health for most of these.

Thank you.

**WOMAN:** Thank you. Everybody has so much to offer, we're sorry we don't have more time. Gay Koopman?

**KOOPMAN:** I'm speaking on behalf of access, delivery, and reimbursement for integrative care, focusing on the aspect of delivery. For my pregnancy, I chose my health-care provider as a licensed midwife, and a birth-center delivery was planned. However, after twenty-four hours of labor, a hospital transfer was done. At the hospital, the nurses were not willing to review the chart with the licensed midwife. They were resistant to hearing about the labor history from her or to allow her to continue to participate with my delivery. When the doctor arrived, the entire atmosphere changed, since there was already an established relationship between the doctor and the licensed midwife. Additionally, the nurses were, at times, bothered by the role and level of involvement of my labor coaches.

With more understanding, education, and respect for what licensed midwives do, this transition would have gone much more smoothly, for the nursing staff, but mostly for me and my daughter.

For a few months after the birth of my daughter, all medical bills were mailed to me, some more than once, even after I contacted them with the correct information. The insurer expected me and the licensed midwife to know which insurance products the doctor was a preferred provider with, and that it wasn't enough that the doctor was a provider with their company. In the end, it was resolved, but if there were stronger relationships with all types of providers, insurers, and their practices, there would be less stress and confusion on behalf of their patients.

**WOMAN:** Thank you. Kathy McVay?

**MCVAY:** Good afternoon. I'm Kathy McVay, and I administer our state's loan repayment and scholarship program for health professionals. Our program was created in 1990 to address the critical issues of shortages for rural and urban underserved individuals in our state. You heard this morning something about our federal program. Our state program was created to mirror that federal program. I'll tell you that connection later.

First, I believe we are the only state in the nation that provides loan-repayment and scholarship support for CAM professions. Currently, our program includes naturopathic physicians and licensed midwives. The midwives are eligible to receive support from both scholarship and loan-repayment programs. However, due to lack of Medicaid/Medicare reimbursement for MDs, they are eligible for loan repayment only. Currently, we have two naturopathic physicians receiving support from the loan-repayment program.

The decision to exclude them from scholarship was based on lack of reimbursement for seeing a population which is required by the service obligation of the program. The lengthy debate by the program's advisory committee determined that the program could not be responsible for the economic viability, or lack of, for a provider with a commitment to serve the Medicare/Medicaid population. As a result, MDs are eligible for loan repayment until a time that the need in the communities outweighs our ability to assign them to the communities. At that point, when we determine that the economic viability for them would survive, they would then be able to receive scholarship, which commits them to an obligation when they're trained.

Second, as a result of this debate, the CAM professions have taken it upon themselves to create outreach and education to communities about their professions. Funding for that ongoing outreach is necessary in order for that to continue.

Third, if CAM providers were included in the National Health Service Corps Program, we, as recipients of federal dollars for state match, would be able to use those dollars across all of our professions that our state now supports.

In summary, we have a successful collaborative relationship among all health professions in Washington State. With more funding and fewer restrictions on reimbursements, that relationship will grow and be stronger.

Thank you.

**WOMAN:** Thank you. Effie, we'll start with you.

**Questions From Commissioners**

**CHOW:** I don't have any questions.

**WOMAN:** I didn't quite understand everything you said, so I just need you to give us a copy of it. I couldn't follow all of the details.

**MAN:** Dr. Labriola, your reputation precedes you. I was flying in yesterday to Seattle, and someone said, "Are you going to hear from Dr. Labriola?" I said, "Yes," because I had just looked through the agenda. So it's nice to meet you. Your reputation does precede you.

**LABRIOLA:** Thank you.

**MAN:** You were talking about bad outcomes, the worst and the best. Has the state developed any kind of tracking system to identify adverse outcomes from CAM practitioners that we could learn from, through the licensing process or requirements?

**LABRIOLA:** It's a very good question. Most of the bad outcomes are from people who are either not in the licensing process -- for example, in Washington, D.C., anybody can walk in off the street, with even a mail-order diploma, and get basically a registration that says, "I'm now a naturopathic doctor," put it up on the wall, and see people. They're not tracked very well. Where these get tracked is in malpractice actions that tend to be practicing medicine without a license. Others are in civil suits. Others are in criminal inquests, when the outcome is really, really bad.

I did review this about twelve years ago, when we were getting our licensure here. It's a long, extended job, but that's possible. It can be done. Many of these cases are documented elsewhere. Some of the cancer deaths that I've seen are actually published papers. So some of that data is available. It's kind of time-consuming, but it can be put together.

**MAN:** But that's a retrospective -- if I may ask a follow-up question, Madame Chairman -- we can look at it retrospectively if there's been an adverse event. But what if a practitioner -- I think there's an argument here for licensure, to teach people to report adverse events. If someone is

not licensed and they're out of the system, they have an observation -- several patients have a certain kind of adverse response to an alternative therapy. What kind of training has been done to train CAM providers to know what to report, to identify trends, so we can track things prospectively, and not have to deal with the lawsuit or the inquest after the damage has already been done?

**LABRIOLA:** In a really good regulated environment, like Washington State, which is arguably among the best, we teach subjects such as drug-nutrient interactions, clinical diagnosis, clinical treatment, which you were talking to Dr. Milliman about before, to try to identify some of those interactions. Unfortunately, the interactions are not always identifiable. The patient comes in with dyspepsia, and the first thing you ask is not, "Are you taking an herb," the first thing you try to do is sort out if something else is going on. Oftentimes, these problems are multifactorial, where there may be a problem that's increased many-fold as a result of something that was done incorrectly in a CAM environment.

It's not an easy subject. But the state of Washington has been very proactive in its training requirements, at least for naturopathic physicians. I think we're going to be incorporating more of that with TCM and others. So there is a model.

**WOMAN:** Effie, did you have a question?

**CHOW:** Thank you for your presentation, and congratulations on all your firsts. There have been a lot of organizations referring to outcomes research in this discussion this morning. You said that you've had really outstanding outcomes research. Is that what I understand?

**LABRIOLA:** I've had wonderful experience. I've been doing this for fifteen years.

**CHOW:** They're large studies, are they?

**LABRIOLA:** There are not a lot of well constructed studies right now. There are some that are very good and valid, that provide us good information. The resources have never been there to really do more comprehensive studies, which I think need to be done. We know many of these therapies work, but we haven't put them into large national cohorts yet, which is something that needs to happen. But that takes research money.

**CHOW:** I hope that you'll do that soon, because your research data will be very helpful to us, in the sense that there is a big debate in the whole research area about the clinical trials and the double-blind studies and all that. Outcomes research and best-case series and field research is perhaps the appropriate area. It would be helpful if you could gather that for us, the data, as much as you have.

**LABRIOLA:** I'd be happy to continue this discussion. It's a pretty big subject we're talking about here. I agree with you completely. It's just critical that those resources be applied and that the people constructing these studies construct them in a way that we're getting really valid results and we're establishing controls -- which is not always an easy thing to do -- establishing crossover, and basically establishing scientific credibility here, so that it just can't be -- you know, what is, is, and what isn't, isn't. Oftentimes, because of lack of resources, we don't have

enough available to us to really make these studies comprehensive. There are a lot of good ones out there. But I agree with you completely; we need to be putting more effort in this area.

**CHOW:** Again, we need good models now.

**LABRIOLA:** Yes, I agree completely.

**WOMAN:** One quick clarification, if you could, for the group. There are schools of naturopathy that you take the boards for. There are also mail-order naturopathic places that you can get naturopathic degrees from. Were you saying that here in Washington, if you've been through sort of a mail-order type of MD training, you can actually be licensed and reimbursed?

**LABRIOLA:** No. This was Washington, D.C. I don't know about reimbursement. No, no, no. Let me be very clear about that. Washington, D.C. -- the state of Idaho is another state where you can do this. I don't know about reimbursement. Actually, I understand that some of these people get reimbursed, which baffles me. I won't even start on that. It's not the only thing I've been baffled about over the years. But in Washington State, they run a pretty tight ship, and I don't know that anyone practicing outside of the legal system is reimbursed. There may be people who could give you a better answer to that.

**WOMAN:** Thank you.

**WOMAN:** I have a question for the Commission. You are looking for large batch studies that are done to clinical specifications that would pass double-blind testing conditions. Do you look seriously also at the literature where individual naturopathic doctors or practitioners of Chinese medicine and other practitioners in the alternative-care field -- do you look at the professional journals, at monographs and so forth, where someone has presented a case study and documented the treatment from beginning to end?

**WOMAN:** Thank you for the question. If you would submit that to us in writing, we'll be able to respond to you, but in this forum, we won't be able to answer your question.

**WOMAN:** My question is, do you honor those the same as you would aggregated data, large batch data from Bastyr University or other things like that?

**WOMAN:** I think we're looking at the whole range of information.

Okay, thank you. Let me call up the next group. Fred Bomonti, Laurence DeShields, Tracy Turner, John Huber. Also, if the following people can come up at the same time: Lawrence M. Jacobson, Laura Patton, Elizabeth Goldblatt, and JoAnne Myers-Cieko.

**MAN:** It's nice to be back. We were just meeting with the county council for a few moments, and felt very warmly received and bring back their greetings as well.

Fred Bomonti?

**Speakers**

**BOMONTI:** Thank you for the opportunity to speak today. My name is Fred Bomonti. I'm a chiropractor, and I've been in private practice for over thirty years. I had the good fortune -- or the bad fortune -- to be in training and begin practice as the AMA began its organized effort to, quote, contain and eliminate the chiropractic profession, unquote. I've been an observer of the assimilation of osteopathy by the allopathic profession and now the beginning assimilation of the other vitalistic professions, including my own.

To, quote, maximize the benefits to Americans of complementary and alternative medicine, end quote, it is important, in my opinion, that we understand that allopathic medicine and the so-called complementary and alternative, CAM, professions are not and cannot be considered by the same standards. They are two different paradigms of health care with a common focus. That focus: the health of a human being. Allopathic medicine has a history and a focus of treatment and prevention of disease by attacking the disease to preserve life. It is the offensive unit. Alternative medicine has a history and a focus of treating people, promoting health, to increase the quality and span of life. We could call it the defensive unit. Both viewpoints are valid and are the flip-side of each other. Both are necessary. Procedures of each can be used offensively or defensively. One is vitalistic, promoting the innate, inborn healing ability of the body, and one is atomistic, promoting the scientific imposition of treatment on the body.

For the past one hundred years, the mechanistic, atomistic philosophy of health care, represented by the allopathic profession, has been the dominant political force in America. It has ruthlessly attempted to stifle, crush, eliminate, assimilate, or destroy all opposing viewpoints for its own maintenance of power. These attempts continue today. Without acknowledging the political conflict of interest and the lack of objectivity brought by our various backgrounds of training, we will not get an objective analysis of the potential benefits of the so-called CAM professions. The focus will be on the atomistic philosophy remaining in power or, from the vitalistic side, what do I have to do to survive? Until we recognize that maximizing benefits to Americans or maximizing the health of people is our overall purpose, not perpetuating a particular political point of view, we will not be able to obtain those maximum benefits. In other words, the integration of members of the recognized accountable healing modalities on their terms into the mainstream health-care system can improve the individual health of human beings, and thus society. Assimilation of CAM proceedings by the members of the allopathic community and calling it alternative will do nothing but continue the present insanity we call health care, "insanity" being defined as doing the same thing over and over again, expecting a different result.

I believe it was Einstein who said the same mind that created the problem cannot solve the problem. It is incumbent upon all professions to focus on the person, not the method; the goal, health, not the one who gets the credit.

Considering that's the last minute, I'll let you read the rest of it yourself.

**MAN:** Thank you. Laurence DeShields.

**DESHIELDS:** Hi. I'm Laurence DeShields. I'm a consumer and a board member of the Community Health Centers of King County. My experiences were kind of vast, in that I've had problems for the last forty, fifty years, and have gone to physicians, in my travels. I traveled all around the world in my work before I retired. I still had the particular problem. When I was here

in Washington, I decided to go to see the Community Health Centers, just as another alternative, just to see what would happen. I went to see a physician. The physician decided to get all my records. She actually got them from everywhere . . . in the United States and outside the United States. After she got all of these records, she asked me if I thought there was a solution. I said, "Well, it doesn't seem like it, in all these years." She said, "Are you open to alternative options?" Then I looked at the naturopathic medicine, and I looked at acupuncture. When I went to the naturopathic medicine, they took time and care and they were very patient. That was the first time I was ever in a doctor's office for an hour-and-a-half that they weren't doing surgery. They were trying to really understand and quiz me, to make sure they had all of the facts before they could go off.

The bottom line was, the result was that they came up with a homeopathic cure that has worked. I have not had the problem since.

Thank you.

**MAN:** Thank you very much. We appreciate it. Tracy Turner.

**TURNER:** Hello. I'm Tracy Turner. I wanted to give you my story as a patient, and how I've benefited from complementary and alternative therapies.

I'm a patient of Country Doctor Community Clinic here in Seattle, Washington. I was AIDS-diagnosed in March of 1995. I also suffer from grand mal seizures, as of mid-1996. I strongly support complementary and alternative medicine. After your review process, I hope you will decide for aggressive study and funding of CAM, which will allow patients more flexibility and alternatives in their health care.

The reasons I use complementary and alternative therapies is that I have such severe reactions to virtually every medication I try, so severe it took me over a year to get on my first anti-seizure drug or HIV medications. After utilizing these therapies, I'm proud to say I've been on them for three years.

Also I have chronic muscle pain caused by my seizures. The three therapies I utilize are acupuncture, massage, and chiropractic services. Acupuncture has by far helped the most in alleviating side effects from my medications, such as nausea, loss of appetite, pain and numbness caused by neuropathy, migraine headaches, chronic fatigue, rash, general feeling of ill health, just to name a few. Massage has also been very helpful in alleviating pain and numbness of my neuropathy. It has also reduced muscle pain caused by my seizures. It has given me an emotional well-being in order to more enable me to deal with my illness. Chiropractic services have also been of great benefit, helping with my grand mal seizures. After each seizure, I have severe neck and back pain that won't go away. I tried muscle relaxants and pain medications, and I either had great reactions to those or they weren't working very well at all. Chiropractic services, I'm proud to say, have made me to the point where I can live without back pain.

Two groups that can benefit most from complementary and alternative medications are those suffering from severe drug side effects -- it might entice people to stay on the regimens when otherwise they wouldn't. Sometimes the side effects of the medications are worse than the illness itself. Also it would give alternatives for people not responding well to medications, Western medications.

In closing, when making your final decisions on the subject, I hope you will recommend aggressive study and utilization of CAM, that adequate funding will be budgeted for study of

various therapies and financing will be appropriated for low-income patients so they may obtain these services as well.

Thank you very much.

**MAN:** Thank you very much. John Huber?

**HUBER:** I'm Dr. John Huber. I'm a chiropractor. I practiced for twenty years in the Kent area and for the last five years, I've been teaching at a community college. We have an integrated health program in our college. In addition to nursing and dental assisting, respiratory care, and medical assisting, we have a chiropractic technician-training program. We teach our technicians how to take x-rays and help with the exam process. They assist in therapy and help in the coding and documentation process.

One of the big problems we've seen with integration of CAM, and especially chiropractic, into traditional forms of payment, like insurance companies, is the type of documentation they require. So we're kind of driving the protocol backward by teaching paraprofessionals how to support doctors in getting their documentation done properly. It's kind of a backward way. The chiropractic schools really don't have time to go into a lot of detail about coding choices and the kinds of things that payers are looking for. We are trying to fill that gap by supplying chiropractors with very competent, highly skilled paraprofessionals. We would like to see that duplicated across the country. There are only a few programs like this in existence.

Some of the barriers are the startup costs -- it costs $100,000 to $200,000 to start up a program when you consider the x-ray facilities, equipping labs. Curriculum is a big problem also. There aren't a lot of programs around, so developing curriculum is pretty tough. We were able to get a federal grant to help with that, to do a skills-standard study, to give us a task analysis to base our curriculum on. So that was very helpful.

Other barriers include enrollment. While CAM services are popular with the public, from a patient standpoint, getting students interested in going into paraprofessional programs to support CAM is difficult, because it's not well known or not well understood what it is that they do, what kind of training they need. Also we had some attitudes to overcome on campus, as you might imagine. When the nursing program heard that chiropractic was coming to campus, there were some issues -- some petitions and those kinds of things.

But here in Washington State, we have a much more open attitude about alternative ideas. We have really come a long way in the last five years. We also now offer programs for doctors and current paraprofessionals. We try to keep doctors up to speed on all the changes that occur every year with coding and relative values and all of those kinds of things, so that the parts of our services that are covered in insurance we can do appropriately and bill for appropriately.

We also teach doctors issues about new outcome tools that are available and how to apply them in their clinical practices. We talk quite a bit about quality-control issues.

I just wanted to let you know that that program was there and that we're trying to help the integration process by bringing CAM education to public colleges.

**MAN:** Thank you very much. We have some time for questions. Would you like to begin, Tom?

**Questions from Commissioners**

**CHAPPELL:** Yes, thank you. May I ask Mr. DeShields and Mr. Turner, as consumers of these modalities, are there some things that didn't go well that you'd like to see changed? Are there some principles that you'd like to see us address as we do our work, from the consumer's point of view?

**DESHIELDS:** I would like to see a way that my health insurance pays for it instead of me paying for it out of my pocket. Had I used the traditional methods, they would have been paid for, but I still wouldn't be cured.

**TURNER:** I thoroughly agree with that as well. Also, I've been fortunate in being in two studies, one for acupuncture and one for massage, which has been paid for. So that's why I was recommending studies as well, so that people could utilize that as a funding source.

**WOMAN:** Dr. Bomonti, I appreciated very much what you had to say. Could you provide this panel, perhaps, with one concrete recommendation for how you think we can help prevent the co-optation of the vitalistic movements, from being sort of co-opted by mainstream allopathic medicine?

**BOMONTI:** I can give you three quick suggestions: One, the utilization of CAM procedures -- and this was in the testimony; it's in written form -- by non-CAM providers after a weekend course or something of this nature be ceased; that the certification by allopathic boards of allopaths of CAM procedures, when they have no training and background, other than through an allopathic model, cease. The other is much more philosophical, if you will, and that is that we each have to recognize that we have strengths and weaknesses, whether we're allopathic or CAM, and that none of us has all the answers. But together we can come together with a way -- not the way, but a way -- that we can improve the health of mankind. I think it's most important also to recognize that it is not something that we do to the patient, it is something we do with the patient. The patient has to also create that responsibility within themselves to make it happen.

**WOMAN:** Dr. Bomonti, I would like to thank you very much for bringing the issue of vitalism and the body's ability to heal itself to the forefront. I hope we'll have a lot of discussions on that subject across the United States -- and also for mentioning that health is a partnership. The doctor does his or her job, and the patient has their sense of responsibility, too. Thank you.

**WOMAN:** I also reflect that thanks to you. You mentioned about the alternative. That term "alternative," from your description of the atomistic and the other offensive unit -- do you have other terms that you recommend for saying "alternative"?

**BOMONTI:** I don't think, in the political environment in this country, that changing the vocabulary right at this moment is possible. If we look at the world -- and I'm sure you're all aware -- allopathic medicine is the alternative, and vitalistic health care is the mainstream. However, if we're going to get anything done at this point, I don't know another way of saying it. I wish I did.

**MAN:** I have a question for Mr. Turner regarding your experience with acupuncture, massage, and also chiropractic treatment. From your point of view, how many treatments do you think are appropriate per week for acupuncture, plus -- is it at the same time?

**TURNER:** Acupuncture, I go once a week. Usually each session is beneficial between one and four to five days, depending upon the severity. Massage, I go every four to six weeks. With chiropractic, I've been fortunate to where I only need it after my seizures, for probably anywhere from six to ten times.

**MAN:** So if you have a choice, like massage therapy and acupuncture and the chiropractor, two or three times per week would be enough?

**TURNER:** I think that would be beneficial in my case. I think it's on a person-by-person basis, and what they're going through at that particular time.

**MAN:** Dr. Bomonti, I appreciate your candor and your comments. You have a quote here in your testimony, that you want accountable healing modalities on their terms -- that is, the CAM providers' terms. With that in mind, how do you feel about the licensure movement and the accreditation movement? How can you envision concrete ways to have a licensing/accountability movement that brings in the voice of the CAM provider, and it's not an allopathic model, but it's a sort of synergistic model? Have you thought about ways of doing that without usurping --

**BOMONTI:** The licensing model is something that -- obviously, each state has its own licensing boards. They are licensed and tested on the basis of their profession, whether it's allopathic or chiropractic or naturopathy or acupuncture, et cetera. I believe that's appropriate, that each profession do that. As far as standards are concerned, what I see today is that we have disease-focused outcomes that do not focus on what is the quality of life of that person, beyond just existing. There is so much potential that I believe the vitalistic professions provide that is beyond just being symptom-free. That's about fifty percent of our potential. The vitalistic professions, in my opinion, can take it beyond that, obviously with the help of the patient or the person, to reach that potential. This is the first time, I think, in history that we have had the luxury to be able to look beyond survival.

As I said, allopathic medicine -- there's nothing wrong with allopathic medicine at this point, except that we are now at a point where we can get beyond just surviving. Now we have the opportunity to enjoy that life that we could have. The vitalistic professions, in my opinion, can assist in that process.

**MAN:** Effie, you had a question?

**CHOW:** I don't think you mentioned it in your presentation, but in your written presentation you're saying you're a little pessimistic; you don't think that much will be accomplished, any substantive change.

**BOMONTI:** Yes. I thought someone might catch that.

**CHOW:** I'm a little troubled by your pessimism in that statement, where all the rest of your statements are so wonderfully optimistic. I just want to say that it's not us that's going to change. Your statement says, "For us to help make the change." But it really is you folks who are going to help us make the change.

**BOMONTI:** If you'll notice in the last sentence, we have to rise above our own personal belief systems. You, though, are the people who -- I can read it, if you would like.

In closing, with due respect, with sincere appreciation of the apparent intent and personal integrity of the fifteen people who are on this Commission, I must state that, given the past, I do not hold much hope that anything more than a small possibility exists that anything will change as a result of this process we have begun. To make any substantive change will require each of you to become more than who you were when you were appointed to this Commission, as distinguished as that may have been, and to overcome not only the obvious politics of Washington, D.C., but to rise above our own -- *our* own -- personal belief systems and professional tribal politics to focus on how all of us can become a team for our common purpose. I wish you well and support you in that quest.

You will notice that it shifted from you to us. We all must do the same, but you are in the spotlight. It is a huge task that is asked of you. You must become more than you were.

**WOMAN:** Thank you. I guess I want to just emphasize again that we can only do what you help us to you -- not only to you, but to everybody who is here and we'll be in contact with.

**BOMONTI:** That's why we're here.

**MAN:** It's interesting. I appreciate the reminder. I'm reminded, of course, that the process of individual healing is very much like the process of collective healing, and that we're engaged in that process here.

I wanted to ask you two guys, who are patients in these programs, aside from the techniques, what do you notice about these clinics that you went to that was different? From the patient's side of going to a community clinic, what was there about the experience that said to you, this is a different or a better healing experience than I've had in the conventional clinics to which I've been?

**DESHIELDS:** I got a sense that they truly cared and that I was not a dollar sign coming through the door. That was evident by the amount of time that they spent. On more than one visit, they spent a lot of time, whereas most of the physicians -- "boom, bam, thank you, ma'am," and you're gone.

**TURNER:** I'd say mine has been in complement with my Western medicine. There is much more touch involved, which I think is important. But it has definitely been a complement to my Western medications. In my case, I had to find something, in addition to my Western medications, to help me stay on those as well. Most of these -- the acupuncture that I do is done right in my doctor's office. They have a clinic two nights a week where these acupuncturists come in and do it. It's in my doctor's office.

But the sense of touch, I guess, is the main thing.

**MAN:** Thank you very much. Thank you all.

We'll go on to the next panel now. The first speaker is Lawrence Jacobson.

## Speakers

**JACOBSON:** Good afternoon. I'd like to thank the panel for taking the time and the effort to come here. We know that it's not an easy thing for you to do and that you're all very busy. Again, thank you very much for the time to listen.

I have five years in my own consulting business, and a little bit of a unique point of view, I think, because I've spent a lot of time working both with the providers and with the health plans. I don't think there are very many people who have gone back and forth, as well as being a consumer. So I try to balance all those points of reference. I think it's very easy to just point a finger and trash the health-plan people. It's also very easy to point a finger and trash the providers. I think the real task is to think out of the box. I think that's the point that was made over here. We have to begin to think differently. We have to think in a multidisciplinary manner.

I've also been one of the facilitators of the group that Lori Bielinski talked about earlier, the clinician work group that was initially proposed by Deborah Sen's office, the insurance commissioner. The task that we as facilitators had was how to bring together some very different kinds of disciplines, bring together massage therapy, acupuncture, chiropractic, the various different CAM disciplines, but then also bring together health-plan medical directors of a number of different backgrounds, and then a little of a unique task that I jumped into, to try to bring some primary-care providers onto the group. So it was a very mixed group, a very challenging group to get to speak the same language. We spent three years working on that project.

The every-category law, which has been mentioned a lot, is the impetus for bringing what was previously underground -- the system of providing CAM services that many people didn't acknowledge -- up to the surface and saying, okay, insurance companies have to begin paying for it. But how do you do that? I'm not saying we have the answers, but I think, through our three-year process, we raised a lot of really important questions. Many of them you've already heard today and I won't spend a lot of time repeating.

I think the key issue from that process that I got was the importance of process, bringing those people together on a regular basis, multidisciplinary kinds of people.

I'll skip now to my recommendations.

First of all, I think we have to solicit opportunities for integration in conventional medicine. We have to look for where within the conventional system we can begin talking about these different disciplines and including them and studying them. We need access to up-to-date, reliable CAM information for consumers. Consumers are very, very confused about this. They don't know, as David Eisenberg points out in his studies, whether to talk about their conventional services with their CAM providers and vice versa. They need better access to information. I'd like to applaud the many providers who have done excellent work in this area, but there is a lot more work to do.

We need resources for multidisciplinary research and opportunities for communication with conventional medical providers. We have the technology now with the Internet to reach many, many people, but we have to figure out what information is good and how to get that information out there.

It has been suggested here that a national multidisciplinary process that includes payer groups, purchaser groups, and consumer groups could be very effective. I think the model we created for the CWIC was a strong one.

We need to move away from a multi-tiered system, where the Medicare/Medicaid people and people who don't have insurance are separate. We need to bring people together who have commercial insurance, people who have private insurance, and find a way of managing the benefits to make it available to all folks, so that these disciplines can be defined. What's quality? What's not quality? Let's work together on it. I think that's the point of our work group.

Thank you for your time.

**MAN:** Thank you. Laura Patton?

**PATTON:** Good afternoon. I'm the clinical director of alternative services at Group Health Cooperative. Group Health is a consumer-governed HMO that 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 health-care system in the nation.

Since 1996, most of our consumers have had access to a program of covered CAM services, which is trying to do what Commissioner Chow alluded to earlier today when she spoke about paying only for services that are effective, and not for anything else, even though it does get into trouble. I don't have time to tell you the specifics of our program, but I will briefly discuss three assertions and make several recommendations.

My first assertion is that consumers value CAM services and are looking to their conventional medical providers to guide them. That they value CAM services is pretty obvious. It's the primary reason we're all in the room together today. But they are being bombarded with information that is often confusing, inaccurate, or incomplete. 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 this area, we have been lucky because that collaboration has been quite a bit easier than, perhaps, in other areas. It's my belief that taking the initiative will become easier, particularly for health plans considering CAM coverage, once our experience in Washington has been thoroughly analyzed and broadly disseminated.

Assertion number three is that collaboration precedes integration. I wrote that because, until today, I had heard very little about the process of how to get to integration. We talk mostly about how important integrated medicine is, but not so much about 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, most of which have been talked about today. But the most basic level for me as a practicing physician is the level of the communication between the patient and the conventional provider about CAM. We've worked very hard at Group Health to make that conversation a little bit easier.

I'm going to move to my recommendations:

Number one, 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.

Number two, work with the FDA or other appropriate agencies to develop mandatory manufacturing standards for producers of herbal products, which are, after all, medicines.

Support efforts of CAM professions in guideline development. I think that's very important.

Encourage conventional medical schools to require at least one course about CAM, including observation of CAM practices and personal experience.

Finally, involve consumers, including skeptics -- the people who are not here in this room -- in all levels of information gathering and decision making.

Thank you for this opportunity to speak.

**MAN:** Thank you. Elizabeth Goldblatt.

**GOLDBLATT:** I'm Liza Goldblatt, president of the Oregon College of Oriental Medicine, Portland, Oregon, and also of the Council of Colleges of Acupuncture and Oriental Medicine, which represents over forty accredited colleges that are located throughout the U.S. There are about 12,000 licensed acupuncturists and about 7000 students. Forty-one states, plus D.C., do regulate the medicine. We're under the purview of the Accreditation Commission for Acupuncture and Oriental Medicine, which is recognized by both the U.S. Department of Education and CHIA (phonetic). We currently offer a master's program and have just developed the final guidelines for the doctoral program.

I was asked to address issues of strengthening professional accountability in our field. At this point, the educational standards for comprehensively trained TCM providers are recognized. There are many health-care providers that are practicing parts of TCM medicine at different levels -- for example, acupuncture. We really need to discuss the educational standards with defined competencies for these health-care providers.

Another issue has to do with titles for practitioners and scopes of practice. These should be reflected in their educational training. For example, the LAC is trained as a primary acupuncture and oriental medicine provider. Most states do not yet have articulated levels of CAM training for MDs. There are over eight hundred public-health clinics in the U.S. that use acupuncture and Oriental medicine for the treatment of chemical dependency. Some of these utilize what is called the ADS, acupuncture detox specialist, which is another level of training.

We're currently working at the federal level on the loan-forgiveness program, including acupuncture and Oriental medicine, and it's stuck in committee. If this Commission can help us move it out of committee, we would be most grateful.

We recommend that all medical colleges, CAM and allopathic alike, begin to require survey courses on the other medical fields, to know when to recommend and refer to other health-care providers. Collaborative internships should be strongly encouraged, as well as working in integrated clinics.

To be quite candid, most of the integrated clinics I hear about throughout the United States are really practitioners under the same roof. A very few are working in what we would consider to be truly integrated models.

Recommendations are to include CAM practitioners in the loan-forgiveness program, to begin to fund think-tanks that would bring together the educators to address the appropriate curriculums to establish in medical colleges, as well as establishing how to work in collaborative internship programs; also funding for truly collaborative medical clinics throughout the United States that could have research branches on the best practices, as well as educational branches that would focus on internships.

I think it's fairly clear to all of us, particularly when we look at the ontological perspective of health care in the U.S., that the future of medicine ideally will focus on health, wellness, and the treatment of chronic diseases. Some of the CAM practices have long histories in focusing on these areas. It's time, really, for the health-care providers to not only be healers, but truly become educators.

Thank you.

**MAN:** Thank you. JoAnne Myers-Ciecko.

**MYERS-CIECKO:** I'm the executive director of the Seattle Midwifery School. It's a private, nonprofit, community-based organization that trains midwives, birth and postpartum doulas, and childbirth educators. I'm not a midwife myself, but came to my work through my own personal experience with midwifery care in a home birth twenty-five years ago.

Direct-entry midwives are experts in normal birth and provide care to childbearing women that emphasizes partnership, informed choice, holistic care, and a wellness orientation. There are over five hundred direct-entry midwives in the United States today who are certified by the North American Registry of Midwives. There are over seven hundred direct-entry midwives licensed or otherwise regulated in seventeen states. All of these states now use the written examination administered by NARM as a required element in the state licensing process. Altogether, these midwives represent fifteen percent or more of all midwives nationwide.

Direct-entry midwives enter the profession through multiple routes, including freestanding accredited schools, programs within accredited institutions, and apprenticeship. Regardless of the path any student might follow to become a certified professional midwife, she must demonstrate competency in each of the core competencies described by the Midwives Alliance of North America and the minimum experiential requirements established by NARM. The Midwifery Education Accreditation Council currently accredits or pre-accredits eight programs in six states and has five additional programs in the pipeline. MEAC submitted their petition for recognition by the U.S. Department of Education as an accrediting agency in November of 1999 and a decision is expected in December of this year.

Most direct-entry midwives are self-employed, providing community-based services and attending births in their clients' homes or in freestanding birth centers. Many direct-entry midwives also do related work in fields such as community and public health, family planning, and health education. This year a local Seattle hospital has initiated a pilot project granting hospital privileges to licensed midwives, who can now offer clients a choice of home, birth center, or hospital delivery. Also this year, the National Safe Motherhood Award went to a midwifery program at Allevial (phonetic) Medical Center, a federally qualified community health center serving the south side of Chicago. This midwifery program employs direct-entry midwives, nurse midwives, and OBs. They do over one thousand births per year, twenty percent of them at home.

I would draw your attention to the recommendations of Pugh Health Professions Commission Task Force on Midwifery. These fourteen recommendations are organized by five issue areas: practice, regulation and credentialing, education, research, and policy.

**MAN:** Thank you very much. Let's begin the questions with Joe.

**Questions from Commissioners**

**FINS:** Dr. Patton, regarding the Puget Sound cooperative, could you sort of break down the number of dollars that are spent in your annual budget on CAM therapies, and what percentage of the capitation fee at the outset is earmarked for those services?

**PATTON:** I'll be happy to send you the information. I'm not sure it will be totally accurate off the top of my head. We have a couple of different funding mechanisms for our CAM program. For chiropractic, which is a pretty longstanding program -- it has existed since about 1992 -- we have a very stable network of chiropractors who are capitated. We spend approximately $4.5 million a year on chiropractic services. In the other three areas of CAM, which are massage therapy, acupuncture, and naturopathy, we have a discount fee-for-service reimbursement arrangement with a contracted network of providers. On those services, just on direct claims costs, we spend probably about $1.5 million a year.

**FINS:** When you send us this information, can we get several years, so we can see trends, if possible?

**PATTON:** You want to see trends?

**FINS:** That would be helpful.

**PATTON:** Yes, all right.

**MAN:** And also, with that, a little bit of history of how the program evolved. I think that would be helpful, too, because your own history as a program overall lends real importance to whatever you can tell us about you've evolved.

**MAN:** I have a question for Dr. Goldblatt. I understand that American acupuncture schools and colleges have been improving a lot . . . the program twenty-seven hundred hours, including five hundred hours practicing, for three-year study?

**GOLDBLATT:** Actually, the Accreditation Commission has two different levels of training. One is a master's in acupuncture, and the other is a master's in Oriental medicine. I would say that the average training programs are anywhere between twenty-five hundred and three thousand hours, not including the prerequisites, which are a minimum of two years of education. Most of the clinical programs at this point probably vary anywhere between seven hundred and a thousand hours. So there is still a good deal of variation in those areas. The doctoral program

that we have just completed the guidelines for is a minimum of four thousand hours, which will include the master's program.

So while the Accreditation Commission has not actually looked at the number of hours, really, for several years -- mostly because it's more vocational programs that tend to look at hours and it's been more focusing on the quality elements -- my own sense is that, having been on about sixteen accreditation visits at this point, the quality of the programs has indeed moved to what we would certainly consider to be a master's-degree level.

**MAN:** By the way, the insurance also covers non-physician practitioners who practice acupuncture in most states?

**GOLDBLATT:** There are several insurance policies that currently do cover acupuncture and Oriental medicine, but I would need to defer that to some other people here with that expertise, such as Barbara Mitchell, who I know is here today. You'll hear from her later on. But there are a number of programs today that do.

**MAN:** You mentioned acupuncture. Also you mentioned Oriental medicine. Can you tell us the definition? You don't have to tell us about acupuncture. We all know acupuncture.

**GOLDBLATT:** Well, it is an interesting semantic issue, that's true. Generally, when we use the term "Oriental medicine," we're basically referring, most of the time, in terms of our colleges, to traditional Chinese medicine. However, we often use the term "Oriental medicine" to encompass the other traditions that exist, such as those from Japan, from Korea, from Vietnam, and from Europe. But the vast majority of the colleges are offering programs in what we would define as traditional Chinese medical colleges. There are indeed often training programs in some of the colleges on Japanese acupuncture, some on the European tradition, which is referred to as the Worsley tradition.

So we tend to interchange TCM and Oriental medicine.

**WOMAN:** I have a question for Mr. Jacobson. In your discussion about bringing together CAM practitioners and care providers, you mentioned speaking the same language. Do you mean speaking the same language or understanding one of the -- do you think we have to speak the same language?

**JACOBSON:** I didn't mean that literally. But I'll tell you, when we brought the work group together, the first six months was just putting multidisciplinary folks together so that they would begin to understand the reference points of each other. One would normally think, in this country, there's so much interaction -- in this community, particularly -- between different kinds of disciplines and different kinds of backgrounds. But we found, without doing that, we would have had to keep going backward. Because we took the first six months to better understand each other and meet together in multidisciplinary groups -- and some of it was just very simple, like seating arrangements, where you would have a health-plan medical director sitting next to an acupuncturist, sitting next to a midwife, sitting next to a naturopathic physician. It seems very simple, but yet it doesn't happen. So by creating that kind of atmosphere, we were able to create a lot of change and a lot of relationship building.

**WOMAN:** So you're speaking about being able to understand what each person is saying, not necessarily developing the same language.

**JACOBSON:** Correct.

**WOMAN:** I'd like to address my concerns to Dr. Patton. Perhaps you can come up with some suggestions and solutions, both in the categories of education and appropriateness of care. Our office has been primary-care providers with Group Health since the beginning. We found out, because there's an administrator, out of state -- back in New Jersey, as a matter of fact -- who's unfamiliar with our state law and unfamiliar with the chiropractic guidelines and clinical practice, unfamiliar with the research that's been done to support the correction of the vertebral subluxation, we've just been stymied, really, in our efforts to deliver what we feel is appropriate care. Just this year, as of December 31st, we have terminated our relationship with Group Health. I feel badly about that. There's a barrier to education. I'd like to know how you think we could overcome that.

**PATTON:** It's hard to know how to answer that. I think what you may be referring to is part of our utilization management and quality-assurance program with respect to chiropractic. These are two functions that we delegate to a network management company, American Whole Health Networks. They have a board of chiropractors that renders determinations to decide whether more care is medically appropriate or not. This actually, I feel, is a good model for the other CAM professionals, to have the professions themselves make those determinations. In that respect, I think it's a good thing.

I don't know how to particularly address the needs -- I know the individual about whom you're talking. I don't know the extent to which regional differences play a part in how he, as the head of that chiropractic board, makes the determinations. But that could be a conversation that we could have at some depth later.

**WOMAN:** JoAnne, we heard earlier from a woman who talked about her experience with a home birth and then being transported, and sort of the less-than-receptive response that she had. As somebody who has attended many home births and had my babies at home, this state seems very open and progressive compared to many states, where midwifery really isn't well tolerated, or even legal. If you had one message to give this Commission, what you would like us to really know -- if you could have one, on behalf of midwives, because we haven't had many midwives come and speak -- could you give us something?

**MYERS-CIECKO:** Well, I think we have a maternity-care system that's upside-down in this country and relies too much on specialist care and not enough on orientation to wellness, prevention, care that midwives provide. There are a lot of historical factors, obviously, that go into that -- I call them technical difficulties, basically -- that need to be addressed. But I think underlying that is sort of a deeply rooted prejudice against midwifery in this country that's social and professional, both. So long as allopathic physicians are trained and oriented and driven to assume the full responsibility for the provision of care, for the health of the women they serve, and bear that awful, heavy responsibility that they feel as a result of that training, those expectations, rather than the partnership model that we've all been talking about here today, it's

going to be really hard to overcome those biases and those technical difficulties. They just keep getting in the way.

**WOMAN:** Do residents follow lay midwives, licensed midwives, to do home births, residents in Ob/Gyn and family practice, to really get a flavor for that?

**MYERS-CIECKO:** They haven't yet. There has been some discussion, but nothing that has really borne fruit yet. An excellent idea, though.

**MAN:** Dr. Patton, I want to be sure I paraphrase what I understood you to say about the preferences of the 590,000 members that they would like their primary-care physicians to provide the answers to their questions about CAM services and products. I just want to check out whether I heard that correctly.

**PATTON:** I think you're hearing me say that, as well as, implied but not stated, that when we started our program at Group Health, I think the most common comment I heard from our Group Health providers was, "How can I possibly guide these people? I don't know anything about any of this." It's both of those things.

**MAN:** Good. But I guess I wanted to check with Mr. Jacobson to just see if in your business experience -- you made the statement that consumers need access to more up-to-date, accurate information -- would you agree that consumers indeed defer to a primary-care physician for the answers?

**JACOBSON:** I'm not sure you can generalize it. There are so many different kinds of consumers. But I think, as a society, we've said to consumers more and more, and I think we'll continue to say, "It's your responsibility, so you'd better try to figure out more about this." We need to provide them more accurate information and a means to educate themselves, because, more and more, they're going to be the ones making the decision rather than the purchasers or the health plans or even the primary-care providers. I think we're sort of stuck in limbo there. We haven't quite decided how far we're going to go. But I think that's where we're headed.

**MAN:** Ms. Myers-Ciecko, I just wanted to ask you about the allopathic approach to infertility, and whether or not midwifery has anything to say about that.

**MYERS-CIECKO:** You're outside of my realm. I'm not the clinician, and it's not a place where I've . . .

**WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY**
**October 30, 2000**
**3:00-4:20 pm**

[Tape 5]

**Female Participant**: Okay, if the following people can come up for the next panel: Suzanne, I mean, sorry, Susan Haeger, Michelle Simon, Julie Chinnock, Chris LePisto. And if Nicole Ellis is back in the hall and would like to join our panel, please feel free. Don Taylor, also please come up with Cindy Breed. Jane Guiltinan and Fernando Vega. Thank you.

**The Honorable James Gordon**: Okay, we'll begin with Susan Haeger. Hi.

Susan Haeger, Citizens for Health (National): Thank you Dr. Gordon. Hello. So I thought first I would just say who is Citizens for Health and why are we here. We are the nation's largest grassroots consumer advocacy group promoting consumer access information and choice for natural health care. I think we've been the strongest voice at both state and federal levels for consumer access, in defense of consumer choice with respect to health care and wellness. And in the past seven years Citizens for Health has worked to generate consumer response to federal agencies and to Congress when there have been either legislative or regulatory challenges that affect that choice, information and access. We've generated millions of letters into these agencies and into the federal government and we really represent a population of people who are taking their health care into their own hands. I think this is the population that has driven the creation of this commission. And my thought on this is to paraphrase Gandhi that where the people lead the leaders must follow.

And I think that's what's happening here. The public seems to be ahead of most practitioners and policy makers seeking innovative health promoting care. It's, we're seeing the development of this emerging model where the population intuits their need for preventative care is receiving conflicting messages about how they should approach it. And that's why we're very grateful to see the establishment of this commission to hopefully give clear guidance.

I believe that for the commission's recommendations to become law and to be implemented into the society we need to mobilize the support of these millions of consumers. Dr. Gordon and I actually spoke about that the other day. And there's three basic principles I think need to drive the commission's work in order for this population of consumers to really get behind its work.

One is access of choice, really insuring choice, freedom of information, and also ensuring protection from unscrupulous providers. Under choice, I think this includes particularly the driving force for most consumers is seeing inclusion in insurance. Access to different kinds of providers. Not just having conventional medical doctors now trained in

certain canned professions, but truly having access to a wide variety of providers. Having access to products, whether it's dietary supplements or health aids and the ability for them to act on those things they believe can most help them. This is reflected in the fact that this is where people are spending most of their out of pocket health care dollars. They're deciding what they think will help them most. They're paying for it themselves out of their pocket, the tune of billions of dollars. And it's critical that government remove artificial barriers to consumer choice. I think state governments, in particular, have to be educated on the benefits of CAM practices because health care truly can't be integrated unless we have credentialed, licensed practitioners who can work along side conventional medical doctors. Washington State has certainly led in this endeavor.

Freedom of information is critical allowing physicians and practitioners to give all range of options to their patients. Many, many circumstances in America today, we find consumers deciding what they think is best for them. We find either their physician by law cannot give it to them. Or that state agencies will take their children if they try to provide it. These kind of barriers need to be removed.

We need to remove sanctions around orthodoxy. One of our efforts that we've worked on quite a bit has been dental boards. We find dental boards had an ethical rule that a dentist could not speak to their patient about mercury in fillings. These are the kind of barriers that create consumers being very upset about their inability to get their CAM provided.

Am I out of time, Jim? Just say really quickly in terms of production from unscrupulous individuals, groups and companies. I think it's, we have to be honest and say that there are unscrupulous individuals who will prey upon people who have diseases, life threatening illnesses. And we've got to create accountability in regulatory agencies. And states have to decide that it's important to regulate CAM professions. So I look forward to presenting more comments in writing. And I apologize, I thought I had five minutes.

**The Honorable James Gordon**: Thank you very much. Michelle Simon.

**Michelle Simon**: My name is Michelle Simon. I'm a third year student at Bastyr University in the Naturopathic Medicine Program. I'm here to address issues concerning the health needs of underserved and rural communities which might best be served by integrated health care clinics. There's a great deal of interest among my classmates to meet this challenge, to work in underserved and rural areas and to help educate communities in good health practices. 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 tenet the importance of preventative measures rather than the costly intern solutions. This economic benefit addresses one of the issues which limits the care communities in need receive as the current state of the medical care necessitates a high cost of delivery. By educating patients with regard to lifestyle choices and their consequences and indeed seek to avoid the costly interventions which may be necessary in later stages of disease. If necessary NDs 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 MDs, NDs, LPNs, DOs, PTs, massage therapists, chiropractors, and acupuncturists. At one integrated clinic, The Healing Art Center in Colville, Washington, strong patient demand has resulted in greater than expected growth of their patient base. Patients are aware of the possibilities. In the 1995 survey of Community Health Center of King County patients indicated that sixty percent of current patients were interested in receiving natural medicine services. Some strengths of integrated clinics are the rich synergy of treatment options available for patients--a high patient satisfaction that focuses on benefited integrated approach to care in Caseco Management, which provides overall prospective and decreased risk for patient health.

My suggestions in specific, are to provide grants to community, rural and underserved clinics for the express purpose of brining aboard licensed CAM practitioners to work in an integrated capacity. Secondly, to include reimbursement for licensed CAM services among federally managed health care plans, such as Medicare and Medicaid. And third, to fund naturopathic medication, sorry, education in the form of scholarships, loans and national loan reimbursement programs for licensed disciplines. Thank you.

**The Honorable James Gordon**: Thank you. Julie Chinnock.

**Julie Chinnock**: Good afternoon. My name is Julie Chinnock and I'm currently a third year student in the Naturopathic Medicine program at Bastyr University. I want to thank you for coming to Seattle and also to provide us with this opportunity to provide you with our prospective and this information. The reason why I'm here is to tell you that once I graduate as a fully trained naturopathic primary care physician it is my goal to practice in a health care shortage area. In this regard I am also speaking for up to sixty percent of my classmates.

Currently this option is not even minutely financially feasible to us in any other state but Washington state. Under the Washington State Health Professional Loan Repayment and Scholarship Program primary care health professionals including naturopathic physicians, licensed midwives and pharmacists doctors are not only eligible but encouraged to work in those areas where there are health care service gaps. But even then there are limitations here when it comes to funding CAM providers. Speaking solely of Washington state, there are community, public and private clinics that have expressed interest in hosting CAM providers with this program. Yet they lack federal CAM health care reimbursement such as Medicare and Medicaid making it impossible for them to fund a salary for a CAM provider. With the funding and reimbursement as it currently is there is little chance that we can practically serve in underserved areas without working for free and or the risk of default on our student loans.

So how is it possible for willing CAM providers to effectively work in those areas which need health care the most? First, funding. Through federal funding in all states rural and underserved clinics should have the option for integration with licensed CAM providers including acupuncturists, naturopathic physicians and midwives. This includes grants and scholarships, subsidies for salaries, student loan reimbursement programs and patient CAM health care coverage through existing federal and state health coverage programs.

Second, legislation. Changes should be made in federal legislation to include licensed CAM providers in all programs that currently cover and fund other primary care providers. Third, outreach and integration. Once rural and underserved clinics are eligible and able to participate in these loan reimbursement programs, widespread outreach is necessary to inform them of current successful integrative clinics, some of which were mentioned, and dissemination of valid information on CAM providers to stanch the myths which may be out there which currently discriminate against our abilities and professions.

There is a current and emerging qualified workforce of CAM providers who are in demand and lined up to work in those parts of our country that are lacking in health care coverage the most. With assistance from the federal government, assistance that is already granted to a portion of primary care physicians, we will be able to afford to provide this care, pay back our educational debt and Americans from all income levels will better receive the health care that they want and they need.

**The Honorable James Gordon**: Thank you. Chris LePisto please.

**Chris LePisto**: My name is Christopher LePisto and I'm a student of Naturopathic Medicine at Bastyr University. The question posed is how can access to safe and effective CAM practices and interventions be improved? An answer is the inclusion of naturopathic doctors in the National Health Service Corps, the NHSC. The NHSC's primary goal is to deliver and retain in underserved communities clinicians that can help meet their health care needs. It currently does not include naturopathic doctors. You might be asking yourself why should we include them on top of the many fine professions already in the NHSC.

First, naturopathic doctors are fully trained and licensed CAM practitioners who can provide for safe and effective access to CAM health needs. Institutions like Bastyr University here in Seattle are now leading academic centers for advancing knowledge in the natural health sciences with world renowned faculty and researchers producing excellent CAM providers.

Second, it is estimated that perhaps sixty percent of naturopathic students are interested in practice within an underserved community. Sixty percent. This is a huge resource that is to date effectively excluded from the NHSC. Lastly, students like myself will be graduating with a loan debt with approximately a hundred thousand dollars. As graduates it is critical we have access to the federal loan repayment programs and the community scholarships contained within the NHSC. Now this access must come through legislation. Renewal legislation of the NHSC is likely to take place in the very near future. This happens once every ten years. If legislation were to include language supporting the inclusion of naturopathic doctors as another NHSC primary care provider. These doctors could care for the medically underserved while participating in the NHSC's programs. Access to safe and effective CAM practitioners could be significantly improved.

Here are the action steps that I am recommending. First, make a strong recommendation that naturopathic doctors be included in the language for renewal of NHSC

legislation, encourage inclusive language concerning all the established CAM professions. Second, support licensure for naturopathic doctors in all fifty states. Lastly, listen to the recommendations of the Capital Area Rural Health Roundtable, a coalition of health professionals which has monthly meetings regarding the reauthorization of the NHSC. The inclusion of naturopathic doctors in the NHSC is critical for underserved communities to have access to safe and effective CAM practices. The solution is legislation and that solution is close at hand. I ask you to support the inclusion of one of CAM's great resources. Naturopathic doctors.

**The Honorable James Gordon**: Thank you. I want to thank all or thank the three of you students of Bastyr for coming and being with us. It was very important to us to hear from students. And thank you other students from Bastyr. I know that you're in the middle of exams now. And actually I'm sure this is a pause that refresh us. So, it's great to have you here. I also think it's very appropriate that that you're on, sitting on the panel with Susan Haeger cause I hear the same kind of fervor. And one of the things I want to emphasize to everyone in the audience is this is truly a popular movement. And it's a movement of people who are looking for care, people are wanting to give care in new ways, people who are coming together to figure out altogether really truly new ways of helping each other out. I'm also extremely happy to hear that sixty percent of your class is interested in serving the underserved. I think that's, that's fabulous. Tom.

**The Honorable Tom Chappell**: Yes. Susan Haeger, my question is: Are you recommending that freedom of choice from the consumer's point of view mean that they have direct access at their will to any of the practitioners as opposed to going through a primary care physician?

**Susan Haeger**: Yes.

**Tom**: Thank you.

**Susan Haeger**: Although what I, I would like to just amend that by saying I think one of the biggest problems right now in the marketplace is that there are not in relation to specific chronic diseases, other critical care kind of situations, primary care providers that really understand the scope of many other CAM professions. And so, yes I think we are advocating people have direct access and at the same time they have to have direct access in an environment in which it's clear what they're getting access to. And that's why we have to have licensed credentialed practitioners.

**Tom**: Thank you.

**Female Participant**: Just a quick comment to the students. You know coming from the state of New Mexico where, where you're not licensed yet, we are hoping that you all will become licensed. New Mexico's, the University of Mew Mexico there, our program is really directed at rural care. Underserved, we still have seven counties, entire counties that have not even an ambulance driver. I mean so we have no health care, so we need all the hearts and

hands that are out there. And so, you know, I do appreciate you coming here and I sure hope that we get you on, on board on those fifty states and on the National Health Services Corps.

**Female Participant**: I have a question for Chris. Excuse me. It's kind of two part. I'd like to know if there is one national definition for naturopathic practice or if they differ within the states. And then the second part is that, that is what is the argument against licensure in the states that don't do it at present?

**Chris LePisto**: So earlier it was brought up the distinction between those students that are at colleges that aren't accredited. In other words, some are graduating with four year degrees and others that have mail order degrees. Those are the same titles nationally--naturopathic doctors. So I'll speak for our profession of four year trained students. There's, there's a coalition called the American Association for Naturopathic Physicians that has a definition for naturopaths and that's the one that we ascribe to here in the state of Washington. And the, refresh me your second question.

**Female Participant**: I was wondering what the barriers were and you explained that basically, the credentialing question and the training question.

**Chris LePisto**: Right, yes. So I, I'm posing licensure in all fifty states. So currently naturopaths are licensed in thirteen states. And it very much depends on a state to state basis the opposition there. Some of that comes from mail order schools. I'll tell you, for example, in the state of Colorado where I'm from the opposition has hired the most expensive lobbyist in Denver because they can afford it and those happened to be from schools that that have mail order degrees. So that's the case for Colorado. It's entirely depending on the states and each state is fighting their own battle.

**Female Participant**: I also commend the students because going into a profession and with all that time and money and coming out and not really knowing where you're going to get your dollars and make your living is very commendable right now. And I guess we need the students to help us make more explicit the requirements to help you people. With that you've begun to give us some outlines that appreciate more detail, not right now, but certainly send it in to us. And Susan Haeger, I want to pursue that freedom of choice. I think that's a very important issue. Are you pursuing legislative action on that too or what?

**Susan Haeger**: Yes we are. As a matter of fact we've had several pieces of legislation in the federal Congress. We've also helped pass medical freedom legislation in eleven states. And I have to say that in those eleven states today those have been revisions in the Medical Practice Act governing medical doctors, MDs simply because medical doctors themselves were being blocked from practicing CAM therapies by the medical boards who were determining that they shouldn't be able to practice though, that they were fraud. We are also pursuing legally that the federal government would mandate the ERISA program the Employment Security Act, the Employment Retirement Security Act. If that covered CAM professions that would give a a big boost to getting licensure in all fifty states to CAM professionals. And it would also give an indication to the states that they need to take this seriously and begin to enact coverage at the state level.

**Female Participant**: And there is a legislative number.

**Susan Haeger**: Well we have others. The Access to Medical Treatment Act, which has been in the House and the Senate and that is again this year not going to pass. It will be probably reintroduced in a new form next year. There is also a Bill HR 3677 in the House called the Thomas DeVarro Patient's Rights Act. That's a specific piece of legislation to allow people to take part in FDA clinical trials as long as they're fully informed through written consent. At this time there are many families who want to get in these trials but the FDA has made the decision that the family shouldn't be in the trial. And these are the type of freedom of choice issues we think need to be pursued.

**Female Participant**: I think we need some more information from you.

**Susan Haeger**: Yes and we look forward to providing that to the commission and we will be doing that.

**Female Participant**: Thank you.

**Female Participant**: This is directed to the students. I want to commend you. I have a lot or respect for the personal decisions you've made. One brief question is, is, have you ever considered or have you done this, is actually spoken or worked with residents of medical residency programs who have made the choice to do National Health Service Corps and what that life has been like for them?

**Chris LePisto**: So I don't have any experience with other medical school. I get the hint that you, that it maybe a grueling life of sorts. I would say that any sort of, any sort of loan repayment program certainly has its considerations that go with that. That's a good suggestion.

**Female Participant**: Yeah, I'm just suggesting that if you're in the same cohort group in age structure it would be a way to actually build some bridges too.

**Michelle Simon**: There's a group of students at the University of Washington who have formed a program called the Sparks Program and it's actually a club of sorts that meets. And it's people who are interested in, in working in rural and underserved areas including the National Health Service Corps. And we currently have a dialogue with them. And we just had a meeting with them last week actually where they came out to our school and spoke to us about our interest in that and how we could collaborate with them and sort of joining them in their informative sessions and field trips that they take that sort of, that gives students who are interested in these type of programs more information about those.

**Male Participant**: I just want to commend the students as well. And it's good to see a graduate school that promotes idealism and doesn't destroy it. I want to ask Ms. Haeger a question about your three categories because there's a, there is a little bit of a contradiction there. You're promoting choice but you're also saying we want to protect patients and, and

families from, from bad choices. So what are the limits of choice and how do we negotiate that, those shoals, those treacherous shoals? Because we're going to probably make recommendations that will satisfy number three but annoy those proponents of number one in your, in your three levels of issues. How do we handle that?

**Susan Haeger**: I think, yeah. We had, we had been proponents of the more fully informed a consumer is the better choice they can make that ensures their safety. One of the problems we have in the market today is people have a lot of contradictory information and not much good guidelines. So, for instance, good government regulation, clear guidelines about what constitutes the different CAM professions, how they're regulated, having credentialing, having continuing education, having information in the marketplace about what that criteria is and so a consumer can make a good decision. I bring up the case of this little eight year old girl in North Carolina who died as a result of going to an individual who put himself forward as a naturopathic physician. He was in fact had a mail order MD license from LaSalle University. He had actually been disciplined in another state ten years earlier. He convinced the mother to take the child off of insulin. The child died. This is someone who is acting completely outside of the scope of his training and experience and yet the mother didn't understand that there were no laws within the state of North Carolina.

**Male Participant**: So would you endorse a provision of having CAM practitioners in the national practitioner databank along with allopathic physicians?

**Susan Haeger**: Yes.

**Male Participant**: You would?

**Susan Haeger**: Yes. I think that the more we can integrate the CAM professions into the system, which has been working, the better. And the challenge is to be able to work within those systems without having the CAM professions completely robbed of what's made them effective for consumers. A good example is state medical boards. The Federation of State Medical Boards is still having individuals at their national conferences speaking from the Quackbusters organization and talking about how the CAM profession is a total quackery. I mean, this is an organization that is giving leadership to all the state medical boards. This is unacceptable when you see the number of consumers that are using these therapies and these modalities. We need to have more integration of good information in the marketplace.

**Male Participant**: So it's responsible inclusion not exclusion.

**Susan Haeger**: Correct.

**Male Participant**: Thank you.

**The Honorable James Gordon**: Thank you all for [applause]. The next panel: Don Taylor.

**Don Taylor**: I would ask that you include a modest new requirement with each new research project that is supported; that there be a brief standardized form to be prepared at the conclusion of each trial that describes the number of subjects that were involved, any controls that were used, how the response observed compares to doing nothing to a placebo and to the most effective treatment that we commonly use. In addition, a description of any side effects that were seen should be included. Asking that these results be collected and published and made widely available to patients so that all of the patients can see what kinds of things we're dealing with here.

We are faced with world limited resources here. We don't have the time or the money to try treatment, after treatment, after treatment hoping something is going to work. There's pain, and there is suffering, and there is progression of disease. Patients and even practitioners are not really well equipped to evaluate the efficacy and benefits, and the potential side effects, and even the harm of even a handful of different kinds of treatments.

There is a social cost associated with treatment and we want to minimize that cost. Thus we need easily available and understandable evaluations of the efficacy, and the side effects, and the uncertainty associated with these treatments. This is not available today and you can help make that available to everyone.

One important point does need to be said. Careful measurement of the level of placebo effective with treatment is essential information and should be included in the published results of, particularly in trials like these. With dedication and some creativity it's almost always possible to get an estimate of how large the placebo effect is out there.

During study after study when initial results have indicated that a treatment is unlikely to be efficacious, is using resources that are probably better spent some where else. When more tests of the treatment are unlikely to change the outcome we should stop the testing and apply the results. Conventional medicine and alternative medicine are both guilty of not doing that in some cases.

I'm the first one to say that one example will prove nothing. A friend of mine was in his eighties when cataracts began to take his vision. He lived alone far from any services or care and driving was the last freedom that he had. He was desperately afraid of surgery so he went door to door paying again, and again, and again for a cure. One sold him a trampoline because zero gravity would cure his cataracts. The next put him on a diet and he drove back home and within days he was desperately ill. But he tried to follow her advice and he tried to stay on the diet. By the time that he figured out that he was in real trouble he drove forty miles to the nearest medical care and they discovered that he had had colon cancer for years; the colon was nearly completely blocked. But that the diet he had lived on for eighty years had been sufficient to be able to cope with this and have a good quality of life. The new diet caused constipation, blocked the colon, the colon died. I spent the last month with him in the hospital as he died. Her diet did not cause that cancer but her diet killed him.

How can a patient today decide whether or not a trampoline or a specific diet can cure cataracts? We need to measure the efficacy of these treatments, particularly those who've not

had careful evaluations. If we don't expose ineffective treatments others are going to use that against CAM. Thank you.

**The Honorable James Gordon**: Thank you very much. Cindy Breed, nice to see you.

**Cindy Breed, ND, Community Health Centers of King County**: Good to see you Jim. Hello and thank you for being here. I'm a naturopathic doctor practicing in the integrated setting of the King County Natural Medicine Clinic at the Kent Community Health Center. In this setting I, along with the other CAM disciplines of acupuncture and massage, practice side by side with conventional medicine providers providing health care services to the medically underserved. Earlier in the day you heard from Tom Trompeter and Judy Featherstone and few others about this same clinic. This integrated care setting gives us the opportunity to improve the quality of care that we can offer to the patients that we serve and the chance to broaden our knowledge of medicine by learning from each other.

Our clinic works because we were able to incorporate CAM providers into an already existing community health center. Initially this idea brought many challenges including acceptance by the existing conventional medicine providers as well as how were we going to make the services available to the people that we serve. Because we have licensing laws here in Washington State for CAM providers we were able to address concerns about standards of training and scope of practice. Through daily contact and cooperation as well as regular meetings we continue to build grow in knowledge and trust among the providers making natural medicine services available to our managed care patients, having a sliding fee scale offered to those without insurance are things that make these services accessible. For our patients with Medicare and fee for service Medicaid, which does not cover natural medicine services we offer the sliding fee scale. This lack of coverage though does limit access for some. Lastly, providing natural medicines like herbs and nutritional supplements to patients on a sliding fee basis is another important piece to providing access.

In order to further expand integrated care-sitting, integrated care settings I believe attention should be focused on these areas. First, nondiscrimination in all government health programs for CAM provider participation and reimbursement. There are many clinics who have shown interest in providing similar services in their communities but the major stumbling block seemed to be lack of credentialing standards for CAM providers in some states, lack of licensing laws for CAM providers in some states and lack of access to Medicare and Medicaid reimbursement for services. To further expand integrated care settings I recommend attention to licensing laws in all states, credentialing standard consistent with the best available in each profession or discipline, access to Medicare and Medicaid reimbursement, access to all government health programs including student loan repayment programs. Thank you.

**The Honorable James Gordon**: Thank you. Jane Guiltinan.

**Jane Guiltinan, ND, Natural Medicine Clinic, Bastyr University**: Hello, thank you. I am a naturopathic physician and dean of Clinical Affairs at Bastyr University. My

responsibilities include the oversight of the clinical training programs at Bastyr where we train Naturopathic physicians, acupuncturists and nutritionists. I have been asked to speak about integrative care from the training model prospective today.

Health care practitioners who train together have the opportunity to build understanding, trust and relationships that benefit their patients down the road. This integrative training model is exemplified by one of our programs called the Immune Wellness Clinic. We have been providing integrated CAM services to patients with HIV or AIDS since 1985. Most of these patients receive care from both their conventional provider as well as a team of CAM students and providers. Regular information sharing between CAM and conventional providers is an essential piece of this training and care model. By working with each other and with conventional providers in other sites students learn how to optimize the healthcare of their patients by integrating services. In addition to training CAM professionals, many conventional medical and nursing students spend time in our clinic familiarizing themselves with different CAM modalities. Again, this cross-training fosters relationship building, trust and knowledge about effective ways to integrate care across disciplines.

Why is Washington State so rich in CAM training institutions? First of all, Washington state has educational and licensing standards in place for many of the CAM professions. This allows CAM training institutions to focus on these standards, design curricula to meet the goals of training safe, competent, practitioners. Secondly, Washington state law mandates that insurance companies provide coverage for all licensed health care providers. The ability for people with commercial insurance to access CAM services helps to keep CAM institutions liable in this state.

Despite these advantages CAM institutions face serious challenges both in Washington state and throughout the nation. One is the fact that public Medicaid and Medicare programs do not provide reimbursement for most CAM services. Another is that CAM institutions receive no public funds for graduate medical education. I serve as a trustee on the governing board at Harborview Medical Center, which is one of the University of Washington's medical training sites. Harborview will receive over twenty five million dollars from public funds this year to subsidize its teaching missions. In contrast, CAM training institutions receive no funding of this kind. I believe these inequities must change if we are to realize the goal of integrated health care delivery in this country.

In conclusion, I urge you to support the following issues: equitable policies in public and private reimbursement for CAM services delivered by CAM professionals. Second, educational and licensing standards that promote quality CAM education and qualified professional CAM practitioners in all fifty states. Third, funding to support integrative training models like the Immune Wellness Clinic and CAM institutions as well as conventional medical institutions. And finally, to support equitable public funding of graduate medical education in CAM institutions, including subsidizing direct and indirect costs of residency programs in CAM institutions. Thank you very much.

**The Honorable James Gordon**: Thank you Jane. Fernando Vega.

**Fernando Vega, MD, Seattle Healing Arts Clinic**: I am a family physician in practice for twenty one years, currently at a clinic called Seattle Healing Arts. At Seattle Healing Arts we've had nineteen years experience of collaboration between MDs, psychotherapists, naturopathic physicians, acupuncturists, licensed massage practitioners, and at one time midwives working in close proximities. Each practitioner was in private practice. This experience includes having, sharing a room with all of our guests in the same room which facilitates daily exchange of views by impromptu consultations as well as co-management scenarios. This is an opportunity for all practitioners to get a glimpse of the, another professional worldview. Treatment in common chronic problems such as congestive heart failure, diabetes, arthritis and chronic fatigue [inaudible] collaboration. Different approaches are applied and all parties involved benefit from subsequent monitoring and observation of the outcome. However, most patients that come into anybody's office come from more subtle problems and lifestyle, lifestyle imbalances. That fits especially well for CAM providers.

Collaboration and integration doesn't occur spontaneously when practitioners are thrown together randomly. It requires a willingness to share prospectives and, more importantly, a willingness to receive another viewpoint while suspending one's own prejudices at least temporarily. Proximity requires a tolerance at least if not friendship. Worldview often conflict and a strong container is needed to hold the process. The practice setting at Seattle Healing Arts may not be easily reproducible because of those requirements but it has served as an experiment in providing opportunity as a tool for observation and examination of the potential for CAM collaborations.

I'd like to share with you some examples of what might otherwise be very difficult and impossible to accomplish in another setting. Treatment of early acute epidedemus [inaudible] with visceral manipulation and lymphatic drainage by licensed massage practitioners; treatment of common acute conditions such as sinusitis and back pain, asthma, eczema, but close follow up of outcome with a fall back plan for conventional medicine, nasal specifics under anesthesia.

My pitch is not necessarily for integration or new modalities under the current health care system as much as integrating practitioners of other professions into the health care arena. I have learned that acupuncture may be taught to a medical doctor but MDs would never offer what acupuncturists and practitioners of traditional Chinese medicine have to offer. Integrating the [inaudible] practice would improve such care, but under these could never offer what midwives could do as a culture. I wanted to underscore what the general [inaudible] statement was about our health care, maternity health care being upside down. Similarly, naturopathic medicine hasn't been a central.

**The Honorable James Gordon**: Excuse me, time is out so if you want to.

**Fernando Vega**: Okay.

**The Honorable James Gordon**: Okay.

**Fernando Vega**: Okay.

**The Honorable James Gordon**: I wanted to say just a couple of words. One is as we go along through the day and I think through the rest of the day and tomorrow I'm really appreciating the tremendous growth and sort of sensitivity, and sophistication, and responsiveness of integrative medicine CAM practices in this area. And so it's wonderful to hear it. Also though I do hear the note Don Taylor in your story and your concern. And I'm wondering if you have a specific, I understood what you said about placebo. But, you see a way to, on the one hand permit the development of responsible CAM practice, and on the other hand to address the kind of issue that you're talking about. Do you have some thoughts about that? And here, won't you take the mic cause it's such a poignant story about your story.

**Don Taylor**: Before the blue ink when it was a five minute presentation and not a three, there's a fairly broad sort of understanding in the conventional community that if you equate something with placebo that's now worthless and to be discarded. That's not really necessarily the case. And particularly I think in these cases showing how large the placebo effect is is something important here. That really does demonstrate something. It's not something just to be tossed away here.

**The Honorable James Gordon**: Right. I think, I think we understood that.

**Don Taylor**: And getting people to actually measure that rather than saying well I just can't. I'm dying, we can't measure anything, we can't do those things. Those things will let someone try to be able to make a reasonable evaluation of these things.

**The Honorable James Gordon**: But the other side as well, the story about your friend.

**Don Taylor:** Yeah.

**The Honorable James Gordon**: Do you have any thoughts about what kind of, how to address that kind of situation?

**Don Taylor**: The opening paragraph saying that the collection and publishing of standards showing whether something is effective or not. It may well be that zero gravity does kill cataracts but if that's not the case then you didn't risk breaking a hip on your trampoline when you're eighty.

**The Honorable James Gordon**: Thank you.

**Male Participant**: Yes, Dr. Guiltinan, could you clarify your comments about GME funding. Are you saying that, that's generally money for residency training and not undergraduate medical education? So are there residency programs that aren't being funded and sharing in those resources or are you just talking about undergraduate students?

**Jane Guiltinan, ND**: No, yes there are residency programs that are not being funded currently at all of the naturopathic colleges and at Bastyr in the acupuncture program.

**Male Participant**: Thank you.

**Female Participant**: This question is directed to Dr. Vega. Was your association or your integration of all of these professionals in your clinic born of necessity, the sharing of the office or was it born of a deliberate decision when you began your practice?

**Fernando Vega, MD**: It was born of a, of an idea of a vision for lack of a better word. It started out kind of accidentally with an acupuncturist starting at the office which brought in patients who had a different prospective, a different prospective on health care, and actually required more, demanded more of what they've already seen. This brought on students from Bastyr as well as naturopathic in the early eighties. We've also had our share of other NDs who've had. As you know there's a discrepancy in funding so MDs essentially carried most of the economic weight so the idea of integration actually was economically sound.

**Female Participant**: Don Taylor?

**Don Taylor**: Yes.

**Female Participant**: You mentioned about the study of placebos and it's kind of been the course of, well it's just a placebo effect. It's like you're breaking that traditional, you know, impression. Do you have the mechanism to study placebo research? Do you have some research programs in studying the placebo effect? At the moment I'm involved in an unconventional application of a conventional treatment and we are wrestling with trying [inaudible] tease apart what's chemical and what's placebo and where is the line between those. And I've spent a year working on that. And I think in most cases with some creativity, and some work, and some dedication it is possible to tease these apart and to be able to see these things.

**Female Participant**: So it's conceptual right now is it, or?

**Don Taylor**: No, we--

**Female Participant**: Actually doing.

**Don Taylor**: No, I have file up subjects. I have subjects in the field now.

**Female Participant**: I'll be interested to hear more about it.

**Female Participant**: Also directed to Don Taylor. I'm sorry, somewhere along the line I don't understand what facility you were associated with from Oregon but I have to say that I'm just sort of, understand some of your concerns. But as providers I think our goal is always excellence. I don't think we'll ever reach perfection. And so you answered part of my

question about. My question was, do you have ongoing or anticipated research to address your concerns about the efficacy of CAM procedures?

**Don Taylor**: I don't practice CAM. I can't address that. But my research involvement, I thought I could contribute what I thought would be a way for patients and practitioners to be able to more effectively evaluate these treatments by introducing some sort of standardized form that people would be able, something that would not be dozens of pages for someone to work on but some simple standardized way that could at least give you an idea. You know, if you were to come up against this, how much of a chance you might have of this being effective.

**Female Participant**: [inaudible].

**Don Taylor**: Portland State University. I don't know how that got lost.

**Female Participant**: Yes, I have a question. But also if you, even just on Medline, if you look up consort, the consort statement that was done, I think it was a very good attempt on researchers' parts to try to organize standards for randomized control trials and also for people to evaluate and trying to simplify that. So there are attempts in conventional medicine to work on that. My question is for anybody who wants to answer on the naturopaths or for the physician, Medicare and Medicaid reimbursement. We have a private clinic in New Mexico and about sixty to seventy five percent of our patient population is Medicaid and Medicare. And the problem always comes down for those of us who take thirty or forty five minutes with a patient and you get paid twenty-eight dollars. And then you have to have somebody bill for that, and you have to have the receptionist and the nurse that it's very poor reimbursement for primary care providers who do a lot of behavioral counseling or this.

And naturopaths, what I've been hearing from some of the patients that were presenting is, took an hour and a half with me, took a lot more time. Have you thought about maybe the down side of reimbursement with Medicaid and Medicare that a lot of us are dealing with as well for? When you take thirty or forty five minutes and the reimbursement is twenty eight dollars and they're also rejected it and you've got to resend it back, it's, it's a nightmare. How well that will work within your model, have you just thought those things through?

**Cindy Breed, ND**: I think that's a very good point. I think in the model that I'm in which is a community health center, probably some reimbursement would be better than maybe nothing at all and maybe there would be other ways to try to make up the difference there. But we do tend to spend, personally I spend an hour on the initial visit and generally a half hour on most follow up visits, although some maybe more like fifteen minutes. So, that's a good point and I don't know how we would want to work that out.

**Jane Guiltinan, ND**: I'll just say I'm, I'm somewhat familiar with your challenges given my work on a hospital board and the havoc that the Balanced Budget Act is wreaking with hospitals being able to stay in business and providers being able to keep on providing

care. But what I'll say is that naturopaths would love to join you in the struggle to try to help fix the problems associated with Medicare [inaudible].

**Female Participant**: We'd be glad to have you.

**Male Participant**: What are the practices that succeed in getting licensing and credentialing in states that have adopted these practices?

**Female Participant**: If I understand your question, you're asking how did the states who got licensing standards do that.

**Male Participant**: Yes.

**Female Participant**: And that is a question I probably can't answer and would refer you to someone like Dan Mavriola or someone at the state level who could talk with you about specifically the standards and licensing issues in Washington state. However, it took a lot of years of talking and discussing and meeting with people who opposed licensing laws, those being either the type of person who does not want a licensing standard or the conventional medical system who is resisting all the licensing alternative CAM professionals. It is all of those people sitting down at the table and then negotiating out the issues, writing the legislature that was eventually passed.

**The Honorable James Gordon**: Thank you all very much.

**Female Participant**: One last panel before we take a quick break. If Judith Kaufman, Stan Lippmann, Valerie Sasson and Scott Barnhart would come up. Thank you.

**The Honorable James Gordon**: Welcome. Goodbye to those who have to go and welcome to the panel. So we'll begin with Judith Kaufman.

**Judith Aileen Kaufman, Emerald City Healing Arts**: Hi, thanks for having me. My name is Judith Kaufman. I'm an acupuncturist and Dental Hygienist and I'm a graduate of Northwest Institute of Acupuncture and Oriental Medicine. And an important part of my training was working in, in Harborview. I did a chronic fatigue clinic there to those international clinic HIV/AIDS. I worked at St. Vincent's Nursing Home, Forty Fifth Street Clinic, a methadone clinic, alcohol and drug detox clinic. And that was a very important part of my training. So that was my experience as an acupuncturist integrating that in my educational training.

I believe in a partnership approach to integrative and allopathic medicine. It's important to recognize the impact of lifestyle, diet, organic and whole foods and environmental exposure to chemicals and the social environmental issues. In a partnership approach free of fear and mistrust with the patient's best interest in mind would come with collaboration. The body is not a machine. The body has an intelligence and is extraordinary. The body can be a teacher and has incredible healing potential. Such an approach would honor the healing capacity and wisdom in the body. Dependence on medical technology is

not the answer for prevention of disease. Taking control of health by making the right food choices, exercise, breathing exercises, education and simple home remedies for health care can be inexpensive ways for empowering ourselves to take the reign for our health. There are always factors in our life that we cannot be controlled, but the simple intention of wanting to bring more love and healing in our lives can be reflected in us inwardly and then thus outwardly.

Health is a presence of vitality and balance in understanding to grasp our personal path and the recurring themes that occur in our life. Each person has an inherent ability to heal and this is our birthright. I believe it is important for all practitioners allopathic and integrative to educate their patient and client and facilitate inner healing. I see access to helping the person in their own facilitation of healing, giving the person power to be their own healing physician. And we as the, the practitioners, we can help the patient facilitate their own healing. Thank you.

**The Honorable James Gordon**: Thank you. Stan Lippmann.

**Stan Lippmann, PhD, JD, Natural Medicine Party:** Hello, thank you for the opportunity to speak. I'm here representing the Natural Medicine Party today and that's something that I created this year in my run for the Attorney General. I'm on the ballot next week. Anyone can find more information at my website www.rebella.net. I am an attorney and before that I was a physicist. So although I'm not a, in the medical profession, I was personally impacted by an adverse reaction to a vaccine a few years ago which has led me down the path I'm on now, which is a little beyond the purview of this commission. Because what this goes to is the fact that the allopathic approach is not only not vitalist, it's actually with regard to the vaccination program anti-vitalist. That is, and there is slowly emerging consciousness, which is still beyond the general acceptable political pale, that the damage being done by the national vaccine program is astronomical. I believe it's responsible for a good maybe half of all chronic illness by the induced autoimmunity processes that are neglected.

So while I applaud President Clinton for establishing the commission, the President, the Governor of this state, Gary Lock, Bill Gates, all the powers that be are in the pockets of the the medical establishment with the backing of the Supreme Court and the AMA. This goes back for over a century and it is actually an actual conspiracy, which goes back even hundreds of years with the British genocidal smallpox policy. In fact, the threat to human and the life of this planet is, is very grave and we see that solely being revealed in the political process next week.

We see an resurgent candidacy, the Green Party, which is just the beginning of the breakdown in the faith of the general public. And what I'm trying to do to the public is to awaken them. I'm trying to awaken all of us to the reality that the, the whole paradigm in which we are living is false and that this, it's almost a primitive blood ritual that we, we do to our infants in terms of injecting mutant viruses and metals. For example, the EPA limits are exceeded by thirty times in a, in a hepatitis B exposure. And this is just one of the bureaucratic insanities going on.

Every week, everyday you find more stories in the news which all plug in the direction of what I'm saying is true that the actual damage being done is astronomical, maybe a trillion dollars so far. Just today the B cell research, you know, I know I'm out of time, but just to mention today's news for example the showing that the B cell, if you kill the B cells through medical allopathic treatment you can cure arthritis. And this indicates that this whole approach of stimulating antibodies is actually stimulating chronic illness and needs to be completely rethought. Thank you.

**The Honorable James Gordon**: Valerie Sasson, LM, Puget Sound Birth Center: I'm here today to describe licensed midwifery in the state of Washington as a model of integrative health care. Before I begin to discuss the successes we've enjoyed, the atmosphere that engendered those successes and the challenging, the challenges remaining, please allow me to introduce myself. I'm a licensed midwife in the state of Washington, trained at Seattle Midwifery School. Prior to becoming a midwife I graduated from Brown University and subsequently worked for many years in community health. My midwifery partner and I currently maintain a busy practice in Kirkland, just across Lake Washington from Seattle, attending an average of eight to ten home and birth center births per month. I'm a co-owner of the Puget Sound Birth Center, also located in Kirkland. And I'm here representing the Washington Association of Midwives, our state professional organization. And then also as you can plainly see I'm a midwifery consumer at the moment.

I will briefly describe the legislation, vision and practices that are responsible for the success of licensed midwifery in Washington and the ways in which this become a model of integrative health care. Free-standing birth centers represent an important milestone in midwifery in Washington. So I'll spend just a moment describing the structure and function of our birth center as well. You'll be hearing about the specifics of direct entry midwifery education, scope of practice and licensing requirements, third party reimbursement, malpractice insurance and quality assurance from my colleague so I'll touch on those just briefly.

Here in Washington state licensed midwifery has greatly benefited from a few key pieces of legislation. First and foremost, is the law under which we are licensed as autonomous practitioners and which describes our educational requirements and scope of practice. Second, is a vital piece of legislation initiated by our insurance commissioner, Deborah Sam, which ensures the availability of malpractice insurance for licensed midwives. Thirdly, we have the Every Category of Provider Act ensuring that insurance companies will reimburse representatives from every licensed health care field. And lastly, we have the Women's Health Referral act, which allows women to bypass their primary provider in selecting women's health care professionals.

In March of 1970, I'm sorry 1997 another analysis of the safety of home birth was published in the birth, in The Birth Journal. The author concluded that out of hospital birth is an acceptable alternative to hospital confinement for selected pregnant women and leads to reduced medical interventions. He describes four factors that must be present to ensure optimal outcomes, specifically, low risk motivated women, planning out of hospital birth,

screened and attended by practitioners specifically trained in out of hospital birth with ready access to a modern hospital. I would add a fifth factor, tthat of access to willing and informed back up physicians and other health care professionals.

I cite this research because it provides an easy construct within which to discuss the extent to which licensed midwifery in Washington state has succeeded in becoming a model of integrative health care and the challenges we currently face. I'll leave the rest of this talk in with my packet so you can conclude. You can also visit us at our website which is www.birthcenter.com. Thank you.

**The Honorable James Gordon**: Thank you. Scott Barnhart.

**Scott Barnhart, MD, MPH, Harborview Medical Center, University of Washington**: Good afternoon Mr. Chairman, members of the commission. My name is Scott Barnhart and I'm the Medical Director at Harborview Medical Center. I wanted to talk to you briefly this afternoon about integration. Harborview Medical Center is a three hundred and fifty bed acute care hospital. We have approximately two hundred thousand out patient visits, approximately fifteen to twenty thousand adjusted admissions depending on who's calculating it on which given day. It is owned by the citizens of King County. It is run by the University of Washington School of Medicine under a long term contract. The hospital is the level one trauma center for the region and it also has a number of missions. But has a very large commitment to service to the uninsured.

We have, I think, taken many steps along the path of integration. We have massage therapy. We have acupuncture. We have affiliation agreements that have included the training of students in those areas. We also have a number of research activities that range from seasonal effective disorder, looking at the efficacy of light therapy. We are studying the impact and utility of virtual reality inpatients with pain in the burn area. We have a very strong pastoral care of program and training program that I think really deals with some of the mind body relationships. And we have program, another research program which is using magnetism to stimulate the brain in a randomized controlled fashion to see whether or not it can reduce the effects of depression.

With all of this, I think when you look at a teaching hospital we are an important community research both in terms of teaching, we provide clinical care and we do research. And as we talk about this issue of integration. I would like to make a very strong plea that you strongly favor the increase in dollars for research cause I think you're the best way to bridge this gulf that many people say is there. And I would say is there and acknowledge that is going to be through very strong research programs. Thank you.

**The Honorable James Gordon**: Thank you very much. Let's begin, Tom at your end.

**Female Participant**: Dr. Barnhart, I commend you on the research that you're doing and your inclusion of licensed massage therapists and acupuncturists. How much do you collaborate with Bastyr and has there been any consideration of, of perhaps residents cross-

training, residents going over to Bastyr and doing some training and residents from Bastyr coming over to your place to do training in patient?

**Scott Barnhart**: I'll look to Jane. I don't believe we yet have an affiliation agreement. We're still working on that. I think we're, you know, if we were to look at the training at this time, you know, we do have students that have come from Brenneke School of Massage and my own. We are discussing within the School of Medicine, there are a number of faculty members who are discussing the training exposure of medical students in terms of complementary and alternative medicine. At this time there's really not been discussion of exchanging residents.

**Female Participant**: For even part-time exchange?

**Scott Barnhart**: Right, not even. And I think one of the things that's important to recognize is that if you really look at say the accreditation requirements residencies. I mean they're quite strict in terms of what they require and how time is spent.

**Female Participant**: I'd like to thank Dr. Lippmann for introducing a controversial concept that I think needs to be discussed and looked at. I missed your full website. But one of my questions is, is part of your website education beyond your campaign? Is it perhaps case studies of vaccine damaged individuals? Or what is accessible at your website?

**Stan Lippmann**: Actually the website is rubella.net which I started a few years ago and one of the main sections is called the Rubella.net News and that gives the latest news stories on the vaccine controversy. It's really a weekly occurrence that a major periodical, the New York Times, Time Magazine will be discussing topics such as the Gulf War Syndrome. Last week it was White Cell Jacob Disease in Polio Shot. Week before that it was New Yorker Magazine had a Yanamami tribe in the Amazon was wiped out by a measles program and so on. So this is something that over the past couple of years, three years of my personal involvement has grown exponentially. It's still a little bit below the radar screen but one of the points of my website is to be a base for all the information on the web. And again there are many, many, many websites that I point to from my website there. So.

**Female Participant**: Thank you.

**Female Participant**: This is for Dr. Barnhart. Is your massage therapist and your acupuncturist on staff or are they contracted?

**Scott Barnhart**: They do have a, they are members of the medical staff. They actually come in I believe largely as volunteers cause they're usually are training students so the faculty come in. But they, the ones who come in are credentialed on the staff.

**Female Participant**: They're credentialed on staff but how are they paid? That's my question.

**Scott Barnhart** : They're paid through the school.

**Female Participant**: Through the school. And is there a, are you developing a curriculum in, for teaching your residents in complementary and alternative medicine?

**Scott Barnhart**: No.

**Male Participant**: Mr. Barnhart, your institution has a national reputation for producing leaders in end of life care, people like Randy Curtis, Gordon Rubenfeld and others. Are you, the activity here in the area with CAM therapy, your relationships with Bastyr and the [inaudible] of expertise in end of life care. Is there any kind of activity where relating CAM and end of life care at your institution?

**Scott Barnhart**: You know I don't want to speak cause I don't fully know all of Randy or Gordon's research. And a lot of the work that they've done, you know, much of it is, is in the setting, the intensive care unit setting. We are an acute care hospital with the case mix is about 1.6. I mean, the people here are extremely ill and my, my guess is there's not that much interaction. But I can't say for sure.

**Male Participant**: Thank you.

**The Honorable James Gordon**: Okay, thank you four very much. We'll take a fifteen- minute break and then we'll come back and we'll have the next panels.