

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

**October 30, 2000
4:40-6:15pm**

[Tape 6]

Male Participant: We're going to begin again.

Female Participant: Would the following panel please come on up? Leah Kliger. Could everyone please take their seats and the commissioners return to the stage. Thank you. Would the following panel please come up? Leah Kliger, Brenda Loew, Robert May, Terry Courtney. And also at this time if the following panel would also come up? Sue Vlasuk, Diana Thompson, Houston LeBrun, Heike Doyle. I apologize if I'm really killing people's names here. I'm trying my best.

The Honorable James Gordon: We understand it's nice to have, it's nice to have breaks, but we thought we'd try to start by about midnight tonight so we want to. Great. Leah Kliger.

Leah Kliger, MD, Evergreen Community Health Center: Hi, good afternoon. My name is Leah Kliger, I'm director for Integrative Medicine at Evergreen Hospital and Health Care in Kirkland, Washington, about fifteen miles from downtown Seattle. I want to talk with you today about how, through educational grants and economic incentives, you could provide access to integrative education and training at the local community level. This can help our health care system, our physicians and nurses and other community hospitals forge better alignment between the majority of our medical staff who currently are not local supporters of CAM integration and hundreds of local CAM practitioners. We need new and different language that encourages participation, not words and actions that raise heckles.

In 1997 we discovered that sixty-nine percent of our physicians felt they did not have the knowledge to communicate and confidently talk with their patients about alternative medicine, nor to appropriately refer to CAM practitioners. Eighty-eight percent of our physicians said they wanted more information and access to credible information. Based on these needs, Evergreen has underwritten a variety of activities including continuing medical education sessions, case conferences and workshops for caregivers and the entire community. But we need your help. Here are our recommendations.

1) Make a combination of educational grants, tax credits and vouchers available to community hospitals, to our medical staff and to local CAM practitioners. These would pay not only for continuing education sessions and workshops, but would also provide economic incentives to the physicians, nurses and community CAM providers who attend them. For example, we want to develop two-way training programs whereby conventionally trained doctors, nurses and CAM practitioners teach each other about specific conditions and approaches and learn new language and philosophy. Grants, tax credits to physicians and

CAM practitioners in private practice and other incentives would make it financially feasible for learning to occur.

2) We ask you to fully fund CAM research studies that make it easy for community hospitals and physicians to participate. Our pediatricians have indicated an interest in participating in CAM research studies about pediatric asthma, yet at the local community hospital level we simply don't have the money or resources that make it viable for us to participate in those research studies in a meaningful way.

3) We'd like you to develop a no-cost or low-cost way to have simple electronic links to credible CAM sites that can be then easily linked to our hospital and physician sites, and

4) we want you to quickly establish an evidenced based national formulary for botanical medicines. On behalf of the three hundred and sixty thousand people we serve, thank you very much.

The Honorable James Gordon: Thank you, too. And thanks for the very direct and pointed recommendations. We appreciate that. Brenda Loew. So be it. Her chi ran out. Robert May.

Robert A. May, ND, Alternare Health Services: Thank you. I'm glad to be here today to be able to present this material to you. My name is Bob May. I'm a Naturopathic physician, a Bastyr graduate, a former Bastyr clinical faculty member and currently the Clinical Director for Alternare Health Services, a CAM preferred provider network here in Washington and Oregon.

Alternare has developed and maintained CAM provider networks in the northwest for over five years beginning with the Washington State legislative mandate. We currently have approximately eighteen hundred providers who are credentialed with our network in Washington and Oregon, and these include chiropractors, acupuncturists, massage therapists, Naturopathic doctors and dietitians and nutritionists.

In addition to credentialing CAM providers Alternare also conducts regular quality assurance procedures that include surveys of consumers and providers, site visits and provider education and recredentialing. Some elements of Alternare [inaudible] experience may offer a model for the development of federal policies. From our beginning we have developed provider policies that have been based upon the NCQA guidelines for provider credentialing. These are the same guidelines that are used for managed care organizations with any type of health care professional. The process includes primary source verification of both educational and licensing for each provider and where applicable, it also includes specialty certification and any national certification. In addition, providers must meet minimum requirements for malpractice and liability insurance as well as undergo state patrol claims made and complaint evaluations, and the entire process is repeated every two years. In our experience, the NCQA credentialing of CAM providers offers a solid initial level of quality assurance and public safety and a foundational step towards integration and inclusion of CAM providers in the mainstream health care.

The most essential element for initial provider credentialing is state licensure. Inclusion within the Medicare and Medicaid system which facilitate licensing efforts for CAM professions around the country and, in addition, licensing is usually a prerequisite for malpractice insurance. Another element that we would have found very essential to credentialing in this mode is clinical training as an essential part of professional CAM education. And that, we feel that if the federal recognition of NCQA standards were to be adopted it would further this process across the board.

I would just like to mention one other thing and that is, that the CPT coding system, which is sort of the language that communicates what providers do in this country has never been designed with CAM providers in mind. And that should be something that should be addressed so that what is done is communicated accurately among all the different professions.

The Honorable James Gordon: Great, thank you very much. Terry Courtney.

Terry Courtney, LAc, Bastyr University: Good afternoon, I'm Terry Courtney. I'm chair of the Acupuncture and Oriental Medicine Program at Bastyr. I'm also a licensed acupuncturist. The availability of reimbursement for acupuncture significantly increases consumer access, choice and increases integrative and collaborative health care options for consumers as well. In 1997 the NIH convened a panel of experts to examine the scientific data on the use of acupuncture. This expert panel recommended the removal of financial barriers by urging insurance companies, federal and state health insurance programs, including Medicare and Medicaid and other third-party payers to expand their coverage to include acupuncture.

What is the current status of acupuncture reimbursement right now in the U.S.? For acupuncturists, 1) there is no Medicare reimbursement. 2) Medicaid does reimburse in some states for chemical dependency treatment alone, and 3) third party private pay is still determined at the company's discretion. It is not mandated coverage.

What are some of the barriers to increasing coverage for consumers?

- 1) Most peers want cost effectiveness studies. At this time, we only have limited funded research available. As a result, peers still see acupuncture as an add-on charge rather than as a potential partner in reducing overall costs.
- 2) As Bob May just mentioned, there are diagnostic differences between acupuncturists and the insurance world. Acupuncturists cannot use a western medical diagnosis unless predetermined by another provider. For example, a patient with migraines may have resolved the condition with acupuncture but because the acupuncturists don't use -- had to use a code of headache rather than a code of migraine acupuncturist efficacy in treating this case is missed in insurance utilization data analysis.

- 3) Medical necessity is often times a requirement for insurance reimbursement. If physicians are uninformed as to the benefits of acupuncture and if they are the ones determining medical necessity they may not support its inclusion in treatment plan. The second challenge is that medical necessity for coverage assumes that a patient is already ill. It does not allow for preventative therapy, which is the strength of our medicine.

What are the next steps?

- 1) There's a need for more funded research regarding clinical outcomes and cost effectiveness. Following the recommendations from the NIH panel acupuncture should be involved in the research design.
- 2) Insurance data banks need to evaluate how to analyze the acupuncture visit codes in order to not miss pertinent data due to restrictions and diagnostic codes by practitioners, and
- 3) Continued CAM education opportunities for other providers is necessary to increase the awareness of acupuncture's role and medical necessity as a stipulation for inclusion of acupuncture in the reimbursement arena.

A minor point in closing, we must also work to complete access to acupuncture in all fifty states. Eleven states remain right now which do not legally recognize acupuncture and or our missing statutory language. Thank you.

The Honorable James Gordon: Thank you. Questions. Joe starting at your end.

The Honorable Joseph Fins: I have two sort of operational questions, one are, one is for Dr. Kliger. Do you have any ideas on how to create a formulary?

Leah Kliger: Well, since Dr. Low Dog is on this panel, she could probably speak more eloquently than I can. I also want to just clarify something. Somehow along the way. I have picked up a medical degree and I'm actually a recovering hospital administrator. So let's do away with the MD. Actually, there are a number of ways we could create that national formulary, and I think working closely with the schools of pharmacy in this country, a number of the schools of medicine and experts like Dr. Low Dog. Something like that could probably be put in place in, without too much difficulty. There are, there is the, there's actually a lot of very good information from Europe and there's some very good information in the United States that make that very do-able.

Male Participant: For, for Dr. May. How do you bill? Do you have a comparable sort of internal CPT code that you use? And if so, could we see it and perhaps examine it?

Robert A. May: We use the standard AMA CPT system. So many of the codes end up being kind of bent, twisted and borrowed to approximate the service provided by CAM providers. It has produced its own share of challenges in the billing process because the code

will initiate a certain response within a health plan and when you try to track it back it, it, it, there's a discrepancy there.

One additional element just that I wanted to mention about codes to keep in mind is that, one of the facts, one of the factors that I believe the public has really recognized in CAM care that is not addressed in the CPT code system is the amount of time that the provider spends with the patient or the client. And that could be something that a CAM panel could really look at in developing specific codes for these services.

Male Participant: Thank you.

Female Participant: [inaudible] I'd like to address this to Dr. May. Our office has been credentialed with Alternare since its, I think since its formation, and to this date there hasn't been one contract available to participate in. So I'm asking you, what are the barriers that you're, you're running into for contracting for CAM services?

Robert A. May: I'm trying to think of a witty comment to make about the vagaries of the health insurance industry and the changes and movement there that are really outside the realm of our network's ability to control. Business decisions made by health plans that contract with network, such as ours, really occur in another world that I'm afraid I won't try to address. And probably won't come up with a witty comment about either.

Male Participant: Dr. May, do we have a critical mass of naturopaths throughout the country? I'm sure we do not. How then do we get states to decide to go ahead and license an entity they're not familiar with, don't see, know nothing about?

Robert A. May: I think it's a question that deserves a lot of focused study, but one of the models that can be used in addressing that is that with a region like the northwest and even some of the New England states that have established CAM licensing regulatory statutes and laws on the books. It is not a real leap to extend that model or those standards to a state that does not yet have the critical mass of providers. Some states right now, I believe it may be Alaska or Hawaii, one of them, requires a license from a state that does license the providers. There are ways to work around that but to uphold the same standard for credentialing.

The Honorable James Gordon: Thank you.

Male Participant: May I?

The Honorable James Gordon: Sure.

Male Participant: Is it Dr. Kliger?

Leah Kliger: Call me Leah, how's that?

Male Participant: Leah, thank you. I do think your recommendation of college of pharmacy is indeed an excellent source. They are right now the centers of knowledge and

they're the ones receiving the grants from NIH to do the specific research so. I do know that they have a very good base of knowledge for these botanicals. Please comment.

Leah Kliger: I'd like to comment on that, I think they're one of the sources of information. I think there are a great many other sources that would need to be consulted with in order to develop that national formulary. There are some particular biases that we all, in our particular professions have. And in order to make sure that all voices are heard we'd need to look across the spectrum of both organizations like the American Botanical Council, the Herb Research Foundation, physicians, the Rosenthal Center and Columbia University plus schools of pharmacy.

Male Participant: CRN, Council for Responsible Nutrition?

Leah Kliger: Sure.

Male Participant: I had a question. How, how is the program evolved and and why do you think you're in the hospital, connected to the hospital? What's, if you just very briefly give us a sense of how and why your program has grown. And why, in a perhaps second question, why in a climate when many of the hospitals I go visit say well we're interested in CAM but herbal therapies scare us mightily? Why do you think you're moving in this direction? What's, what's happening?

Leah Kliger: Well, a couple of things. As you know because you've keynoted a couple of our symposia, Evergreen Health Care includes not only hospital but thirteen community based programs, a hospice, a home health center and has always seemed to have gotten the idea that we exist to serve the community. And because we've also done a number of studies that indicate well over fifty percent of the people in our service area use complementary and alternative medicine our board and our community advisory said, yes, we do need to take a stand. We do have policy statements written into the governing board policy that indicate individualized care that take into account body mind and spirit will be part of the service that we provide.

That said, we do a lot of education. We've spent a lot of money on education and now we, as I indicated, we need your help with that. However, someone mentioned earlier, I think it was Jane Guiltinan from Harborview, as well as the one from Bastyr, who talked about the Balanced Budget Act. And we're pretty much affected, we're very affected by that Balanced Budget Act as well, by the Balanced Budget Act, the Medicare Balanced Budget Act. So at a time of scarce resources, I actually find that our budgets that have been designated specifically for integration of CAM activities continue to shrink. And I have actually been challenged now in the next year to go and find at least half of my budget from sources outside of the hospital. So it's not an easy task. We continually face uphill challenges, and it seems as though with our integrative medicine task force their recommendation, our recommendation is continually more and more education and rubbing elbows.

The second piece about the botanical medicine piece, what we know is so many of our physicians get asked these questions all of the time. And so they're saying, we don't know

what to do. We need to know what to do in order to be responsible physicians. Hence, help us figure out what the best botanicals are. We need a national formulary.

Female Participant: Just a quick comment. I mean, and one of the reassuring things for physicians, I think, is that eighty percent of the sales of botanicals in this country only consist of twenty botanicals. I mean, so there is a lot that are used, but eighty percent are only of twenty botanicals. And so it's not a daunting task to really provide a substantial amount of information based, and most of those twenty actually have a fair body of research, some good and some bad for them.

Leah Kliger: And it would be really wonderful if at a national level those twenty were made known and then physicians would, all the way from the AMA through the American Holistic Medical Association, through the schools of pharmacy, would recognize the efficacy of those twenty.

The Honorable James Gordon: Thank you. I, one of the things I wanted to say is that just sort of really to tell the commissioners is that as with Harborview, Evergreen also is one of those hospitals that really has stepped out and I did participate in a conference with them. It's quite wonderful. It's quite impressive the way you've mobilized people. And I would, if other thoughts come to you and if there are people, other people in the medical community here, about some steps that you might recommend or pathways for conventional hospitals to open up in the way you have, I think that would be very helpful as we move ahead. Thank you very much. Next is Sue Vlasuk.

Sue Vlasuk, DC, DABCO: Good afternoon.

Male Participant: Good afternoon. Could you tell us what DABCO stands for?

Sue Vlasuk, DC, DACBR: Well, that's a mistake actually.

Male Participant: Michelle is very curious.

Sue Vlasuk, DC, DACBR: A different collection of letters. That's actually an error. DACBR, Diplomate American Chiropractic Board of Radiology. What is there is incorrect. I am a chiropractic physician. I've been asked by the Washington State Chiropractic Association to make these comments. Also as alternate delegate to the American Chiropractic Association, I also represent those thoughts. And I also have been asked to speak specifically on the issue of reimbursement related to chiropractic.

So the things that have changed over the many years, well thirty years that I've been in practice, there was not much insurance. And I've heard comments made of other CAM providers that don't necessarily have the insurance coverage that chiropractic has right now, but there are problems still as was mentioned by Dr. Low Dog. And these problems, to summarize, even though you exist in a system are still severe barriers to an individual trying to seek an alternative method for their health care needs. It is an actual barrier to them because they have to pay twice. They have to pay for their health care insurance and then

they have to pay out of their own pocket to go seek whatever alternative care they want. So some of the barriers, whether they exist in the system or not, I'm speaking from one who does exist in the system. A gatekeeper is a significant problem.

You're asking someone who is not necessarily familiar with the method to make a recommendation. It delays the care, it increases the cost and it decreases the likelihood that that referral will be made. Second, the coverages are frequently very limited. They may not include the full scope of what the CAM provider is authorized by state law to do. Just an arbitrary decision--we will pay for one thing but not the other. And another problem is we may pay for it but we're not going to pay for it at the same level for the same service that we would pay another provider, like forty percent less just because the degree is less. And also down-coding and bundling that I'm sure a lot of physicians have. And capping services too.

So what would be the recommended methods of recovery for this would be legislative and regulatory. And we're looking for direct access without a gatekeeper according to the full scope of practice in each state and like reimbursement for like services so that the patients don't have to pay twice to get the kind of health care that they wish to have.

The Honorable James Gordon: Thank you very much. Diana Thompson. Houston LeBrun.

Houston LeBrun, LMT, American Massage Therapy Association-WA Chapter: Good afternoon. I'm Houston LeBrun, I'm currently the President of the Washington Chapter of the American Massage Therapy Association. I'm a past national President of the American Massage Therapy Association and also an educator in Washington at the Brenneke School of Massage. I understand there hasn't been a great deal of LMTs before you today so I'll give you a little bit more background than a specific topic.

The American Massage Therapy Association currently represents over forty three thousand massage therapists and in the state of Washington more than three thousand. Currently there are twelve thousand LMTs in the state of Washington or plus. And the AMTA is currently affiliating with several organizations such as the Commission on Massage Training Accreditation, the National Certification for Massage Therapy and Bodywork Association and the AMTA Research Foundation, the AMTA Council of Schools.

One of the issues that I want to focus on is research and the American Massage Therapy's Research Foundation. Currently we, the research foundation holds the most complete database on massage therapy in this country and also has created a research agenda as of 1999. Both of those entities if utilized by the National Institute of Health would give us better access to the research that currently does or does not exist on massage therapy in this country. Often massage therapy has to ride on the coat tails of other research due to financial costs as well as the limited perimeters of research base that massage therapy can provide due to the fact that it's very difficult to provide imitation massage. So once the body is, often once the body is touched the process takes place, so.

Another issue is, the Commission on Massage Therapy Training Accreditation is currently seeking USDE approval and COMTTA is the most thorough body in regards to evaluating and accrediting massage therapy education institutions in this country due to the fact that their facilitators. And their managers for site visits are all practicing massage therapists and or educators in current institutions. which does not exist in other accrediting bodies in the country. And so in other words, increasing our ability to evaluate proper curriculum continues to be a challenge and one that COMTTA is serving this country very well with. Thank you.

The Honorable James Gordon: Okay, thank you. And Heike Doyle please.

Heike Doyle, LM, Puget Sound Midwives & Birth Center: My name is Heike Doyle. I'm a licensed midwife in Washington State. I'm a certified midwife nationwide. I have graduated from the school, midwifery school here in Washington State in Seattle and I've been in practice for twelve years. I have practiced in states where midwifery is legal and recognized and integrated and I have practiced in states where it is illegal and you might go to jail if you transfer a woman to the hospital. I can clearly say looking at research and my own experience, women get better care in states where midwifery is legal. Less babies die and women get much better care.

I'm here to present some information on reimbursement. We had, what has worked for us is we have three fabulous laws that our legislation has put in place. One is the direct access law. We don't have to go through the gatekeeper any more, which has significantly improved access of care especially for low income women who don't have transportation so they don't have to go see a physician before they can even come to us.

The second thing that we have like before we had the Every Category of Provider Law meaning insurance companies had to cover some providers from each licensed medical profession. Reimbursement coverage was very spotty. Now that we have that our midwifery has changed and has moved more into mainstream women and has gone away from, you know, the counterculture on the whole range. And the people that were willing to pay out of pocket in addition to their health insurance if they did have it.

The other thing that was I think the key issue for midwifery care to move into reimbursement is the mandate to have medical liability available for practitioners. That got us in the door with insurance companies and also we sat down and we talked to each other and we learned from each other like, what do you guys need from us and what can you give to us? So that was fabulous.

What has not worked is the third party payers that have headquarters outside Washington State are not as willing to negotiate with midwives because they're not aware of the standard of education and the standard of health care here in Washington State. The other thing that hasn't happened is reimbursement in Washington State is absolutely inadequate. We get OB care less than seventeen hundred dollars for nine months of care including delivery, prenatal care and postpartum. While physicians in hospitals get up to eight to twelve

thousand dollars for the same services with less personal attention and for the same outcome. Thank you.

The Honorable James Gordon: Okay, questions? Joe, you want to start?

The Honorable Joseph Fins: Yeah, on the financial theme from Ms. Doyle. What's the malpractice cost for a midwife per year and what is it for an obstetrician in in this area?

Heike Doyle: I don't know what it is for an obstetrician. For a midwife it's a minimum of twenty four hundred a year even if they just do one birth and after you've done twenty four births you have to pay a hundred dollars per birth. That will significantly increase next year [inaudible].

The Honorable Joseph Fins: And how much coverage does that buy you?

Heike Doyle: That covers one million three million.

The Honorable Joseph Fins: One three, okay.

Heike Doyle: Yes.

Female Participant: I am interested to know is there not a national licensing for, for this?

Female Participant: No, [inaudible].

Female Participant: There is a national licensing for certified nurse midwives who primarily practice in hospitals. There is a state by state licensing mechanism or no mechanism for direct entry midwives. So the states that have licensure also have educational requirement which improves care.

Female Participant: Dr. Vlasuk, I'd like to ask what would you like to see as a minimum standard of care each patient could expect as they enter a chiropractor's office across the United States?

Sue Vlasuk, DC: A standard of care?

Female Participant: Yes, a minimum that each patient could expect when they enter a chiropractic office.

Sue Vlasuk: I would expect that a thorough history would be taken and a good physical exam directed toward their complaint and whatever care turned out to be necessary based on that. I, I don't think you're asking about how much care are you?

Female Participant: I'm asking this question because I'm sure you have the same experience. I've referred patients across the United States and they can go into other offices

and not get their spine checked and an adjustment but they can get a series of modalities and a massage and so forth.

Sue Vlasuk: Oh.

Female Participant: I'm asking you what is the minimum expectation every chiropractic patient could have upon presentation.

Sue Vlasuk: That is a tough question. Definitely, the history and the physical examination and the hands on manipulative treatment--the spinal adjustment, whatever you call it, and the other things are ancillary.

Female Participant: Thank you.

Female Participant: Thank you for your presentation. When you are working in an underserved area midwives in Washington is there a reduction in fee for your malpractice insurance.

Heike Doyle: No.

Female Participant: There is no compensation for the fact that you're working in an underserved area?

Heike Doyle: No, there is not. What is available is school grants that you can work off if you then work off in an underserved area so it helps you pay for your education. That is available.

Male Participant: On the question of direct access, I'd like to just raise a thought, if we are not working with the idea of a primary care physician, is it your speculation or experience that the consumer is still looking for some kind of coach, or counselor, or consultant to work with as he or she pursues a variety of modalities to try to solve ones own health needs?

Female Participant: Are you asking me?

Male Participant: That's an open question to whomever would like to answer.

Female Participant: If I could reply I would like to.

Male Participant: Thank you.

Female Participant: Yes, I think they are looking for a coach. However you've probably heard in prior testimony that you have a whole different approach of someone who wants to maintain health is looking for a little different type of coaching than how do I quit being sick.

Male Participant: I hear that.

Female Participant: Yes.

Male Participant: But you do still see the legitimacy of one consumer selecting a coach?

Female Participant: Yes, I do see that legitimacy very much so. And on the other hand of that this, this reimbursement issue that we're talking about actually keeps people from being able to make that decision. No, they are shunted into the tradition that their payer will pay for. And so they don't necessarily get to seek the kind of coach [inaudible].

Male Participant: I realize that. But in the absence of our present system it's helpful for me to hear that you, you think the consumer may still prefer to choose someone with whom to work.

Female Participant: I'm certain of that.

Male Participant: Yeah.

Female Participant: Absolutely.

Male Participant: Thank you.

Heike Doyle: I have a lot of clients that have a primary care provider and midwifery care takes care of everything that has to do with child birth, pregnancy and the new born during that ten month period. And if there is anything outside of that they go back to their primary care provider. And then, you know, I work in conjunction with the primary care provider which is the beauty of integrated care. We call each other and say this is what's going on what do you think and it really gives wonderful care to the women. So they do go back to their primary care provider.

Houston LeBrun: Yes, I think that in massage therapy is very involved with a scope of practice and staying within that scope of practice. So I believe that people are looking for a coach whether it is through an injury or towards a wellness modality. And I think that just as a physician would refer because they are beyond their scope of practice with massage. They don't, they don't have the scope of practice with massage that a massage therapist would have. So a massage therapist should be referring back to the primary care practitioners.

The Honorable James Gordon: I have a couple of requests actually. One is for you, Houston LeBrun. If the AMTA, and I'm asking you as a state representative, could give us whatever information they have about cost effectiveness studies. The only ones I'm really familiar with are Tiffany Fields, but I assume that there are others as well.

Houston LeBrun: There are several Tiffany Fields are of course the most wide ranged at this point. But there are several through the AMTA Research Foundation and I'll have them sent to you.

The Honorable James Gordon: That would, that, that would be great. A question, quick question about midwifery. What is the training? Licensed midwife training can be a whole variety of different things I assume?

Heike Doyle: In Washington State, there is a law on the books that clearly describes the requirement to sit for the state license.

The Honorable James Gordon: I'm sorry, it's what?

Heike Doyle: There is a law that clearly describes the requirements in order to sit for state boards. So it tells you, you have to attend a licensed school, licensed by the state. You have to be involved and deliver a hundred babies before you can even go and sit for the board. So there's a really clear measure on how many practical hours you have of the preceptor and how many hours you have to have theoretically in a formal education setting.

The Honorable James Gordon: How, how many states have licensed midwifery as opposed to certified nurse midwives?

Heike Doyle: I'm pulling this out of my hat. I'm thinking there is licensed probably about seventeen now.

The Honorable James Gordon: Seventeen.

Heike Doyle: That have licensed midwifery.

The Honorable James Gordon: And the data that you gave, again this is a similar question. If, whatever you could do to help facilitate bringing us data about cost, cost effectiveness, malpractice, etc. whatever you have for licensed midwives would be very helpful.

Heike Doyle: I left a packet upstairs that has several, that has several studies on cost effectiveness of midwifery care in comparison and outcome studies.

The Honorable James Gordon: And is there now a [inaudible] between licensed midwives and certified nurse midwives?

Heike Doyle: Well we're dancing with each other and sometimes it goes better than others.

The Honorable James Gordon: Okay.

Heike Doyle: So I think in this state it works.

The Honorable James Gordon: Any guidance you want to give us as we approach the whole, the whole issue of making recommendations. For example, as a licensed nurse, as a licensed, sorry as a licensed midwife are you covered by any insurance here at all?

Heike Doyle: Yes, actually after the Every Category of Provider Law we started sitting down with the insurance company. I [inaudible] have a contract with about ninety five percent of all insurance companies in Washington state in my area. So—

The Honorable James Gordon: Could you give us since not necessarily here but of a, of some kind of model that would make sense to you for coverage.

Heike Doyle: I will be glad to.

The Honorable James Gordon: Okay, great. Thank you very much.

Female Participant: Thank you.

The Honorable James Gordon: I'm going to call up the next group of panelists. It says Upledger Institute. I don't think that's a name, I think, but somebody must be representing the Upledger Institute. So if you are here please come. Jerri Fredin, Don Sloma, and Robert Nicoloff will be the first panel. And then we'd also like. Did I skip over somebody?

Male Participant: No.

The Honorable James Gordon: Robert Nicoloff and then Richard Whitten, Andrew John Brunskill, Karl Peterson and Pat Prinz. Okay, so, is there a representative from the Upledger Institute. No, okay.

Jerri Fredin: I'm Jerri Fredin of Seattle and I have been an alternative health care activist since 1980. Excuse me. Today I'm speaking on behalf of a statewide volunteer organization Citizens for Alternative Health Care or CAHC. My testimony focuses on your question how can access to safe and effective CAM practices and interventions be improved. Currently the number one barrier to CAM practices in Washington is the law that grants supreme authority to our state's medical disciplinary board with no provisions for checks and balances. Therefore, to improve access to safe and effective CAM practices we must change that law. Many of us in CAHC know conventional physicians who would like to include CAM in their practices but they dare not for fear of losing their licenses.

While Washington has state laws that permit judicial courts to overrule decisions by other state commissions statutes governing the medical disciplinary board, medical quality assurance commission make it an exception. For this reason CAHC, with the guidance of a state Senator has proposed five amendments to the laws currently governing our medical disciplinary board. One of those five, a checks and balances amendment stems from the Board's 1996 revocation of the medical license of CAM oncologist, Dr. Glen Warner. When

Dr. Warner appealed to the King County Superior Court for a reversal of the board's decision revoking his license, a decision I would like to add was made by just three board members who were neither oncologists nor CAM practitioners. The Superior Court Judge, who handled the appeal, informed Dr. Warner that even though he considered the Board's decision wrong he could not overrule it. Later, following an appeal to our former governor, Dr. Warner was likewise advised the state's chief executive did not have the authority to intervene.

However, the governor's legal counsel acknowledged that license revocation requirements do need to be changed in this state. Our proposed checks and balances amendment would give courts the authority to either affirm or overrule contested medical quality assurance commission decisions--an amendment that I would like to emphasize can benefit both CAM and conventional physicians. Draft copies of all five of CAHC's proposed amendments have been submitted to your commission and we seek your support in our endeavor. And I would like to thank you.

The Honorable James Gordon: Thank you very much. Don Sloma.

Don Sloma: Welcome to the northwest and thank you for the opportunity to talk with you about CAM in Washington. I don't speak today for my current employer, the Washington State Board of Health, but rather for one of my former employers, the State Senate Health and Long Term Care Committee. When I was working with that committee in the state Senate for over a period of ten years I had a hand in crafting and modifying lots of the legislation that you've been talking about. And most specifically a bill in 1993 called the Health Services Act that created the Any Category of Provider Law and also the Health Personnel Resources plan. Subsequently, I was involved in the Direct Access to Women's Health Care legislation that was discussed just a moment ago and other pieces. Also earlier in my career I spent time looking under sunset review in our state legislature at acupuncture, midwifery, chiropractic care and others in advising the legislature about those things. I was asked to come today to talk with you about how these laws got on the books. And in particular I want to focus on the Any Category of Provider Law and the law that had to do with Health Personnel Resources Plan.

The long and the short of my comments here really are that those laws depended upon an already established climate of acceptance for alternative medicine here in Washington that stretched back at least into the 1970s. And that was fairly thoroughly examined as a matter of public policy during the 1980s. So that when we came in 1993 to creating what was a sort of public private partnership, if you will, called health reform which in fact actually lasted here for a year or two on the books. The question became not so much should we create a policy for CAM but rather should CAM be included or excluded in a scheme that would regulate and extend access to health care interventions to all citizens in Washington. And the answer to that question [inaudible] climate and the political activism of the CAM community here was, yes it should be included or at least it shouldn't be excluded. And so for that reason, the Any Category of Provider law was included in the Health Services Act in '93.

The Health Personnel Resources Plan followed on that and essentially said, let's make sure we have an adequate supply of these providers and do what's necessary to plan for that. So that's the thrust of my comments. And I'd be happy to answer any questions you might have about any of those other statutes.

The Honorable James Gordon: Great, thank you very much. Robert Nicoloff.

Robert Nicoloff, WA State Department of Health: Hi.

The Honorable James Gordon: Hi.

Robert Nicoloff: I'm Bob Nicoloff, Executive Director of the Health Professions Division with the state of Washington Department of Health. I have two brief information documents I would like to share with the commission. The state of, the State Department of Health, among its varied functions and activities, oversees licensure and regulation of over forty health professions. The first document summarizes the five complementary and alternative professions that are regulated, administered by the department. For each profession we include a list of the year the profession first became regulated in our state, the statutory scope of practice of each profession and the current number of licensees in each profession. This is for your information.

As you've heard throughout the day, Washington State has a long tradition and heritage in the utilization of alternative therapies and this is borne out in the history of regulation as well. Of particular note are several professions, which have been recognized and licensed for over eighty years going back before the twenties. The second document highlights the consumer protection education activities of our agency. Consumers at this point can call twenty four hours a day on an automated line to obtain basic licensure information on any provider including alternative providers they are considering using. This includes information on the length of time the licensee has practiced in the state, as well as information regarding concerns that might have been received concerning the practitioner. And this also outlines our disciplinary and complaint investigation process for your information. Also, numerically we've received over a half a million inquiries and verifications of licensure during the 1997-1999 period. So this information is being requested and utilized.

And in terms of the disciplinary data, in closing, it shows that the alternative and complementary approaches professions generally have about the same number of complaints as other professions and in some cases there's some of these professions they actually have less than the other health professions that we regulate. I'd like to thank the commission for this opportunity and I'd be happy to answer any questions.

The Honorable James Gordon: Thank you very much. Richard Whitten.

Richard Whitten, MD, Washington Health Care Authority: Thank you. I'm Dick Whitten, I'm a general internist. I've been for ten years the Medical Director of Washington's Health Care Authority. Our Health Care Authority administers three different care programs

for our public employees in the state, for our basic health plan--which is a plan focused on the working poor, those under two hundred percent of federal poverty level, not eligible for Medicaid, and our community health services--our community clinic program. We provide access to our contracts to about half a million enrollees. Health Care Authority also overviews the Uniform Medical Plan which is a state administered self insured provider, a preferred provider organization and Dr. Brunskill's here from that prospective and will provide some comments after mine.

I was asked to help provide a prospective on what we've learned, what we think we've learned in the past dozen years from the Health Care Authority viewpoint in administering and restructuring state health programs that might help you. We think we have three suggestions. They are to eliminate arbitrary exclusions, to avoid mandates and to structure benefits in such a way that they focus on outcomes in a scientific basis. And I'll comment on each of these three.

The first was to eliminate arbitrary exclusions. Each of our programs historically had some exclusions. You've seen lots of them. They're real common for CAM to see something specifically excluded. Now let me give you an example. Basic Health since it's inception in 1988 excluded chiropractic. However a little short time after that the Agency for Health Care Policy and Research, now the Agency for Research and Quality came out with a study that showed allopathic physicians were not very good at treating either acute or chronic pain. By removing the exclusion for chiropractic in Washington's Basic Health Plan we made it possible and encouraged our health plans to work with individual providers and provider groups to seek better outcomes, eliminating an arbitrary exclusion.

The second recommendation was to avoid mandates. This may be less popular here, but we believe that where legislation or a regulatory body or a purchaser mandates a specific coverage we create an entitlement. When we create an entitlement we get both the good and the less useful. After having established such an entitlement it's very hard to get anybody to focus on optimizing or again regain any focus on improving efficacy and cost effectiveness. An example, our Basic Health Plan once had a specific exclusion for out patient supplies and equipment. By removing this and instead putting in words where the use of the services, supplies or equipment is expected to result in a lower total out of pocket to the plans if the enrollee stays present for four years. We turn the focus around and try to get emphasis on what's cost effective, avoid a specific mandate.

Thirdly, to structure the benefits such that they focus on outcomes in a scientific basis. Our plan, Basic Health is one example, like many others had a specific exclusion for experimental/investigational. This is a national topic now. Rather than just finding a way to mandate this, we put in certain coverage criteria which established the services required because of a disease, illness or injury performed for the primary purpose of preventing, improving or stabilizing the disease, illness or injury. There is sufficient evidence to indicate that the service will directly improve the length or quality of life. The service's expected beneficial effects on the length or quality of life out ways its expected harmful effects. And fourth, the service is a cost-effective method available to address the disease, illness or injury. Such criteria are equally friendly to all types of efficacious care including CAM. We believe

the three guidelines to eliminate arbitrary exclusions, to avoid mandates and to structure benefits such that they focus on outcomes on a scientific basis will help you and has continued to help us.

The Honorable James Gordon: Great, thank you very much. I'm sure, at least, I'll want to come back to that. I want to hear more about it. Andrew Brunskill.

Andrew John Brunskill, MD, Uniform Medical Plan, Health Care Authority: Welcome to the northwest. I'm the Medical Director for a self finance, non-profit health plan for state employees here in Washington, the Uniform Medical Plan. But I am representing myself not the agency in this statement. There is a strong movement to encourage plans to support evidence based, cost sensitive care. But in reality there are a lot of pinnacle practices being undertaken by both CAM and non CAM providers whose evidence base is poor or do not appear to be cost sensitive. Examples include injections with placental extracts, nutritional counseling, massage therapy, or on the other hand stem cell transplants, pet scan imaging and newly produced medications. The situation is exacerbated by different patterns of billing practices by different providers.

I'd like, happy to give examples of why it can be helpful for plans to be able to refer to federal materials on what treatments should be supported and what the present evidence on cost and effectiveness is for these treatments. Consistent support for federal agencies, like the U.S. Preventive Services Task Force Guidelines or for the Agency for Health Care Research and Quality, can provide useful and accountable resources which, as long as CAM advocates are represented, can provide a well documented and reasoned basis for our health plan coverage decisions.

The Honorable James Gordon: Thank you. Let's begin Tom at your end. Any questions?

The Honorable Tom Chappell: Well I hate to keep asking this question but I will. Mr. Sloma how does, what are the key strategies of political activism that result in success of licensing in a state where CAM practitioners? You mentioned, I, your story was political activism is what resulted in a change in the law to include CAM practitioners. What are the? [cross-talking]

Don Sloma: I would say, yes.

The Honorable Tom Chappell: I'm not a politician. I'd just like to know how it works.

Don Sloma: Well, if I knew that, we'd still have a Health Services Act sir.

The Honorable Tom Chappell: However, you were there [inaudible].

Don Sloma: I think really it was a combination of citizen effort and the health professions organized and bringing those issues forward in the political environment. But I

would also say that our state, and you can see Dr. Whitten on the panel with me today, enjoys a, I think uncharacteristically progressive medical communities sort of leadership. And I think some of those bridges being built across professions before anyone comes politically to the legislature means that the very considerable influence of the medical association was not brought fully to bear to kill some of this legislation over the years and it could have been. When Medical Directors, like Dr. Whitten and others, who have been served in state government come forward and say, we're not sure that there isn't something here. It isn't a ringing endorsement. But sometimes all that's necessary is for powerful people to take a step back in order to let something happen in the political process. So I'd say that sort of combination.

The Honorable Tom Chappell: Thank you.

Female Participant: Yes to Dr. Whitten. I noticed your reference to chiropractic being included because they were deemed to be effective for neck and low back pain. And I can only speak from my professional prospective, which was, that means that chiropractors were not allowed to participate based on their practice act. And I'm wonder in the Health Care Authority as they integrate other health care professionals will they be allowed to participate based on their practice act or will some other group decide the scope of their practice within the Authority?

Richard Whitten, MD: We've worked hard to remove any practitioner specific items in any of the contracts we've written. As I tried to give, chiropractor was an example to specifically remove anything that limited practice by a specific category provider. The practice, the extent of practice is completely governed by the individual board. So that's not something that comes under the Health Care Authority. We're a contractor for the, for the provision of services. We are trying to structure things in such a way that the health plans will look for evidence and for, and making arrangements within the limitations of the Practice Act. We all must be governed by that within our state. But try to look for evidence bases of which types of procedures and activities are most useful.

Just to build on what Mr. Sloma said a second ago the AHCPR study was based here. Dr. Rick Dayo, Group Health and others helped show us that there were some really much better ways of taking care of back pain than taking people who didn't need it and giving them surgery. So and there's a lot of physicians that are really interested in trying to find what's a better way to treat people.

The Honorable Effie Poy Yew Chow: We have a group of very impressive kind of history on influence of our health care here in Washington. And thank you for all your efforts. I have a generic question. We talk about CAM and integrating CAM and CAM practitioners, non CAM practitioners. Do you have a definition of what CAM is? We, you know, I myself, it is like we haven't really described. It's like everything outside of the modern western medicine. Is that what you take, or do you have a more definitive definition?

Male Participant: I'll be honest with you, we use the CAM terms these days because that's the term everyone else uses. During the years we were doing this it was about what's

the care, people with Asian and Pacific Island background want. What's the care that people who've grown up in and around the northwest want? What's some of the traditional medicine that people who live in this country, who've been here for thousands of years want and use? Is there any value there. Does it improve people's health status? And it came up as naturopathy. It came up as acupuncture. Only in the last number of years after much of the work was done and much of the research was done here in Washington did the term CAM come to prominence and be sort of talked about. So I'll take the definition that that you want to take. What we're interested in I think and what, I should add to that question that was asked earlier.

One thing that helped in Washington was people in Washington politics have kept a bit of an eye on the ball in terms of looking at health status improvement. The fact that these treatments are, have been demonstrated to be safe, and effective and inexpensive recommends them highly to policy makers in Washington. The only thing that's stronger than biomedicine perhaps in America is pragmatism.

Jerri Fredin: The written testimony that I've handed in here on our five amendments, we came up with what we thought was about the simplest way of [inaudible].

The Honorable James Gordon: Could you speak closer to the mic please?

Jerri Fredin: Excuse me can, is that better? In the written testimony that I have handed in on five amendments that we're going to be proposing we had included what we hoped was a rather simple definition of CAM. Integrative or complementary health care also known as complementary or complementary and alternative medicine (CAM) shall mean those health care methods of diagnosis, treatment or interventions that may depart from conventional health care and the conventional standard of care.

The Honorable James Gordon: Thank you. Linnea.

The Honorable Linnea Larson: Yes, this is directed to Dr. Whitten. I very much appreciate all of your pretty formidable work and your brevity in your recommendations and therefore I would actually like you to submit any kind of what you said to us cause I cannot really remember it. You know the examples that you used to illustrate avoiding mandates and eliminating arbitrary exclusion.

Male Participant: For Mr. Nicoloff. A question about the scope of practice.

Mr. Robert Nicoloff: Yes.

Male Participant: Thank you for providing that to us. I was reading the naturopathic physician scope of practice, which I observed was first licensed in 1919 and I'm just wondering if it's time for a change. There's some, there's some sort of oxymoronic pieces in here. They are excluded from treating malignancies or neoplastic diseases. Now I can understand perhaps chemotherapy would be excluded. But what about ancillary care, palliative modalities for someone who has cancer? Would that person be disciplined by the

board? The second question where I'm taking for an expansion of scope. Here I'm looking for maybe, maybe a sort of constriction in scope. Radiography, they're allowed to order but they can't interpret an x-ray. So as an internist, I have a hard time ordering tests that I don't understand and I can't interpret. So what's the range of the scope and has anyone looked at the?

Robert Nicoloff: I might note that in 1919 it was really a predecessor profession. It was called drugless therapy and really this law was rewritten. I think Dr. Labriola talked earlier today and in the mid-eighties this was written. I know there's a proposal in our legislature to update the scope of practice and I think it addresses several areas that you mentioned but. But obviously in each case, we will look at the specifics with the consultation of our naturopathic advisory committee and identify you know, do the specifics apply within the scope? And was it reasonable given, and obviously in any of this language there's some interpretation.

Male Participant: Could you supply us with the bill even though I understand it, you know, it hasn't passed.

Robert Nicoloff: We will and I think the association, Naturopathic Association will as well.

Male Participant: Thank you.

Robert Nicoloff: And I also have full copies of the, of the laws I can leave.

Male Participant: Great, thank you.

Male Participant: Dr. Whitten, I have a question. The three principles are very clearly articulated. Can you give us a sense of how, how this works in practice. If you're guided by eliminating arbitrary exclusions, etc. what does this mean for the people of Washington? What does this mean for the statutes? And what does it mean for the people of Washington in terms of what kind of health care they can look to and how does it affect coverage and all those things?

Richard Whitten: It's a big question. Two cautions, it, it, it needs to take place over time and it doesn't take place the same. You asked a question a minute ago can you define CAM. Well obviously you have many different things here together. We've attempted to identify in specific areas where there is good evidence. These would be things that would be good substitutes or changes from what we now have in our benefits packages. We've made those changes. This has taken place over about eight or nine years. So these aren't something, it would be very difficult to eliminate exclusions and not have, do all these things at once because of the dramatic impact on utilization. But taking some time with, and others have pushed you in which you're helping us do, to identify good sources of data to be able to identify what are cost effective useful alternatives. No only to, things were currently [inaudible], but also to change some of the things we're currently doing. I think that would, that's what we have done with some of the ones I've outlined.

Male Participant: But can you give me a sense of what this might mean practically for someone?

Richard Whitten: Well, sure. We have, for instance, within our contracts with the state Health Care Authority over the last several years. We now have Naturopathic physicians with some of our plans that are primary care providers. We have chiropractors who are part of the provider network with a number of our health plans providing care in concert with some of the others. Now they don't all have this and in some places we certainly don't have what many people in this audience would like to have. But it has enabled and encouraged this to take place over time. First remove the exclusion and try to help identify and motivate changes in this direction.

Male Participant: And this is health contracts for?

Richard Whitten: The State Health Care Authority has contracts for the, as I mentioned, the public employees for our basic health plan and we also help with the contracting. And we coordinate with our Department of Social and Health Services Medical Assistance Administration contracts.

Male Participant: Could you give a, and those, so state employees then sign up for a particular plan that you offer?

Richard Whitten: Yes sir, that's correct.

Male Participant: And your plans would include these five groups that Mr. Nicoloff's told us about or not necessarily?

Richard Whitten: Some of our plans would have a variety of the different providers. I'd have to, I could certainly get an answer for that. And we've certainly seen a change over the last few years. But I'm not sure which. I know some of them do.

Male Participant: I think what will be helpful and obviously there is not time for it now is to give us, give us those plans and if you would and I know this is, again, you're very far out ahead of most if not all of the country. So it would be very helpful if you would give us the plans and the rationale for each plan and some sense of what that would mean in terms of what an employee would pay and what an employee could expect.

Richard Whitten: We can try. May I encourage you, you have several people providing testimony to you or on the formative committee who represents some of the health plans and they may be able to answer the reasons, the motivations better than I can. But we will try to do what you're asking.

Male Participant: It would be extremely helpful because we're in a position to be able to make national recommendations and perhaps recommendations for federal employees. So the data that you have here is really, you know, and what you've learned, the lessons

you've learned in these eight or nine years. Anything that you could sort of, I'm not asking you to write a Ph.D. thesis on it but, anything that you could take out, lessons you've learned and specific suggestions you would give us and why you would give us those suggestions would be very helpful.

Male Participant: I'm sure you don't have enough else to do but.

Male Participant: Jim, one more question please. Dr. Whitten, your third criterion on structuring the incentives on scientific outcomes -- just, help me understand where the promotion of wellness fits within that idea. For instance let's just think about regular cleaning of teeth. It's not a disease. It's a preventative measure. To what extent does this criterion embrace promotion of wellness or prevention?

Robert Whitten: There are several parts to that question. The perception of how much benefit it has may be different from what others might think. Just to pick the example you have. Not many of us relish going to the dentist. But there are few things shown that have better proven preventive benefit than prophylactic dental services for children. So you would try to look at and weigh that benefit what way. If you were to just base it on a survey of children and how happy they were to get their teeth cleaned you would come up with a different conclusion than if you. So I'm, and that's a problem when we try to look at who is making a judgment on whose behalf.

On the other hand, we're now making many more, doing many more surveys of people satisfaction with the care they're receiving in addition to their return to work, they return to function. As we begin to get some further objective measures I think a lot of those will play a role in our ability to assess the outcomes of various alternatives in care. Am I answering your question? I'm trying to.

Male Participant: No, that's helpful. And I guess I, I'm also aware that the real efficacy is in consistency of the consumer to keep coming back for the same preventative practice because he or she decides that it's very efficacious and then there's market and now there's thirty billion dollars of a market and, you know, that's a measure. The measurability can be in the consumer's consistency to keep coming back for the same practice.

Male Participant: Consumers and plans and we as purchasers are all influenced by things such as Dr. Brunskill mentioned. When we have something like AHRQ that helps identify what our effective prophylactic benefits. It helps get us all on that page. We need a lot more research along those lines.

The Honorable James Gordon: Thank you very much. We'll be back in touch. We look forward to hearing from you as well. Earlier I called Karl Peterson and Pat Prinz. Is either one of you here? Okay. Kay Lahdenpera, Jane Nelson, Sheila Rhodes, Vera Ridderbusch, Katherine Schmidt and Ronald Schneeweiss. Okay. Then we'll begin with the three of you who are here. We thank you for being with us through this long day. And let's begin. Kay Lahdenpera.

Kay Lahdenpera: Well I bring you greetings from Alaska. I'm from Anchorage and I wanted to tell you that I'm recently retired and my efforts will be in the area of public health and a public health nurse manager. I've also had my MPH. I feel strongly in a few areas here. One would be in the area of research. I feel that it's terribly necessary for CAM to be recognized within the western medicine research that I realize a CDC and some of the other areas have perhaps specific criteria for their research. But I would hope that we have the finders from both sides--conventional and CAM--coming to the table with open minds to gain an understanding and appreciate both types of research. Until we can reach that level we will probably have some problems.

We need to establish a common ground that both can agree upon to further expand the research of CAM. And I can tell you that CAM is alive and well in Alaska. I recently attended the Alaska State Nurses Association. We had a very exciting track on alternative health care. And then I also attended, and this has been this past month, and I've also attended the Alaska State Nurse Practitioner Program. I am not a nurse practitioner. I did receive a recent award from, a national award as an advocate and I do feel strongly that we have a lot of clinics in Alaska, physicians and nurse practitioner run. And the nurses and the nurse practitioners were extremely interested in CAM. So I feel strongly about training education certification and licensure. And until we can have this agreement, depending on the scope of practice, we need to have in addition to specialized institutions of current CAM learning, like here in the Pacific Northwest, the Bastyr University, we need to have CAM curriculum should be available in traditional universities, such as schools of medicine which I know there are many. But we need to expand that into schools of nursing, schools of pharmacy, schools of dentistry, schools of public health and schools of veterinarian and I'm sure [inaudible]. But we need to have this and there's a request among professionals in this area. And we need to have, I feel that it can be done. But it needs to be done with leaders in the different disciplines in CAM working with traditional leaders.

May I finish my sentence? Thank you. Traditional leaders in the, traditional medicine as well as teams of faculty from the various universities, health care professional schools to standardize, long sentence, the necessary required [inaudible] to each school's scope of practice to include CAM education and services. This would be an additional basic component to existing curriculum. And the University of Alaska, Anchorage School of Nursing would love to have a CAM component but money is the issue.

The Honorable James Gordon: Okay, thank you. Jane Nelson.

Jane Bernice Nelson, MA, North Bend Elementary: Hi.

The Honorable James Gordon: Hi.

Jane Bernice Nelson: I'm speaking regarding the guidance for access to delivery of and reimbursement for complementary and alternative medicine practices and interventions. I'm here today as just an ordinary person, a school teacher to testify to the fact that if it weren't for CAM, complementary and alternative medicine, I would still be confined to a wheelchair that I had been in for over ten years. Although I had the mechanical ability to

walk I was not able to walk even across a room because of a lingering sports injury from tendonitis in both legs and ankles. And after several years of physical therapy doctors and physical therapists had given up on my condition. It took only sixteen treatments of complementary and a combined alternative medicine, including Chi Gung treatments, acupuncture and Chinese herbs to get me up walking without pain, no longer needing the wheelchair and therapy, thus stopping the continual cycle of injury re-injury. So I'm here today before you to sing the praises of CAM. And my vision is that these procedures would be covered by medical health coverage so that ordinary people just like myself who really need these beneficial treatments don't have to spend their life savings in order to get the treatment they need.

Recently, I attended a health benefits fair for teachers and realized as you were commenting previously that in the state of Washington, more and more health care providers are now beginning to cover some form of acupuncture treatments on insurance, such as the one I have, Premiere Blue Cross and Group Health. Large health insurance companies like Group Health are now providing specific coverage for complementary and alternative healing treatments. I read the brochure and read a list off of acupuncture, acupressure, yoga and Tae Chi. I would hope that medical Chi Gung and Chinese herbs could be added to this list as very beneficial forms of complementary and alternative medicine. And I hope that in the future both will be covered by insurance. Thank you very much.

The Honorable James Gordon: Thank you. The next speaker, I have to preface it by saying I, she gave me a lift to the airport in Bellingham at five o'clock in the morning and was telling me about her work. And I said will you come down here so I really appreciate your coming Sheila. Sheila Rhodes.

Sheila Kennedy Rhodes, Mt. Baker Care Center: That's to tell you that I am the country mouse in the city. I am from a community a hundred miles to the north, twenty miles from the Canadian border. This reality that was presented to you today is not mine. But it is the second most exciting day I have spent in the last month because you and everyone who's spoken today brings us so much hope.

In my community, I want to tell you the rest of the story after Dr. Gordon came. I had the privilege of helping our medical society, the Executive Committee, bring Dr. Gordon to speak to our community about integrated medicine, to introduce the concept. He can tell you how well received it was. It was very exciting. The rest of the story is I saw my primary care practitioner in the medical society meeting that night. So I trotted in two weeks later and asked him how he received the information. And he said it was very persuasive. He would use it if he knew how, but I needed to address for him how in the managed care climate when he must spend no more than an average of ten minutes per patient per day. He must see thirty patients a day in order to break even, quote. But he would have time and the leisure to listen and work truly collaboratively with his patients. He wants to do that, he's frustrated by not being able to do it but sees no other way to feed his family. And he used those terms.

The second part of the rest of the story is as we were discussing this in a patient treatment room there was a knock on the door. He opened the door and a pharmaceutical

representative was on the other side of the door and he said, I'll be with you in a minute Jim. He finished his conversation with me and he walked out and I heard him say. What have you got for me today Jim in your Pandora's box? I was going to tell you about Trudy who is my patient. I work in a long-term care facility, I'm Director of Social Services. Trudy is on twenty-nine different medications. It takes her ten minutes morning and evening and three quarters of a cup of applesauce to get that stuff down. She's not hungry for breakfast afterwards. And she's not hungry for dinner. In a way I am talking about Trudy because I see and work with the vulnerable population enthralled to conventional medicine and the pharmaceutical industry.

My recommendations are: 1) That you investigate the perception by primary care providers that they must devote so little time to every patient in order to meet expenses and 2) endeavor to bring into balance the enormous influence that pharmaceutical has on our conventional medical practitioners. Thank you.

The Honorable James Gordon: Thank you very much. I would like you to, take the chair's privilege, to just say a few words in addition to what you just said that was so powerful about your sense of the utility of CAM and of another approach in working with older people in nursing homes and long term care facilities, if you would.

Sheila Rhodes: I can give you a specific example. I come from an advocacy background. I joined the long term care industry, changed careers three years ago. Early in my career as Director of Social Services, I didn't know about all the rules and regulations that govern long term care. And one of the major concerns in every nursing home is strong urine smell. And you want a smell free environment. Well the way it was handled was with a chemical spray that caused an allergic reaction with some of our staff members and patients and diligence on the part of the aids. I went down to our local herbal specialist and said, this is our problem what can you recommend? And she came up with a what we call the SFPT, the smell free PT. And I was able to smuggle it into our nursing home as a food because the three items that are in that tea are so well known and trusted that it did not arouse the concerns of our medical practitioners.

However, on the strength of that success, and by the way we are a smell free environment, I, then the nurses approached me and said, what can you do about chronic UTIs, urinary tract infections? This is a terrible problem among our elderly. And in fact there was one lady that I had admitted who had had so many that her doctor had just prescribed life time antibiotics for the remainder of her life. This was three years ago. So I trotted back down to the herbalist and I said, what have you got for this? And she did some research, came up with a tea that has a number of different elements in it, some of them more esoteric. I presented that to the physician and the physician said absolutely not, unless you can show me how it interacts with her other medications. I sent him what I could find from medical journals and a reference book like our PDR from Britain. His response was until I see you U.S. evidence based information absolutely not. However, this lady now has been on antibiotics for three years. Since she was put on antibiotics six more medications were added because of side effects of lifetime antibiotics.

Another patient that we have, a long term care patient who is forty four years old suffering from an aggressive form of MS elected to try this tea because she too was averaging a UTI every six weeks. She has not had a UTI in two years and one month and she drinks a cup of that tea every morning.

The Honorable James Gordon: Thank you very much. Tom would you like to begin? While you're waiting if you're waiting, Ming definitely has a question.

The Honorable Xiaoming Tian: Okay, the question regarding, Ms. Nelson, and the regarding, you mentioned that you want to add medical Chi Gung into CAM. Why you use medical Chi Gung? What is definition of medical Chi Gung?

Jane Bernice Nelson: Oh, healing form of Chi Gung as opposed to a Marshall Art form.

The Honorable Xiaoming Tian: So the Chi Gung and medical Chi Gung you think no definition the same, because there is association in the [inaudible] association of medical Chi Gung? Because using the medical Chi Gung either using external Chi or teach patient to treat patient has to be treated the condition not only for prevention. So I think you mention very interesting in a definition. Thank you.

The Honorable James Gordon: Tom, want to start?

The Honorable Tom Chappell: Well, thank you. Mrs. Rhodes? I'm curious and I don't mean this to be a crass question but is the economic survivability of your primary physician essential to you or is the access to the care that you need sufficient?

Sheila Kennedy Rhodes: Guess who changed doctors October 15?

Female Participant: It also is sad that, you know, for like patients with chronic urinary tract infections that you know the United States pharmacopoeists reviewed the evidence on cranberry and the studies in elder patients actually in long term care facilities and looking at the overwhelming evidence that it reduces bacteria and pyrexia in female older women with chronic recurrent UTIs. This may, there, what I guess my point is, there are, there is more research that is becoming available and it is U.S. based. And I think a lot of our work and part of what our commission will address is, how do you get that information to busy practitioners so that, you know, that that perhaps he or she could have said to you well I feel uncomfortable with those herbs. Because we don't know a lot about them and she's on a lot of drugs which. is also a valid concern. But we maybe could try her on cranberry concentrate either in pills or in juice. So I applaud you for your work, especially with people in these long term care facilities. And also ask that you be hopeful because there is more U.S. research that is becoming available and hopefully we can get that information out so that, so that all people benefit from their care.

One other thing is that a lot of physicians, we have moved from seeing the ten minute patients. But it also has meant that you live on thirty thousand dollars a year instead of ninety thousand. But it's a matter of physicians deciding how much you need to live on.

Sheila Kennedy Rhodes: That's correct. There seems to be a snowball effect in order to meet their perceived demands of managed care they've had to in my, as a particular doctor now has a seven day a week practice. And he has hired enormous numbers of people to manage the paperwork. So he has to see more patients to pay the people. [inaudible] is beautiful. We do offer cranberry. And in that particular patient who is on three years of antibiotics thus far, age ninety one. She does also have prescribed chlorophyll tablets and cranberry.

Female Participant: And she still is on the antibiotics?

Sheila Kennedy Rhodes: Yes.

Female Participant: Thank you very much for your presentations. Jane, you're a teacher and you experienced this, this recovery. We haven't had many teachers on our panel if any at all. And I wonder if you would say anything about your impression in how CAM could help with the teaching profession or the students or whatever.

Jane Bernice Nelson: Well, part of my recovery also includes continuing to do the exercises and so there is an active, you know, part that I play too to keep that going, my health going. And I've also in the last year done some things with my students to do some, some of the certain exercises. And some teachers use some of the Chi Gung practices for reducing stress and exercise also from a stressful job.

The Honorable James Gordon: Thank you. I want to thank all three of you and thank, thank all of us. One thing that, one of the reasons why I particularly wanted Sheila to come, and this is really speaking to the commissioners, is I really think it's important that we address more some of the problems of the elderly and particularly institutionalized elderly. So I hope that we'll do that in subsequent sessions. I was so struck by her example. Also what she did is I was giving a talk up there to the community and there must have been, you must have had a hundred and fifty people over seventy five elderly people who were there aside from everybody else in the community. So it was really extraordinary. Joe.

The Honorable Joseph Fins: I do have a, Jim's comment provoked a a question. There is in the NCI a best case sort of methodology where practitioners who find something that might help malignancies can write in and access people at the NCI to to cultivate the story so we can generate, they can generate a hypothesis that can then be tested. What kind of services would be helpful to you in a long term care facility that the government could provide, a comparable thing for say geriatric medicine to help you interact so that some scientist at the NIH could develop a hypothesis that could then be tested? I mean, what, what kind of resources would you need to sort of write up these cases and what you shared with us today so that it could be studied further?

Sheila Kennedy Rhodes: I would have no trouble writing up the cases. I would need to know where to send them.

The Honorable Joseph Fins: And how would you get that message out to you know, your colleagues?

Sheila Kennedy Rhodes: Same way I got all those old people to come and hear Dr. Gordon.

The Honorable Joseph Fins: All right, maybe we should.

Male Participant: I think one of the things that we need to address too is how do, how do we encourage the various institutes at NIH as well as the sort of public agencies to sponsor demonstration projects and to really encourage people who--

[End of tape.]

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

October 30, 2000, 6:15 – 6:17 PM

October 31, 2000, 8:45-10:15am

[Tape 7]

The Honorable James Gordon: We're adjourning now and we'll be beginning again tomorrow morning at 8:30, and we'll go till 2:00. And we look forward to seeing you and please encourage others to come. We welcome everyone. Thank you. Thanks.

Okay, good morning everybody. We're going to get started now and we'll begin at the beginning, that is, with a moment of silence. Okay. Thank you very much. I just want to say a word of, what a pleasure we've been talking about it among ourselves, what a pleasure it was to be with you all and to listen and to have a chance to talk with you all today, yesterday evening and coming in this morning. It's wonderful to see and feel the energy around what you've been doing for all these years, the intelligence and energy you bring to this discussion with us. So thank you all very much.

We're going to, we'll begin now with the first panel. We'll be going. You want to bring that person up with the rest of the people. We'll begin with the first panel. We'll be going till about, till 2:00 today. And we're on a strict timetable because apparently the room gets cleared out and the place gets closed up not too long after 2:00. So we'll make every effort to end by 2:00 2:10 anyway. Michelle.

Michelle: We're actually going to start bringing up the first panel and we'll begin with Katherine Schmidt from the Bellevue Massage School and how she waited patiently all day yesterday only to miss her panel when she had to go move her car. So if Katherine Schmidt would come up with the following Paul Saunders, Karta Purkh Khalsa, Jennifer Jacobs and Emma Bezy.

The Honorable James Gordon: So we'll begin with Katherine Schmidt. The last, the last shall be first right?

Katherine R. Schmidt, Bellevue Massage School: Mr. Chairman, commissioners, I wanted to first start off by thanking all of you for being here in this capacity for this is a very exciting time of expansion and growth. And I know I'm excited as probably many of us are here. And I appreciate your inquiries, your questions and just the focus on this very important issue that's before us. Thank you.

My name is Kathy Schmidt and I'm Co-Director, along with my husband Jim, with the Bellevue Massage School. I'm also a strong advocate for education in CAM and am currently a certified reflexologist and touch for help kinesiology instructor at our school as four other

community colleges. I also feel strongly that CAM practices and interventions should be accessible to everyone including people with low income, a system whereby people seeking health care options can choose from wide range of CAM or conventional medicine practices. And have it be reimbursable through federal programs or health care coverage and not just accept treatment on the basis that their health care coverage is limited to what it will cover.

When I was twenty years old and suffering from chronic condition, I was told by a doctor I would probably have this condition for the rest of my life, and that I would be on medication for it for the rest of my life, which I was having reactions to. And I started looking into other options, thus started my journey into health. It included chiropractic, also kinesiology, homeopathy and reflexology. And I'm glad to be living in the state of Washington, where most of these services were covered by insurance. They had not, had they not been I would have not had these options available. And I feel they were largely responsible for some of my healing process.

A lot of people giving testimonies have addressed some important issues such as collaboration, bridging the gap between conventional medicine and CAM, quality of life, cross-training. But I would also like to bring up four other important points. Intention, referral, preventative care and empowerment. I mention all three of these in my natural healing classes. Intention is for the best outcome when acting as the facilitator for someone's healing process. I think it's so important, a very important part of the healing process is our attitude towards someone that we're helping. 2) knowing when it's not in your scope of practice to be able to refer to another provider. Again I really encourage that. And that is a very important thing to remember. 3) teaching people to work on their health maintenance from preventative approaches and not wait until they're suffering from a particular condition or wait until they're thinking of contacting or using, you know, a health modality when they're in acute stage. So I feel these are really important.

I have three people in mind right now that stand out in my mind that were deeply affected by these. A woman in her seventies that wanted to learn how to work on her husband's hands and feet who had quadruple bypass surgery, congestive heart failure, is recovering from an abscess around his pacemaker and reacts to many of his medications. A mother wanting to learn reflexology for her thirty-year old son diagnosed with MS. And my mother diagnosed with breast cancer that had metastasized to her lung and brain.

The Honorable James Gordon: Time is up.

Katherine Schmidt: Okay, I'll just finish real quick. Lost her eyesight during radiation treatment. I have something to look forward to besides her pain medication. I did reflexology on her on a regular basis towards the end of her stages of cancer. So I, all these people were deeply touched by CAM. Thank you.

The Honorable James Gordon: Thank you very much. Paul Saunders.

Paul Saunders, ND, Ph.D.: I want to thank the commissioners for allowing me to present this morning and to come from Canada to do this. I'm employed as a Naturopathic

physician and a Chair of [inaudible] at the Canadian College of Naturopathic Medicine in Toronto. And today I'm representing the Office of Natural Health Products as a member of the transition team of the Office of Natural Health Products and as a member of the Expert Advisory Committee in that capacity.

The theme that I want to talk about is the regulation of natural health products and the way we've approached it in Canada and it relates to item three in President Clinton's recommendations with respect to access and delivery of CAM services. The issue that we faced in Canada is a lack of access to a lot of health products, the fact they were either regulated as drugs or foods and not really accessible to many of the practitioners who use them or to the public. And there have been significant problems with respect to the quality of materials available. As a result of this, there was a strong public movement within Canada which led to the development of a parliamentary committee on natural on health.

And this parliamentary committee made up a variety of recommendations to the Minister of Health in a publication consisting of fifty-three specific recommendations in order to create a new office of natural health products that would actually regulate these and take these products out of the drug category. And out of the food category and give them separate recognition.

In November of '98, the Commission released its report, and in March of '99 the Honorable Minister Allen Rock accepted all three, fifty-three recommendations which is unheard of in Canadian government politics, as I'm sure it is here. The fifty-third recommendation was to establish the transition team in order to create the framework for this new office. That transition team was established and met a week a month from May of '99 to March of 2000 and released a report called a new vision in which it set out its framework. And the seventeen members consisted of government members, pharmacists, Naturopathic physicians, medical doctors, members of the public, people in the manufacturing, members of traditional Chinese medicine and the public and produced this report. They also were given the mandate to hire an individual to head this office, and that Office Director was Dr. Phil Waddentuden, who is a naturopathic physician.

That office has now created, gone ahead to do public hearings over the last three months and will be putting together regulations, which will go forward into Canada because that one in the early part of 2000 and based on public response to those will lead to a final set of regulations in Canada Gazette II, which will be released some time in late 2001 and 2002. And this will then make accessible a variety of products which are quality, which will have regulation with respect to labeling, content, advertising, manufacturing and licensing, and will make these available to the public, to the patients and to the practitioners of these therapies.

The Honorable James Gordon: Thank you very much. Karta Purkh Khalsa.

Karta Purkh Khalsa, AHG, CN: Distinguished commissioners, thank you for inviting me today. I am submitting these initial comments on behalf of the American Herbalist Guild. The American Herbalist Guild is the only purview organization in the United States for the community of practicing herbalists specializing in the medicinal use of plants.

The AHG maintains a basic policy of full disclosure and informed consent. Public health policy must ensure that herbal practices are utilized in a way that promotes patient safety. Herbal medicines are notably safe. CAM policy can best be developed by recognizing each individual modality on its own merits and by actively creating opportunities for interfacing at length with the professional leaders of these communities of practice including herbalists, such as you're doing today.

Let me discuss reimbursement issues. Reimbursement is currently available for some herbal practitioners primarily naturopathic physicians and traditional Chinese practitioners who are licensed. There is currently no reimbursement for direct entry herbalists. At the least reimbursement programs should be developed for herbal practitioners in states with existing practice standards. Proper reimbursement programs should also be investigated and encouraged for traditional healers in ethnic communities of practice and for direct entry herbalists. Herbal supplements are not currently reimbursed under any health care program. The exception is a few private insurance carriers who have instituted small experimental pilot programs.

Current policies of drug reimbursement do not adequately address the issue of herbal medicines. Reimbursement programs should be established for herbal products that are prescribed by recognized herbal practitioners including specific preparations that are approved for specific indication. The use of botanicals as specific medicines does not sufficiently represent the practices of the emerging body of knowledge of herbal medicine. None the less, it can offer a beginning for making determinations about reimbursement. The reimbursement process must include botanical preparations that are used for illness, acute and chronic and those that may be prescribed preventively. In most cases, health professionals in the given community of practice should be relied upon to make that determination.

Herbalism has existed as a respected profession for many centuries and is the backbone of both self-care and professional natural healing in well-established systems such as [inaudible] and traditional Chinese medicine. Today there is a critical shortage of well-trained herbalist. There are increasing number of people who desire to become direct entry herbalists. It is essential that these students be afforded the opportunity to finance their education in a manner similar to that of other health professions.

The HG has established educational guidelines for programs of study in herbalism and is instituting a school assessment program. In the process of developing herbal education services it is important that CAM practices not be overwhelmed by conventional sciences thereby losing the essence of the CAM practices. It would be appropriate to convene an advisory panel of CAM and professional practitioners to review the level of science requirement in herbal and CAM education. Thank you for this opportunity. We appreciate your invitation and we look forward to communicating with the commission in greater detail as development progress.

The Honorable James Gordon: Thank you very much. Jennifer Jacobs, good morning.

Jennifer Jacobs, MD, MPH, American Institute of Homeopathy: Hi, Jim. I'm here as a conventional family physician, who has been using homeopathy in my practice for nearly twenty five years. I also do clinical research at the University of Washington here. I have seen many patients helped by this practice without the high cost and dangerous side affects of conventional medications. I believe that the best way for homeopathy and other CAM modalities to be integrated into the health care system is train physicians like myself to use it in their medical practices.

Homeopathy is the primary care modality being used in Europe. In the U.S. homeopathy has increased five-fold in the past ten years. Homeopathy is used mostly by upper-middle class patients for chronic health problems not helped by conventional medicine. Except for three states there is no licensure for homeopathy. It is practiced by a wide variety of licensed practitioners--MDs, DOs, physicians assistants, nurse practitioners, chiropractors and naturopaths. There are a growing number of non-licensed homeopathic practitioners whose legal status is undetermined. There are three certification boards for homeopathy. Some health insurance companies offer optional coverage for homeopathy but most patients pay out of pocket.

Homeopathy is not taught in any U.S. medical schools although it is often included in CAM courses. It is taught in Naturopathic schools. Most practitioners study homeopathy in post-graduate courses run by private institutions. The American institute of homeopathy is the professional organization for medically trained homeopaths and sponsors educational programs research and interfaces with government agencies. Research opportunities for homeopathy in the U.S. are few due to the generic nature of the medicines which cannot be patented. The NIH has funded several studies and is now considering new proposals. Currently I'm heading up a study of homeopathy for hot flashes in breast cancer survivors at Providence Medical Center here in Seattle.

Actions that can improve access to homeopathy include: establish departments of CAM in medical school and residency programs, cost effectiveness research to document the fifteen percent cost savings of homeopathy found in France, reimbursement policies that allow adequate time for homeopathic consultations, inclusion of homeopathy in low income clinic, hospital privileges for homeopathic physicians, and licensing of non medically trained homeopaths to work legally under the supervision of a physician. As the President of the American Institute of Homeopathy I hope to speak with you at more depth at a later meeting. Thank you.

The Honorable James Gordon: Thank you very much. Emma Bezy.

Emma Bezy, MA, Spirituality Program, Bastyr University: Good morning. I'm Chair of the Department of Spirituality Health and Medicine at Bastyr University and I'm going to share with you today some of the things that we have discovered that have worked and that do provide a replicable model for.

The Honorable James Gordon: Speak a little closer to the mic please.

Emma Bezy: For the integration of spirituality into health care. Should I repeat any of that for you? Okay. We're building upon the groundwork here that's been laid by the palliative care and the hospice movements which really opened the door for the inclusion of spirituality into medical and health care practices. The program we have is two hundred and forty hours, ten weekends from September to June. And a wide variety of health care professionals come to this program--MDs, NDs, nurses, nurse practitioners, counselors, social workers, clergy. And they have a very intense experience working with one another. They travel from as far as southern California and Alaska to be part of this program because they haven't found anything like it anywhere else.

So what I recommend to you that has worked in our program is providing such health care professionals with a time and a place like this, in which they can study these subjects with an interdisciplinary group of peers and colleagues. Where they can learn the skills to comfortably non judgmentally discuss spirituality with patients who want this to be part of their health care, where they can learn how to include spirituality in advanced directives and other end of life planning issues. Where they review the research about how and why prayer and meditation is an effective aid to health and longevity, and also how to access the soundness of research studies being done in these areas, that they can also learn how spirituality can help them as professionals recover from burnout, and revitalize their original calling into health care. Our graduates continue to serve as mentors and role models in the community building bridges between professions and present at conferences throughout the region and the country.

So I encourage and recommend that you encourage other professional organizations to support the inclusion of the spiritual dimension in practice. I was asked to help the state social work conferences last year included and including this and mind body medicine. And their theme drew many more people than they had ever had before and the professionals were most grateful to have the permission and the encouragement to as they said, come out of the closet and discuss what they were already doing in their clinical practices. I would hope that you would encourage HMO's to follow the model of Sloan's Lake in Colorado. They're the only HMO I know that is covering spiritual advising as a legitimate health care benefit. And that you continue to encourage research studies and encourage collaborations and partnerships that increase the opportunities for this kind of training. Thank you.

Male Participant: Thank you. Emma, thank you so much for all the good work you're doing in training practitioners to care, perhaps our most neglected and most vulnerable population, those who are terminally ill and their families. What recommendations would you make for us in our report to improve the care of the dying and having a very integrative approach to the need of this population? What would be on your wish list?

Emma Bezy: I think one easy and definite thing would be for hospitals that already have hospice services available or as part of them to really look to their hospice staffs for in house training and encouragement of other practitioners to do the things that are already working more extensively throughout the departments and other parts of hospitals and clinics. To encourage them to look at what Jaykell is already encouraging about including this and put those processes to work and to just continue to ask patients to guide it. It's the patients that

are really driving this--patients and families who are saying they want this and it gives them great comfort and great ease in dying. To really listen to their consumers and take guidance there.

The Honorable James Gordon: Thank you.

Male Participant: I have a question for all of you regarding the herb. If you can suggest, first of all if we go as a consumer, if we go to a vitamin store or nature food store, dietary supplement you have so many. And also I'm a believer of a herbal medicine and a food supplement. I think it carries a lot of value for patients. How can we tell the consumers and also we can summarize a report, what are the most, let's see, the first twenty herbs? It doesn't matter from which culture is generally considered as safe and effective. Then we can give the information to the public.

Paul Saunders: One of the things, if I may in answer to that question, one of the things that we've done in Canada is a joint venture between the Canadian Pharmacy Association and the Canadian Medical Association. And I was the naturopathic physician on this board. And we actually published this spring in March of 2000 a book called *Earth: Everyday Guide for Health Care Professionals*. And it actually has the top fifty-seven herbal substances, mostly herbs in it. They are peer reviewed individual articles. They are geared at the level of medical professionals. They're geared for medical students, pharmacists and physicians to be able to use so that if a patient comes in and, let's say, they're on Ginkgo or Echinacea or one of these top things, they could read about it. They could know about the interactions, they could know about the clinical trials and they can be aware of what are the positive or the negative side benefits with respect to those top sixty substances.

Karta Purkh Khalsa: Well, to second those comments, there, much of this documentation in fact already exists. The American Herbal Products Association has established extensive documentation on exactly that issue. The American Herbalist Guild from the clinical side has established guidelines of practice. And I think what we need to do is get these groups together, have serious discussion in implementing some policy.

Jennifer Jacobs: Yes, I'd also like to add some comments. I would suggest that the herbal profession take a leaf from the book that the homeopaths have been using for the past sixty years. There is an official homeopathic pharmacopoeia of the U.S., which was established in 1939 by the Food Drug and Cosmetics Act, which runs parallel to the pharmacopoeia of conventional medical drugs. Because of this homeopathic medications are all standardized, they're manufactured in the same way. If you buy different medicines from the same company you can be assured that they contain the same proportion of medications. It has been suggested by others, and I second this suggestion that the herbal community also establish a similar pharmacopoeia with standardization and regulation of manufacture of their products.

The Honorable James Gordon: I'm wondering is that something you've done in Canada?

Paul Saunders: That's well, we have, the regulation are coming in place and that's something that will happen certainly. [inaudible] around 2002 or so that'll actually be in place to occur.

The Honorable James Gordon: I'm wondering if you could send us the book that you're talking about and any other, any other guidance about how you've taken these steps.

Paul Saunders: I'm going to make an electronic submission and I'll have that, I'll have that in there.

The Honorable James Gordon: Great, thank you.

Female Participant: I have a question for Dr. Jacobs and I might have misunderstood so I want to just clarify. We talked about the, the history of homeopathy and I thought I heard you say that you felt that homeopathic physician should practice under the direction of medical doctors. Were you talking about independently licensed homeopaths or were you talking about someone who might have taken some weekend training courses?

Jennifer Jacobs: There are not independently licensed homeopaths in this country. That is one of the problems that we have. At the current time homeopathy is practiced by people who have other licenses that allow them to practice medicine such as MDs as myself, chiropractors, naturopaths, and so forth. There is a large number of non licensed people who are practicing homeopathy in a very gray area of the law. Some of these have been prosecuted in some conservative states. Other places they're allowed their kind of a liaison attitude towards them.

But this is a big problem we need to solve. Should people without medical training be treating sick people. The consensus of our group is that there should be a new licensure created for non-medical homeopaths, who would practice under the supervision of a trained medical person. This could be a physician, it could be a naturopath, it could be a physician's assistant. But we feel that people who are treating sick people need either their own medical training or supervision by someone who has medical training.

Female Participant: A simple question is, is there a certification for or licensing for practice of herbs? The National Commission, the National Certification for Commission on Acupuncture and Oriental Medicine has that in place for oriental herbs. But what about the other aspects of herbs?

Karta Purkh Khalsa: [inaudible] herbalists now undergo a peer review process that investigates their qualifications and allows them membership in the professional association at a professional level. The national certification is almost established. Within a year that'll be in place and there will be a two tiered exam for professional basic certification and board certification, very similar to the acupuncture model.

Female Participant: Thank you. May I just, one more? You talk about research and spirituality. I appreciate the topic area because the aspect of spirituality had not really been

brought up in many of the testimonies. And you mentioned about research. What kind of research and do you have collective database that you could share, not right now but--

[cross-talking]

Emma Bezy: Yes ma'am, I would be glad to do that. And certainly people like Dr. Larry Dasse have been taking the lead in this for a number of years and really bringing the research that has been done forward into the mainstream consciousness. So for us, what that means are studies that can be done, classic double-blind studies even that will pay control groups. And look at what happens when a group of cells in a petri dish or a group of people in a room are prayed for at a distance or are prayed for directly in the presence of another person? And what happens physiologically and mentally and emotionally with their health conditions, what can happen on a cellular level with some of these things. So it's research on all of those areas that helps build a bridge between the hard sciences and people who are believing by faith that these things work so that the two can talk to one another and there's not such a split there anymore.

Female Participant: Thank you.

Female Participant: Thank you for all your testimony. Just for the purpose of disclosure cause a woman asked. I'm a member of the American Herbalist Guild, a professional member, was the former President of the American Herbalist Guild and now sit on their Admissions Board. And I just want to say the AHG is doing a lot of work. One of the questions I have for the commission, for us, is that amongst herbalists there continues to be a concern on the part of many lay herbalists direct entry who don't really have medical training but are recognized in their communities as caretakers and as healers. How, how would you best advise this commission on how to address their concerns that licensure, reimbursement, that these things may actually affect their ability to use herbs and to be able to continue to practice? You know the fifty-five year old woman in Appalachia or the -- you hear what I'm saying. So, do you have any words of wisdom for the commission on how we can take that group into consideration?

Karta Purkh Khalsa: Well as a professional organization the American Herbalist Guild has been addressing this issue for twelve years. And we've taken the policy from the very beginning that herbalism is the medicine of the people and that people need to have access to traditional herbal remedies used in the traditional way. So we understand that nothing that we do from a legitimization or legalization prospective is to exclude these people who want to make sure that ethnic or community caretakers continue to be allowed to have access to their medicine, access to their patients and to have the role in their, in their community. Nonetheless, we recognize that things are moving on. Herbs are being used by people with possibly medical training but very little herbal training; that herbal medicine is working its way into conventional settings very quickly and that we need to have a role in that and a participate in shaping policy. So both need to be considered.

Male Participant: A couple of questions on the subject of herbs. How can we as a commission help you protect the integrity of your teachings culture by culture? Because

herbalism is not a uniform methodology. It's a function of different cultures and I'm just wondering what standardization of licensure really accomplishes for your particular modality.

Karta Purkh Khalsa: Well let me suggest that as an organization, the American Herbalist Guild does not support licensure for herbalists. We support voluntary standard setting and national, national certification so that people can identify excellent and well trained herbalists. There still needs to be certification mechanism for, for traditional knowledge. That's what we have now is the peer review situation. Because we have, and Dr. Low Dog is involved in that, because we have people with training from all, every paradigm around the planet who are qualified and need to be able to see their patients and take care of them. So that, that has to remain in place.

We're also concerned that as these professions become more and more formalized, it seems that the trend is that each step of formalization and education is adding more hours of western scientific study at the expense of less and less clinical practice hours and the actual modality that people are there to study. So we want to have a role in fashioning educational criteria. We've established the appropriate educational criteria in our educational guidelines. And they do include appropriate background in western sciences. We just want to make sure that those two are balanced.

Male Participant: Thank you. May I ask one more question of Dr. Saunders? How did the transition team deal with the efficacy of the botanical products for consumer?

Paul Saunders: A very good question. The way that we've dealt with the efficacy issue is that there are different levels of evidence that can be used. We can use traditional sources such as the, you know, the western botanical literature, or the traditional Chinese Medical, or the Aerobatic literature. There can also be references with respect to a consensus group meeting around discussing the use of the herb all the way up to double blind placebo cross-over kind of trial studies. And all of those levels of efficacy would be, would be accepted for making different kinds of levels of claims.

If you wanted to make a traditional claim, for example, you might cite Kings or Mrs. Greaves or one of those things. If you wanted to make a traditional Chinese claim then you might cite the Yellow Emperor or something like that and show its use in that respect. Or if you want to use a recent study that's been done with Hyperic [inaudible] St. Johns Wort, comparing it to, you know, trycyclic antidepressant then you could cite that and make that. That would then allow you to make a label claim, which would say this is, this is as effective as an antidepressant or this has a long history of being used for antidepressant and could put that on the label.

Male Participant: So short of clinicals –

Paul Saunders: Right.

Male Participant: Your country is providing an opportunity for herbal blends to be marketed with a claim?

Paul Saunders: With a claim. That's right.

Male Participant: As far as I understand that's unique. Is that correct?

Paul Saunders: Yes that is, that is unique. And that's what would come before the office to determine, and if the office needs advice then they would send it to the Expert Advisory Committee to actually look at that and help them make some adjudication on that.

The Honorable James Gordon: Thank you all. One thing I want to say just in closing is that I'm observing once again that the kinds of comments that you're making are not only helpful to us now. They and the materials you provide are going to reverberate throughout our, our meetings. And Michelle and I were just thinking about certain topics and certain speakers for certain topics. So we, we may be getting back to some or all of you. And that goes for all of, all of the speakers. This is really a, an ongoing process. And thank you very much for working with us.

Michelle: Okay if we could have the following speakers come up. Tom Shepherd, Robert Anderson, Charlotte Coon and Jeffrey Goin. And as well at this time could we bring up the following. Barbara Mitchell, Mark Tomski, Christa Louise and Todd Richards. Thank you.

The Honorable James Gordon: Wonderful. Good morning Tom.

Tom Shepherd, DHA, Bastyr University: Good morning, and good morning everyone. My name is Tom Shepherd. I'm the President of Bastyr University. The Pacific Northwest is on the road to integration but we're not there yet. What you have seen is a shared vision of those who have collaborated or worked together to try to create a true health care system, not just a disease treatment system. Bastyr has been mentioned in numerous initiatives. This was not due to funding being available to do these things but this was due to it being the right thing to do. At Bastyr and other co-collaborators have dedicated resources and sometimes scarce resources to make it happen. Our relationships with all those with whom we are working jointly are maturing in this point in time and the possibilities are endless. Particularly with appropriate funding that could help escalate the collaboration efforts that are ongoing at this time.

I have three observations and three recommendations.

Observation 1) CAM is about systems of healing not isolated therapies. Natural medicine is defined by a philosophical system not modality. And this system changes the way we think about and provide health care. Dr. Effie Chow said yesterday that in China the doctor keeps the patient well. And this is a paradigm shift that we are dealing with today.

2) Consumers are ahead of government and providers in their demand for CAM. Why a White House Commission? Why in CAM? Because the consumer demand has been there for this past decade and they were willing to pay for it out of their pockets. But being

ahead of baseline, being ahead of the government and providers and having a lack of baseline regulations has a potential to lead to a) consumer fraud, b) inability of poor and underserved to access care, and c) the grafting of certain modalities into the current system without recognizing the paradigm shift that is taking place. A quick shift is not sufficient.

3) Systems are trying to define CAM and CAM curriculum without going to the source. CAM educators CAM researchers and CAM providers. Collaboration is necessary of true integration is going to result. CAM professionals should be at the table at all levels of discussion. Medical schools should be breaking down the doors of Bastyr for development of CAM curriculum. And yet they are currently receiving funding to develop CAM curriculum themselves alone. The same applies to research.

Recommendation 1) If we truly want integration we need to fund CAM institutions at the earliest level of medical education. We need to provide accredited CAM schools access to funding to allow for collaboration between medical schools for joint training programs and clinical experiences for graduate and post graduate training. We also need to provide access to loan forgiveness in underserved areas for CAM graduates.

2) We need to invest in research infrastructure at CAM institutions and include CAM credentialed experts in research design and policy decisions.

3) we need to recommend guidelines to the states for credentialing and licensing of CAM providers. This is not a monopolistic system to exclude providers but this is a public health and safety issue that provides the public the confidence that their provider is adequately trained to render the services needed. If I was to be in a car with, was in a car accident this morning, I would have the confidence that whoever in the emergency room was rendering treatment to me knew what they were doing, they were credentialed, they had the educational and the experience to treat me. I would expect the same if I went to a CAM provider or a conventional medical doctor to manage my diabetes. I would expect that they would have the necessary experience and education and there would be no harm to me in going to them for care. The public expects this and the public deserves it. Thank you.

The Honorable James Gordon: Thank you very much. Bob Anderson. Good morning Bob.

Robert Arthur Anderson, MD, American Board of Holistic Medicine: Good morning Jim. Thank you for the opportunity of contributing to these proceedings. My name is Bob Anderson. I'm the President of the American Board of Holistic Medicine and the founding member and the Past President of the American Holistic Medical Association.

The American Board of Holistic Medicine was incorporated in 1996 for the purpose of evaluating the candidacy of applicants desiring certification to specialists in holistic medicine. Candidates must currently be licensed medical doctors or osteopathic physicians. Several hundred enthusiastic candidates will be sitting for the initial certification examination, which will take place this December in Denver Colorado. The holistic medical organizations are identified by an integration of the art and science of 1) caring for the whole person, body

mind and spirit to treat and prevent disease and 2) empowering patients to create a condition of optimal health far beyond the mere absence of illness. Both outside and inside the medical profession this concept of medicine to the whole person is gathering increasing support. The body mind spirit approach integrates many disciplines and modalities including physiology, bowel chemistry, nutrition, exercise, environment, emotions, attitudes, beliefs, social relationships, manual medicine, biology, homeopathy, energy medicine, acupuncture, meditation, prayer, biofeedback.

Holistic medicine is based on the core belief that an unconditional caring approach to Dr. patient relationships releases powerful forces of healing. At it's essence the practice of holistic medicine embraces a spirit of interdisciplinary and physician patient cooperation. It balances the mitigation of causes with the relief of symptoms, integrates conventional and complimentary therapies and facilitates the experience of being fully alive.

Our concerns have revolved around issues of 1) Assembling a database of published medical, psychological and alternative studies in these fields of interest. To date, over four thousand citations have become the core of this database. 2) Providing opportunities for continuing medical education for practicing physicians who have an interest in the field. 3) Presenting a peer review process for certification to establish standards in the field and the upcoming examinations in the culmination of this process. 4) [they said number 3] Cooperative reidentifying opportunities to provide for training of students and residents in the field, and 5) Identifying successful examples of collegial interdisciplinary practice models in which conventional and alternative approaches to medical care are more optimally combined.

Holistic physicians will ideally work in groups which include Naturopaths, chiropractors, nutritionists, counselors, acupuncturists, exercise specialists and others from the many disciplines. As an organization, we wish to be involved in the process, which appears to have been envisioned of the formation of the office of complementary and alternative medicine. We are ready to contribute our professional experience and willingness to bring together elements, which I have touched upon above. With the intent of providing a wider array of informed practitioners thoroughly trained to meet the interest of the consuming public which is recognized by everyone involved in these proceedings. I appreciate the opportunity to contribute to your hearing this morning.

The Honorable James Gordon: Thank you. Charlotte Coon.

Charlotte Coon, Hellerwork International: Hi, Good morning. I'm really encourage sitting here listening this morning that most of what I'm going to say you're already hearing. I'm a Hellerwork practitioner. I'm not the president of the organization or any part of it. But I do practice an alternative form of medicine and I participated, I'm a consumer of it. So I'm here today to speak to both. Hellerwork is an eleven series of structural integration that includes the mind body dialogue and the movement reeducation, works hands on with the soft tissue of the body to bring alignment and balance to the structure. So that gives you a little idea of kind of what I do as a practitioner perhaps.

But what I really want to say is that these alternative practices complementary alternative practices, Hellerwork included, I think is attempting to bring back to medicine what medicine left behind which is the patient as a whole person. The heart of any health care practice needs to be the patient and certainly not just his symptoms or his wallet. Many CAM practitioners see the patient for twenty to thirty minutes at a minimum compared to the average eight to ten minute doctors office visit. And while any, while most of us come to an alternative practice with an illness or a discomfort initially including my Hellerwork practice, what they leave with is often a more empowered sense of who they are in relation to their health care, with skills and knowledge they can use in everyday life to reduce their need for health care [inaudible]. As deliverers of CAM we should be, we should not be so eager to join the current playing field of insurance, dollar driven health care where the consumer remains unempowered. And that my feeling is many physicians have remained frustrated where more and more often nobody is winning and an increased at an increasingly high cost to all of us, if not an insurance cost then in litigation.

As the Hellerwork practitioner I touch not just the myofacial system but also the heart of the patient. I listen to the total life of the person who sits in my office asking for relief from shoulder pain. I deliver a type of care, which acknowledges that neither I nor my system of body-work is the miracle here. The human body and the spirit that animates it is the miracle. I am simply assisting that natural process back towards more balance and integrity. This used to be what all medicine was about.

While we're all clamoring for more attention from insurance companies and for more research dollars let us not forget what the American public has by choosing CAMs in an every increasing number is already mandated, that wherever the current system is lacking they will seek out methods that work better. Let us remember that what drives up the cost of health care, western or alternative, is the mistaken believe that the consumer is passive in the process and that every aspect of health care delivery should be paid for by insurance dollars. I'm saying again in case it was misunderstood that's what I believe should not be happening. We need to stop insuring our nation to death. So I encourage the commission to move boldly and swiftly to what the public is already clearly saying at once, more choice for the health care and a return to more human methods of its delivery. Thank you.

The Honorable James Gordon: Thank you. Jeffrey Goin.

Jeffrey Goin, Coalition for Natural Health: Mr. Chairman, members of the Commission, my name is Jeff Goin and I'm President of the Coalition for Natural Health which is a grassroots organization that represents over twenty two hundred natural healers nationwide. Over the last couple of days I've noted a few points relating to the misuse of CAM terminology and philosophy. I'd like to use the bulk of my three minutes to, to try and clarify some of those matters.

Throughout this town hall meeting both speakers and members of the commission have been using the terms "naturopathic medicine" and "naturopathy" interchangeably. It's imperative for the members of the commission to understand that traditional naturopathy involves natural non invasive modalities that serve to stimulate the body's own intrinsic self

healing capacity without the use of drugs. Naturopathic medicine on the other hand is a hybrid approach to health that combines traditional naturopathic modalities with allopathic procedures such as prescription of drugs and use of surgery. There's a very material and a very important difference between naturopathy and naturopathic medicine. Similarly throughout the two days of meetings the titles naturopathic physician and naturopath have been treated as though they're synonymous.

Furthermore, some speakers, most speakers, some inadvertent, some not, have implied that naturopathic physicians comprise the entire universe of qualified naturopaths. This is most assuredly not the case.

I'll give you my organization's take on the naturopathic universe. There are naturopathic physicians and then there's everybody else. The everybody else in the field of naturopathy is the constituency that my organization represents. And the everybody else is comprised of generational healers, Mexican American *kieranderos*, Native American tribal healers and yes naturopaths educated through distanced learning. And by the way, I'd like to say that I think distance learning is a more respectful term to use than mail order diplomas which is the moniker of choice used by Dr. Labriola yesterday and the three Bastyr students who were here [inaudible]. But lest I digress, please let me make one point very clear, in the entire naturopathic universe naturopathic physicians are the minority.

The distinction between titles and terms becomes very important when considered within the context of licensing and regulatory activity that this commission may be considering. I'm almost out of time so I'll give you my organization's abbreviated recommendations. It invites you to review them in more detail with written testimony that I provide to you.

Recommendation 1) is to please distinguish between the terms, between the fields of traditional naturopathy and naturopathic medicine. 2) is to differentiate between naturopaths and naturopathic physicians, and 3) should the commission concern itself with the matter of regulation and licensing matters, something that I'm not sure is at all advisable or appropriate, I would respectfully ask you to please develop an approach that serves the needs of consumers and practitioners and not one that is exclusionary. Thank you for your time.

The Honorable James Gordon: Thank you very much. Tom, would you like to begin?

The Honorable Tom Chappell: I do have questions, could you come back to me?

The Honorable James Gordon: Sure, of course. [inaudible].

Female Participant: Mr. Goin, thank you actually for some of that clarification. I'm not sure that was clear to all of us. In the state of Washington where there are licensed naturopathic physicians, is that the same for those that you represent or people who have done distance training are they also reimbursed? Are they licensed just as the, for instance, graduates at Bastyr are?

Jeffrey Goin: No, my, Mr. Chairman, commissioner, my constituents are not permitted to practice naturopathy in the state of Washington and as such are not eligible for third party reimbursement.

Female Participant: They're not allowed to, they can practice but they're not reimbursed? Is it legal for them to practice?

Jeffrey Goin: There are, there laws in eleven states, as I'm sure you're aware, as I'm sure you're aware and they differ from state to state. So, I'm not as familiar with the state of Washington as a lot of people in this room are, but a standard naturopathic physician licensing bill precludes non-naturopathic physicians from practicing modalities that are considered to be naturopathy or naturopathic medicine, and likewise are not allowed to refer to themselves as naturopaths, naturopathic practitioners, doctors of naturopathy or naturopathic physicians. So by virtue of the, of the law in Washington as I recollect they are not allowed to offer their services and if they do so, if they hold themselves out to be a naturopath they are subject to, to incarceration and and monetary fine.

Female Participant: Could I have one more?

The Honorable James Gordon: Sure.

Female Participant: Mr. Shepherd, you know one of the collaborations we talk about this so much, the argument that always seems to come up is in western medicine or allopathic medicine more and more research based, evidence based medicine is being required and we're finding many of the things that we do aren't based on good evidence so we're changing things around. And there is the argument that much of what CAM practitioners or naturopathic physicians do is not evidence based. Colonics, hypertherapy, some of the use of botanicals, yeah, yeah, yeah. So there's there's a lot of this. And so it's one of the reasons, excuses whatever that is used to sort of keep this integration and collaboration from occurring. How would you respond to that? If I was like the dean of a medical school and we were talking, how would you respond to that in a way that would maybe help breakdown these barriers?

Tom Shepherd: I think the Bastyr was founded twenty two years ago. It was science based and that was basically the tenet that that draws the research and the education that is going on there today. We do need outcome data. We do need research in a lot of areas in order to show the efficacy of what has been passed on either from generation to generation or word of mouth. If I was speaking to a dean of a medical school I would seek to collaborate from the standpoint of a) they have the infrastructure for doing the research science based and b) we have the education, the knowledge and the client base in order to seek a truly collaborative effort in research. And I think it would benefit both of us to a) understand what's going on and seek a closer relationship and b) to get the research done.

Female Participant: And funding.

Tom Shepherd: And funding, yes.

Female Participant: I'm just delighted with this panel's presentation on the overall vision and philosophy and which we haven't touched very much on. We've been in focus on like therapies and integration of therapies. But so there's a question whether CAM then and I want comments on this. Is CAM to be integrated into a medical model or is it a separate system that's going to be developed, or an integrated model? How do you see this? And how does energy come into this? I don't see energy being expressed in most of the, you know, presentations. And so I'd like to see what your vision or view is on the integration of CAM. Is it a model, a health model is it both or, you know?

Male Participant: I believe we have a system right now of health care which has been very good for the United States which is an interventional type of system. You wait for a symptom, you wait for a disease, you wait for some trauma. And then we intervene. That's very expensive but it's also yielded some very good results over the past century. What we're talking about with CAM though is not the interventional type of system. But what we're talking about is wellness. We're talking about what the HMOs talked about twenty years ago in saying, fund us, help us to get started and we will seek preventative care, and wellness and quality of life versus just interventional care. Well the HMOs basically have gone to the medical model and have not been true to the traditions of what they sold twenty and thirty years ago. And that is a key component of when you're talking about integration.

The practitioners you have heard from over this past day and today are very principled people. They believe in dealing with the whole person--mind, body and spirit. They believe in dealing with the energy of the individual and the body and it's its ability to renew itself. And they will not sell out their principles in order to become mainstream. This is a basic tenet of this health care system. And this is a tremendous paradigm shift. And this part of the reason why integration has become a problem, because there is a real difference in models there now. Can these two systems collaborate together and become complementary medicine versus alternative medicine? I believe they can. I believe part of the problem with, such as with licensure and credentialing is when a patient has been seeing a CAM provider for a number of years and ends up with something that is drastic and goes into the hospital.

There is no continuum of care. Alternative practitioners are not allowed into the hospital, and I have managed hospitals for twenty-eight years so I know what goes on. They are blocked from entering and there is totally separate system of care that is rendered for a week or two weeks until they come back out and then they're released back to their other provider. And where we're really missing the boat is that continuum of care and the collaboration between these two systems.

Robert Anderson: I think the question is very apropos and I would say that the question of how integrated these systems will become is not so much dependent upon the attitudes and position of the holistic community as it is listening to what the conventional community eventually will do. And as you know the conventional community has an attitude towards a holistic approach, which varies from great resistance to tentative acceptance. And the holistic philosophy at least that espoused by the groups to which with which I've been associated views sort of three areas 1) acute care in which American conventional medicine probably has no peer around the world in a chronic disease which is not well handled by

conventional medicine but to which holistic and CAM approaches grant a great deal of [inaudible] answers and finally the preventive or health promotion aspect in which as I stated it earlier it's our intent to help people experience the issue of being full alive.

And so the latter two are the areas in which holistic medicine has much to offer and medical and osteopathic licensed practitioners are imbued with the responsibility of doing their best to integrate both approaches. And it's not that either is bad or good but we wish to take the best from both. And we think that can be done but whether or not this eventually becomes mainstream is not so much dependent upon our viewpoint but how the conventional community eventually decides to respond.

Female Participant: Thank you very much.

The Honorable James Gordon: I just want to say to the commissioners, we're going to have to do one question at a time. So I was, slipping a little bit behind time. The answers are great it has nothing to do with that. So please.

Female Participant: My question is to Dr. Shepherd and is based on the testimony of Mr. Goin. and I'm wondering as we move ahead and design a new paradigm for health care and wellness, do you see naturopaths are licensed in thirteen states I understand, and as licensure goes forward, do you see more of an effort to be inclusionary rather than exclusionary when addressing the naturopathic approach to health?

Tom Shepherd: Yeah, I don't think licensure and credentialing is exclusionary to the standpoint that if someone has a basic educational background and has the experience and the clinical expertise to deal with a number of issues and either diagnosing or treating people that that's exclusionary if you have the credentials to do that. If you do not, if you can't pass say a national test or you can't meet the qualifications of peer review then yes that would be exclusionary. Being in hospitals for twenty-eight years there are levels of expertise within the hospital. An anesthetist is different than an anesthesiologist in their training. An ophthalmologist is different than an optometrist in their training. And there's different levels to be able to differentiate what is their scope of practice and what are they able to do. So if it's exclusionary to the point that someone is not trained or capable of treating a variety of illness or wellness, then yes that would be exclusionary. But my point is it's for a matter of public health and safety that the consumer knows what they're getting when they walk in the door.

The Honorable James Gordon: Got to be very brief. The reason we're having this discussion is because we're already lapsing behind about fifteen minutes. And it's not that the discussions aren't good it's just that it takes time.

Female Participant: Are you suggesting then that bands of competency might be an appropriate approach?

Male Participant: Bands of competency?

Female Participant: You're not familiar with that? Okay.

Female Participant: Really, briefly Dr. Anderson, is were CAM practitioners involved in writing the guidelines for this test in December of 2000?

Robert Anderson: Yes we have had a variety of inputs from from different disciplines.

Male Participant: Dr. Shepherd, first of all thank you for your hospitality last night at Bastyr. We all enjoyed it very much and it was a really lovely experience. I got to meet your, many of your students and it was a real pleasure. I want to ask you about the question of the false dichotomy and not demonizing the other side. And how do we avoid that? Cause I saw at Bastyr last night that you were really trying to reach out and trying to blend the best of science and the best of CAM and trying to create a new synthesis. But you did say in your testimony that there's a whole new paradigm out there. That it's really a paradigm shift, that you're doing something different. There are progressive elements of medicine that embrace patient centered care. There are venues like hospice, palliative care where things that happen there are perceived by what traditional practitioners as being alternative but it's mainstream and they're they're bored [inaudible]. So how do we avoid inculcating in the CAM practitioner a sense that that there really is something unprincipled about traditional medicine and avoid that sort of educational inculcation? When in fact there are pockets of people who share the values that were espoused by your students last night.

Tom Shepherd: Yeah, that's a good question. The, I think that one of my recommendations pointed to the fact of having both graduate and post graduate training be done jointly between CAM practitioners and medical students. Because there is a vast void of ignorance between both parties. And what that leads to is, when you go out in practice and you have not had any collaborative efforts, you will not affiliate with anybody on the outside because of that ignorance and failure to recognize or even have -- I forgot the word I was looking for, but they won't be able to work together collaboratively. If you train together, you'll work together. And, for instance, we have a program we're in the discussion now with Children's Hospital, University of Washington, to have our, their medical students and our medical students, they have to make grand rounds together, take up case studies and then differentiate how each practitioner would deal with that particular disease entity so that there's a knowledge base and a real working relationship that is developed on the front end versus the back end when you're actually out in your practice.

Male Participant: If you could provide to us any examples of structural ways to promote that collaboration, curricula, shared transcript that would be very helpful because we're trying to understand how to bring the two camps together.

Tom Shepherd: We will do that and I think you've seen that we, we really do want to work in an integrated system. Fighting each other is not helping the patients and the families at all.

Male Participant: Dr. Shepherd and Dr. Anderson, I want to explore this term collaboration at a deeper level for my understanding of where you are. I'm assuming that

philosophy is driving the differences in the health care total realm. Consumers are making choices about those philosophical orientations. And so when you, when I think as a consumer about the idea of integration, I'm wondering what's been gained for me as a consumer with the word integration. I'm wondering if what we're really talking about a CAM as a free standing and interdependent reality rather than one that is in any way dependent. And so the vision that we are talking about it would help me to understand what your motives are for integration. Are you thinking about the consumer? Do you believe we can integrate two very different orientations? That's all I'm really pressing for what it is, what's the outcome you want to see? I mean obviously equal opportunity to access and licensing and funding and so on, but just how far to you want to push this collaboration and integration?

Tom Shepherd: I do believe that the two systems can work together both interdependently and dependently. I think when you look at the total aspect of the total aspect of health care in the United States where we spend more per capita than any other country in the world and we're ranked thirty seventh in our health indices, that there is a significant problem. And the problem is our total system up until the last ten years at least has been based on an interventional type of system which is expensive and we need to get on the front end of that. The consumer wants to be healthy. The baby boomers like me are reaching out for natural health products, for natural health practitioners. We want to live healthy, we don't want to go through our last stages of our life like our parents did or we have experienced. And so that is where this whole paradigm shift is taking place. And we need to capture that and get on the front end of that or we will lose the initiative. We will lose the point in time that we have to integrate our health care system, both the CAM providers and the allopathic system that we have. And the end result is a better consumer, a better educated consumer, they take more active choice in what they're doing. And lower cost.

The Honorable James Gordon: Thank you. I want to say one more about. Go ahead.

Male Participant: Very briefly, what I see is is a collegial kind of outpatient clinic where eighty percent of chronic disease is cared for in which practitioners of different disciplines are philosophically recognized as equals. And I think it is consumer driven. I think it gives the consumer the choice and I think equal funding for all practitioners involved in such an interdisciplinary clinic is the eventual goal. Thank you.

The Honorable James Gordon: Thank you. I would like to see from each of you actually, you were representing different stages of evolution in a sense, different kinds of practices and different groups of practitioners. So I'd like to see some statement from you if you could provide them, both documentation you already have and any thoughts in writing. Cause I think one of the reasons we've gotten into such a long discussion is cause these are very complex, interesting and fundamental issues that we're talking about here. And so I've been loathed to cut off the time and we have to move ahead.

What would be very helpful to us is for each of you to explore the cutting edge of your evolution as organizations or people representing organizations and some of the most difficult issues that are coming up. So for example, Bob from you I'd be very interested in the whole

issue of creating this board. How, what does this mean? How is it going? What does it suggest for the future for physicians? What are the issues with CAM practitioners that have come up from your side?

And Tom, same thing from you, something about where, where you see yourself going. Here's a time when you're on the one hand dealing with more organized courses of medicine and on the other hand you're dealing with community practitioners that Mr. Goin represents. So what are the issues for you?

And Mr. Goin, the same thing. What are the issues? I've worked with traditional healers in many societies who are facing the same kinds of issues. So I'd like, I think you spelled out nicely some of your concerns. I'd also like to see some of the larger, some of the issues and the larger solutions that you think we ought to be paying attention to. How do we work with a group of people who are define themselves as naturopaths and another group that defines themselves as naturopathic physicians? What differences are there? What do you really think about licensure? Cause I understood there's an ambivalence about it. So I'd like to hear both sides from your point.

And if you have, if you'd like to contribute from, you know, your Hellerwork practitioner, you know, you're not a social worker, you're not a psychologist. So from your point of view what insights do you have that you can share with us? Thank you very much all of you. Barbara Mitchell.

Barbara Mitchell, JD, LAc, MAc, Standards Management, Inc.: Good morning. My name is Barbara Mitchell. I'm a licensed acupuncturist and an attorney. I served as the national Certification Commission for Acupuncture and Oriental Medicine chair for eight years. I write the book on state laws as well as for [inaudible] field of acupuncture and oriental medicine. And I chair the [inaudible] Acupuncture and Oriental Medicine Commission that is MDs, PTs, LAc, etc. that have been meeting across North American for the last six years. One of my jobs for the last nineteen years has been to go out into various states and work for acupuncture licensure, which has been a truly entertaining thing to do. I have the following six recommendations for you.

1) Several CAM professions at this point in time have externally validated standards of certification and accreditation. I believe that if this commission issues a recommendation that states move forward to use these to adopt laws, that this would indeed be a very powerful statement. By externally validated, I mean they are accredited by the U.S. Department of Education. They meet American Psychological testing guidelines. They may have been accredited by the National Organization of Competency Assurance.

2) For those emerging professions that have not developed these standards and there are a slew of them behind us, I strongly recommend that we establish a task force to give them guidance from those of us who have reached this area. They need to know how to develop these standards and they need to know how to develop a flexible model bill so that they can go into states and work with options and ramifications. I have submitted copies that the acupuncture world developed eight years ago. So that if I go in where the MDs are wanting

supervisional referral which is guaranteed to tie up access I can counter with as suggestion of prior medical diagnosis within the previous six months. There are ways of working with the constraints of having very few practitioners in a state.

3) The third recommendation is that we get out of the turf discussion and get into a competency discussion. We need meetings of all practitioners, western and all CAM professionals to discuss what it is that can be incorporated into western medicine, what is the curriculum that they need to be able to do this? When they should refer an appropriate title distinction so that the consumers can tell the difference between a DC with a hundred hours and a licensed acupuncturist.

4) The inclusion of CAM practitioners in any discussion regarding botanicals is essential. We are about to lose access to our botanical medicines by licensed providers because western medicine does not understand that the use of a whole herb is different than the active ingredients.

5) That we include CAM in Medicare because I believe that this would open up state licensure, and the last one is,

6) That we develop a series of continuing education seminars for western medical providers so they begin to understand who we are, what we do, when they can appropriately refer and what they can expect when that happens. We need to start talking about medicine and not about CAM and western medicine. Thank you.

The Honorable James Gordon: Thank you very much. Is Mark Tomski here? Would you come forward if you are? I'm sorry he's what.

Male Participant: [inaudible]

The Honorable James Gordon: Okay, thank you very much. Christa Louise.

Christa Louise, MS, Ph.D., North American Board of Naturopathic Examiners: Hi, commissioners, I'm the Executive Director of NAMNE, the North American Board of Naturopathic Examiners. The demand for CAM is currently being addressed by three types of practitioners. First of all they're licensed and certified cam practitioners. They're unregulated practitioners and there's an existing medical or allopathic profession.

In regard to the first, licensed practitioners are not universally available as not all states regulate the practices. In regard to the second, unregulated practitioners pose a potential threat to public safety. In regard to the third, not all CAM practices can simply be added to existing allopathic systems because this assumes that the foundation of allopathic medicine is compatible with the underlying CAM philosophy. This is not always the case. CAM modalities can be used allopathically. For example, the use of Hyperaphin as a substitute of Prozac, or they can be used within a system of treatment that is based on a different underlying philosophy.

CAM education, the CAM education that conventional providers receive is often not sufficient for effective and safe practice. Patient outcomes will vary depending on both the qualifications of the practitioner and also on the appropriateness of the modality within the larger treatment philosophy. Because of this variability of practitioner effectiveness credentialing and licensing standards must be specific and consistent so the consumers can evaluate the legitimacy of a practitioner who claims expertise of CAM practices.

Take the case of naturopathic medicine. To become a licensed naturopathic physician an individual must be qualified first by education, and then must pass the naturopathic physician's licensing examinations or the NPLEX. NPLEX was established fourteen years ago to produce national board licensing exams that qualified naturopathic physicians must pass in order to practice in any state that regulates the profession.

The North American Board of Naturopathic Examiners or NABNE was formed because states were not consistent in applying credible criteria for qualifying applicants to take the NPLEX. NABNE ensures uniform standards of qualification and exam administration in order to protect public safety in the eleven states that license naturopathic physicians. In the other thirty-nine states the public has no reference against which to judge the qualification of an individual who calls him or herself a naturopathic physician or a naturopath.

In an uneven regulatory environment there needs to be some means 1) for consumers to evaluate the qualifications of practitioners; 2) for members of the health profession to feel confident referring to them, and 3) for insurance companies to determine which practitioners they should reimburse.

So our recommendations are: 1) for sponsorship of a national conference of CAM practitioners to explore options for levels of national credentialing standards. 2) federal support of these national standards that would give consumers, insurers and other health care professionals a criterion against which they could access a CAM practitioner's legitimacy, and 3) finally support for the development of credible structures such as NABNE and NPLEX for other CAM systems and modalities. Thank you.

The Honorable James Gordon: Thank you very much. Todd Richards.

Todd L. Richards, Ph.D., University of Washington: I'm Todd Richards from the University of Washington and I am a neuroscientist. I do research on neurological disorders such as multiple sclerosis and learning disabilities. We do research on both conventional treatment and alternative treatment. But I have to say at the medical school there, I'm sometimes in a hostile environment trying to test some of these new alternative treatments. But I have been involved in clinical trials for, example, testing magnetic therapy and mind over body medicine and energy medicine. So we've been testing these different treatments. We've been using techniques such as magnetic resonance imaging and we're also interested in developing new diagnostic tools that rely on the subtle energies coming from the subject. So I really believe that the current medical system of their diagnostic ways to figure what

illness is needs to be revised. The whole system needs to be revised. We need to look at the more subtle energies to find out the early signs of illness.

But the question that I'd really like to address is how can we move our alternative treatments to mainstream medicine? And since I've been involved in so many clinical trials, I know what the FDA wants to see. If we want to move a alternative treatment to be accepted by the AMA and the FDA it needs to be, there needs to be a trial and there needs to be a proven efficacy of this treatment if it's going to be accepted by the regular medicine. So, as an example, we've used outcome measures in our trials that are very recognized by the medical community. And when we did a trial on multiple sclerosis we were using outcome measures such as a twenty five-foot walking test. And there was a cognitive test. And then there was a hand function test. So we need to prove efficacy using outcome measures that are accepted by the medical community. And I'm open to new outcome measures and I'm very receptive to new kind of outcome measures that involve say spirituality or subtle energies coming from the subject. So my, my main message is that if we want to get to the medical community we need to use recognized outcome measures. Thank you.

The Honorable James Gordon: Thank you very much. Tom do you want to begin?

The Honorable Tom Chappell: Yes, I wonder if you could give us your three recommendations that would provide freedom and equal opportunity for CAM, CAM modalities.

Male Participant: In order to, for CAM modalities, I think that there.

The Honorable Tom Chappell: Or practitioners, medicine, however. How do you in your mind bring the kind of equal opportunity to the CAM orientation that exists presently with the conventional orientation? You've been in clinical trials. You see the orientations. What do we, what are your recommendations of how we bring equal opportunity to CAM?

Todd L. Richards: In order to have equal opportunity you need to be have the same standards that the medical research is expecting. Now it doesn't always need to be expensive. Sometimes some of the tests or the trials they don't need to cost millions of dollars like they do in the pharmaceutical companies. But you do need to use outcome measures that are accepted by the medical community. And some of those can be very simple. Like I was saying like the twenty-five foot walking test. That's very simple, very inexpensive. There's other tests that the physicians can use in their clinical practice either as a sometimes the practitioners can't always use a double blind trial. And I understand that. But they need to establish some sort of outcome measure that they can use and test in a very unbiased way.

Male Participant: Another recommendation?

Todd L. Richards: So the, in order to establish efficacy I think equality means that you need to be on the same footing with the other medical community and you need to have standards in their practice that are up to the same standard as the rest of the medical community.

Male Participant: Thank you.

Female Participant: Thank you for all your testimonies. My question is for Dr. Louise. Yesterday we were told that one of the commissioners asked the question about difficulty of obtaining licensure for naturopaths in some states. And that one of the respondents felt that this may be in part due to those who've gone through distance learning sort of lobbying against. So today that became a little bit more clear as within our own almost group, those who've been to four year training programs and those who've chosen an alternative pathway are now almost battling one another in states which is keeping, which isn't benefiting anybody. And you know I understand the problem because, you know, if my mother was going to see somebody and five different groups had MD behind them. How would she know who had what training. So I think that that's something that needs to be address. How are you, have you thought about how you're going to address that and what sort of collaboration or how can you get that? Because that seems like a very bizarre stumbling block that's preventing you from getting into some states where we sure could use more naturopaths.

Christa Louise: I agree it's not, shouldn't be a turf issue, it should be a qualifications issue. So if you set national standards for levels of credentials, whether you call a naturopathic physician and then somebody else who's got training in natural medicines that kind of thing. I think you need to set some national standards so that people can look at well what is an ND and what is a naturopath and what is somebody who has training in natural methods of healing?

I think it's also important to understand that there is, that naturopathic medicine is talking about a system. It's not just a bunch of modalities stuck together. It's really based on a system and it's important that that be differentiate from somebody who just uses natural methods of healing, so.

Female Participant: From an outsider's point of view I think also one of the difficulties that naturopathic physicians have had is that they have the title doctor and they also go in as primary care acupuncturists and some of the others have not done that and we have not encountered as great a resistance from the western medical community. So there's several pieces to that.

Female Participant: I appreciate your presentations. And Dr. Richards, you specifically mentioned about new diagnostic tools and subtle energy and I think in our CAM this is the dimension that is very important that makes it different from just integrating another modality, you know, into the system. And do you have the diagnostic tools at the university or do you know of diagnostic tools? We certainly would be interested in in that.

Todd L. Richards: We've been testing. We actually have a new detector that's been developed for [inaudible] some of the subtle energies that come from the body. This detector was developed by a company up in Canada called Energy Medicine Developments. And we have been testing this detector on various states and there's a lot more research that needs to

be done but we do have this detector that's very scientific and can measure signals coming from the body.

Female Participant: That's one measurement, instrument, instrumentation.

Todd L. Richards: And then another instrumentation we have is using heart rate variability. And it's in some ways it's an old measurement. But the new aspect of measuring heart rate is that there's some subtle autonomic features of the heart rate variability that can be detected that are very sensitive to the state of consciousness of the individual. So that's another very simple inexpensive tool that we've been researching that can be easily applied in the clinic.

Female Participant: What's your attitude towards thermography and like curtionics [inaudible] developed in Russia? Or are you familiar with? [cross-talking]

Todd L. Richards: I'm very familiar with it. I'm very interested in new of these new cameras that can measure the aura. I'm very interested in those and I think that more research needs to be done. We need more funding to test these new kinds of cameras, new scanners. I mean, I want to see new scanners in the clinic that measure either the subtle energies, the aura field, cranial [inaudible] photography. I think they all need to be integrated to measure these, possibly very early signs of illness.

Female Participant: [inaudible] This is what is exciting about energy medicine, getting the early sign. I'd really appreciate if you have more information and can provide us with more information in that aspect.

Todd L. Richards: I can send you more information on this.

Female Participant: Yes, and then I think how to overcome the medical resistance that you speak of.

Todd L. Richards: Right.

Female Participant: That would be very helpful.

Todd L. Richards: Okay, I'll send you some more information.

Female Participant: Thank you.

Male Participant: I have a question for Dr. Barbara Mitchell. And I appreciate the work you have done for nineteen years to set up the standard of acupuncture and also herbal medicine. So you and NCC offering acupuncture certificate and also Chinese herbal certificate. Are they acceptable, totally accepted in all the states or what's going on now?

Barbara Mitchell: Right now, the thirty-nine states plus the district, the NCCOM [inaudible] certification in acupuncture is used in every state except California and Nevada

which have developed their own exams and Louisiana which has none. With respect to herbal medicine within the oriental medicine field and frequently we use that to denote acupuncture and Chinese herbalogy from all various traditions, Japan, Korea, Thailand, China, etc. Right now there are five states that require either examination or competency in herbs before you can do it. I believe that two of those use the NCCOM examination and the others do not. One state has said that if you are an acupuncturist and you wish to do herbs, then you must demonstrate competence.

[End of tape.]

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[SIDE A]

Female Participant: Actually, the best model to be used.

The Honorable James Gordon: Thank you.

Male Participant: Dr. Louise, a question. Professions have always been self-regulating and then the right examinations and accreditation's for their practitioners and they say this person is best. What kind of assurances do we need to know about to say that a board exam is legitimate? Because an illegitimate board would confer illegitimacy upon the practitioner who passed it. So, what kind of criteria should we look for as we, the other fields that are downstream that you suggest, very intelligently, we have to help them come aboard, but, what would be the criteria of a legitimate exam? Either one of you.

Dr. Christa Louise: The National Organization of Competency Assurance in Washington, DC is a voluntary organization that has set standards for accredited certification agencies and beyond just healthcare. They look that your eligibility criteria must reflect training. They look for a variety of standards with the examination itself. It should be based on practice and not on academic theory. This should be a competency-based examination. They have a number of standards that the certification agency should be independent from your professional association. Because otherwise you are in danger of getting swayed too much by the professional association. They have standards regarding reporting on the field, what it takes to change eligibility criteria. And, interestingly enough, for some of the discussions that have come earlier, that if there is a route of training outside standard schooling, for example, through apprenticeship, that the certification agency must demonstrate that this is not feasible to use as a route of eligibility before they can eliminate it.

So, for those traditional healers who may have apprenticeship or years of experience, a certification can validly set that as a route of eligibility to sit an examination. So, I can have Noka [sp.] send you all copies of their handbooks. And, I think they actually have done a very good job in setting standards of certification.

Male Participant: Great. Thank you.

Male Participant: Thank you. Thank you all very much.

Female Participant: Okay. We can have the last panel before we break. Lisa Alschuler, Jeff Novack, Sevak Kroesen and Robert Shook.

The Honorable James Gordon: While they are coming up, I want to not a couple of things. These proceedings have been taped and they may be broadcast at a later time. And, also, we will be, we do have transcripts of previous meetings and will have transcript of this meeting on our website. So please keep up with us. And, also, keep communicating with us, both those of you who have had a chance to speak formally, and those of you who haven't. You can send us communication by email. We are very happy to receive it.

One final announcement to, I suppose, prepare for, we are going to be, because of the, sort of, interest, the high interest of the Commissioners in asking questions, we are going to have to take a shorter lunch break. So, the lunch break will only be about 20 minutes. So, we understand that some people may not be back and we don't want to hurry people through their lunch. So, I just wanted to let you know that we will take a shorter lunch break. And that is really in the interest of making sure that we have full time, both for everybody who is on the formal program and for also all the members of the public who have signed up who also want to speak to us. And yet, we do have to be out of here before 3:00. So, we are trying to be flexible within constraints.

First speaker will be Lisa Alschuler.

Lisa Alschuler: Good morning. I am an atropathic [sp.] physician and I am the Clinic Medical Director at the Bastyr Center for Natural Health, which is our training clinic. I'd like to discuss, this morning, the type of training and training resources which are needed to facilitate appropriate referral and co-management techniques among conventional and CAM providers.

The basis for building successful relationships is the establishment of mutual respect and openness to new ideas. The foundation of a functioning referral network between CAM and conventional medicine providers is a better understanding of each other's language and philosophies. These values and concepts must be integrated into educational training models for all providers. Recognition of areas of mutual interest should be made explicit, while areas of divergent needs and priorities should be acknowledged and engaged constructively.

Research is a top priority. Research is needed to develop clinical guidelines and condition specific care pathways that will assist CAM providers in conveying rationale to conventional providers. We need to initiate pilot projects to study the role of practice guidelines in determining the entry points for referral. We need to gather outcome data on best practices based on tracking patients who have received specific therapies for specific conditions. We need to conduct comparative outcome studies for different CAM approaches, conventional approaches and multi-disciplinary care. And we need to enhance funding on a national, state, local and private sector level for research on CAM clinical efficacy and cost effectiveness.

The training of providers must emphasize several areas. CAM and conventional medical training must stress the development of multidisciplinary integration in the management of specific conditions. CAM and conventional medical training must delineate appropriate criteria for referral and for coordination of care, in order to decrease the

redundancy of interventions. Conventional medical training must include discussion of credentialing and care standards for licensed CAM providers, particularly related to scope of practice.

In sum, a foundation of trust and openness will form a collaborative relationship between CAM and conventional providers. This relationship will utilize national and local funding to research CAM, clinical efficacy, cost effectiveness, and referral criteria in order to promote the coordination of care. The training of CAM and conventional providers will promote cross-fertilization and understanding of multidisciplinary care.

And, finally, the promotion of health and well-being of the patient remains the basis of all forms of healthcare.

Thank you.

The Honorable James Gordon: Thank you. Jeff Novack.

Jeff Novack: Good morning. A couple of things I'd like to cover today. First of all, I'm from Bastyr, but I'm a Ph.D., not an ND. And, secondly, I want to pickup on Dr. Shepherd's theme of science-based medicine a little bit. And, I want to talk particularly, today, about drug/herb interactions and training and research that needs to go into this field because I think it is crucially important that so many people are using drugs, so many people are using herbs and there is going to be more interactions. We need to know and we research them in a systematic way. And, that is not being done now.

So, let me give you a little bit of my background first. I am, a have a Ph.D. in pharmacology from the University of Washington School of Medicine. I've done post-doctoral research in immunology and psidacon [sp., sounded like he said si-da-con] signaling in at Fred Hutchinson [sp.]. Cancer Center. I am currently an Associate Professor at Bastyr. And, I've taught courses in drug/herb interactions and pharmacology. I am currently conducting research on Chinese and Western herbs, trying to design an herbal combination for HIV aides and tuberculosis by examining specific psidacons. That is a little bit of my background.

What I am interested in is what can we do to increase the knowledge of drug and herb interactions? What I see out there, unfortunately, is an appalling lack of data in this area. Most of the data is either theoretical and is often contradicted by actual practice. And, the other is anecdotal. That is, negative interactions tend to get reported into the literature.

And so, let me give you an example of that. It is commonly reported that, as long as we are doing St. John's Wort here, it can interact with so-called SSRI's, such as Prozac, Zoloft, Paxil. And, if you examine some of these actual case reports that are in the literature, you see that it turns out that, at least in a couple of these, somebody was using an MAO inhibitor and an SSRI, which are two drugs that should never be used together to begin with anyway, and the herb too. And, of course, what is reported then, is the herb causes interaction. And, so, I find that to be a major problem. And so, one of the solutions I see is,

we need specific funding to be earmarked for CAM institutions, people who can look at this. And, it can be done in a collaborative way, but we need specific funding for researchers who are more familiar with herbs. We also need funding for people to look at Chinese herbs and Western herbs together. That has not really been done.

And, also, what I find is, there is a lack of research on the positive interaction between drugs and herbs. What is typically done is the negative interactions are looked at. So, that is the second thing I'd like to point out. And then, finally, we need to take this research and apply it. So, people need training, both CAM providers and medical doctors need more training in what the potential interactions are for safety of the patients.

The Honorable James Gordon: Thank you very much. Sevak Kroesen.

Sevak Kroesen: Good morning. Thank you for the opportunity here to address this Commission. You guys have got an incredible job, a burden here, before you. My comments this morning are directed towards, specifically, towards the question that you asked in your proposal to speak here, is what types of CAM practices and interventions should be reimbursable through federal programs or their healthcare coverage systems.

Wow, I mean, just a big question. And the ones that come to mind here are the practices that have been identified under the CAM guidelines.

Now, CAM is a hot word in some circles, chiropractors, in particular, oh which I am one, do not believe that we practice alternative medicine any more than medical doctors practice alternative chiropractic. So, there are some issues here with words and we can get lost in these words and I think that that's a waste of time and energy. We have a basic understanding, a definition in this direction we should pursue is, looking at all systems of (inaudible) and their efficacy and do they work and how do they work and how are they reimbursed:

Interventions that I feel should be reimbursable are osseous- manipulative therapy, supplements that have been certified to consistency and quality via independent laboratory assays, homeopathy, physical medicine modalities. And, probably, the list could go on and on and on, things that I am not qualified to speak specifically too.

Concerns that I have, concerns involve education to eliminate professional bias. And, education to maintain the highest professional standards utilizing deferential diagnosis. Barbara Mitchell and Dr. Louise, I think, spoke to this very eloquently in pointing out the fact that we need national credentially standards. And, I think, that is in the best interest of the patient. Because the bottom line is, as we have already discussed here, who is this serving? And the needs of the patient must come first. And, one way of doing that is through national credentially and making sure that a practitioner is coming up to at least a certain standard of awareness about a person's health.

Thank you.

In closing, I'd just like to mention that CAM is bastardized when it is formulated within the Cartesian logic model, which is the foundation of conventional medicine. In other words, we are looking at something with a different type of lens. Alternative medicine, for lack of a better phrase at the moment, is exactly that. It is alternative. It is different. There is a difference between treating disease and healthcare. And that needs to be addressed and that is an overwhelming concern for all positions, I'm sure.

Thank you.

The Honorable James Gordon: Thank you very much. Robert Shook.

Robert Shook: Good morning Mr. Chair, members of the Commission. My name is Robert Shook. I am the President of the Northwest Institute of Acupuncture & Oriental Medicine here in Seattle. Our Institute is the oldest and the largest school exclusively devoted to the education training of acupuncture and oriental medicine. We are actually celebrating our 20th anniversary this year. Approximately 20 years ago we graduated six students to the Seattle area. Currently, we are graduating between 60 and 70 students a year. We've had a strong history and tradition and have been able to influence other training programs across the country, stimulated growth of alternative medicine practice at the northwest and nationally. We have a tremendous growth in enrollment, student interest, increasing strong interest by patients.

And, my concern, as a healthcare administrator and academician, is our ability to continue to train practitioners to meet this increasing demand for services. My concern is funding for education and training of future CAM practitioners.

For the last 20 years, I have worked in large healthcare systems, western medicine, multi-hospital systems, managed care systems, and I have spent one year as President in a CAM institution of training, so I am new to this field. And my, I think, awareness and disappointment in moving to this field was the lack of funding. Working in large western hospital systems with interns and residents, there was often, and many times, no lack of funding for medical residents. However, in CAM practitioners, I find that there is a tremendous lack in funding.

Specifically, I'd like for you to look at, in your deliberations, the expansion of the accreditation counsel for graduate medical education. Which is, some of you know, is specifically designed for residency programs, both for inpatient and ambulatory care services. I'd like you to consider expanding that to include training of, in schools, for CAM practitioners.

We have 14 clinics throughout the Seattle area, low-income clinics, that are funded primarily by students. I would like to suggest that this be shifted to a national funding base to include demonstration models to fund low-income clinics that our students can work in these clinics under supervision with licensed practitioners.

So, specific recommendation would be for you to review existing funding opportunities, develop a funding model of medical education, support clinical services and review and develop grant and aid programs for demonstration models, especially in application of clinical services for training and education of CAM practitioners.

Thank you for your time today and thank you for taking your time out of your busy schedules to devote to this important and exciting initiative.

The Honorable James Gordon: Thank you. And thank you all for your specific suggestions. These are, we are writing notes, and these are extremely helpful to us.

Joe, do you want to begin?

The Honorable Joseph Fins: For Dr. Novack, you, sort of, straddled the fence and you lived in both worlds. When you have a publication that you want to get out about a drug/herbal interaction, what journals do you like to publish in and what has been your experience with the traditional journals? How receptive have they been? And, what can we do to promote dialogue with the mainstream medical journal editors to help get words out?

Jeff Novack: If you look at the research that is being published, you will see that a lot of it is on specific constituents. And the way that people are using these herbs is mostly whole herbs. And, while I agree that it is useful to know what the active constituent is for standardization, it is also useful to understand what the whole herb is doing and that is the way it is usually used. The problem is that that is not looked at kindly when you submit something on the whole herb, or herbal combinations. And, in particular, nowadays, for tuberculosis, for aides, we are using four, five different drugs. But if you try to use four or five different herbs in a combination, it is not looked at kindly. It is criticized, you don't know what's in there. There could be interactions. A lot of different things like that. So that is one of the major problems.

And, so, it is difficult to get published in more mainstream journals. Even if you are going after some of the latest psidacons or the newest things that are involved in particular diseases like betachemakinds [sp., sounded like he said, beta-chema-kinds] and aides or anything like that, you still are criticized because you are using multiple herbs. When, in fact, we know, for drugs, that is probably the most effective way of dealing with things at multiple sites.

Male Participant: I have a question for Dr. Robert Shook regarding acupuncture. Your program graduate is the school and this [inaudible] acupuncture has graduated. They got covered by licensed acupuncture in this state, are they covered the same as a physician covered?

Robert Shook: Regarding?

Male Participant: License in acupuncture in this state.

Robert Shook: Yes, the licensed, and what was the question?

Male Participant: The question was whether the insurance cover the service provided by licensed acupuncturists graduated from your school?

Robert Shook: As you know, the state of Washington is pretty progressive in that respect in the licensure. and, included in most of our health plans, if that is your question, specifically.

Male Participant: And you have doctorate degrees also, program, your school?

Robert Shook: We do not have a doctor degree, currently. The Accreditation Commission is currently going through those discussions and, I believe, there will be a couple of schools in the next couple of years that will start offering doctoral programs. Specifically, our school may be interested in the next three or four years. But, I think in the next year or so, we will see some schools offering doctorate programs.

Male Participant: Thank you.

Female Participant: Dr. Kroesen, I'm wondering what the model is at your integrated healthcare center and if any of the services provided require referral within your system?

Sevak S. Kroesen: The model that I utilize in my practice is one that looks at all systems of healthcare, conventional medicine, atropathy [sp.], chiropractic, acupuncture, nutritional medicine, also known as functional medicine. And, yes, it does require tremendous amount of referral. I worked with medical doctors, acupuncturists, massage therapists, psychotherapists, naturopaths, and, we do a lot of referring back and forth, inter-referral, referral to practitioners that I may not even be familiar with sometimes, if I feel that it is in the best interest of the patient. And, that is a big process in terms of analysis and figuring out what's best for the patient. Sometimes the patient is the best indicator of that. That is a very important part of my practice. Does that answer your question?

Female Participant: Yes. Thank you.

Female Participant: I appreciate your comments and I am directing my question to Jeff Novack. In terms of whole herbs, what is your experience and your concept about isolating factors in herbs? In Chinese medicine we feel that the whole medicine and its environmental relationship has a lot to do with the effectiveness of the herb, and there is a movement on isolating certain factors, just like in medicine. Can you comment on that?

Jeff Novack: Well, I think this is similar to the last question which, basically it is useful to have some constituents for standardization if you know they are the major active components. But, I think most, as you said, most medicines that use herbs tend to use the whole herbs, or, many Chinese medicines tend to use combinations of herbs. And, so, I think we should be doing research on how things are used as opposed to, well, there should both.

There should be both constituent and active constituent isolation. I mean, that, and also, but, there should be research on whole herbs and combination of herbs, the way they are used, to test their effectiveness. So, I think both should be done.

Female Participant: Dr. Novack, thrilled with this whole area that you are interested in. I think, you know, with botanical sales down now 38% from last year, industry is falling flat, there has been an 8 to 1 negative media campaign. So, for every one positive report on botanicals there are eight negatives. A lot of articles being written by people who don't know anything about botanicals. And yet, on the other hand, St. John's Wort, and a couple case reports of rejection of heart transplant that was reported through Who [sp.] and now we are having reports on Kava through Upsala [sp.]. You know, the whole thing about botanicals is that they are already out of the barn. You know, a drug has to go through all of these things before it is entered into the market, and then there is post-surveillance. Have you considered working or making a proposal from Bastyr to NCAM, or to be one, because, they just were pointed four sites for botanical medicine. You know, with a proposal to study P450's and effects on, the sub-enzymes and protein displacement pharmacokinetics, all of these things which, for most botanicals, we have nothing? Have they contacted you?

Jeff Novack: No, they are not out there contacting me. But, yes, we have our own research ideas and things we are working on and we have our research department at Bastyr. We are very interested in research on herbals and botanicals in whole and combinations and we are trying to do that. I think that is true. I agree with what you are saying that there is a lot of negative publicity. That is part of the way things are reported in an anecdotal manner in the research. That is, what gets reported is a single case report of somebody and that is what gets published. What doesn't get published is the 100,000 other people who are using the drug just fine, or the herb just fine.

And, drugs do have their problems. I mean, just because a drug has been tried for four weeks and found safe in the clinical trial, doesn't mean it is safe to use for the rest of a person's life and so that was never tested either. So, I look at things from both sides. There are problems either way. And, the more research we can do, the better. And, we need to do research on the way people are using them now.

Female Participant: Are you looking at foods too, since, I mean, there was a great call in the U.K. to ban St. John's Wort, but I didn't see anybody who wanted to take grapefruit juice off the market?

Jeff Novack: [Laughter] That's a good point.

The Honorable Tom Chappel: Dr. Alschuler, your perspective to the differences in orientation to healthcare, that being research, I'm interested in the pragmatism of being in the trenches of collaborating. I hear you talking about learning one another's vocabularies, aims, goals, philosophy's and develop, a process that is developing mutual respect. Is that what I'm hearing? And, so, out of this practice, different philosophies evolve into a pragmatic mutuality of all being part of the same system and each one just having different ways of contributing?

Lisa Alschuler: I definitely spoke from a futuristic perspective.

The Honorable Tom Chappel: Oh, you did. Okay.

Lisa Alschuler: In a sense. I think, right now, what's happening is parallel medicine so that from the perspective of a patient, and I'll speak from my own experience as an atropathic [sp.] physician. We see patients and we may refer to a conventional provider or we may get the patient referred to us from the conventional provider. But, essentially, what's happening, is the patient is experiencing therapies from each provider set, from each philosophical set. And, integrating those therapies in their own body and psyche. The providers themselves are not coming from an integrated perspective at the outset. So, I think that, and, actually, that is the first step. I think that parallel medicine is probably okay at this point. I think that as we do that and gain familiarity with one another and the paradigms start to touch in the patient, over time that will actually develop into true integration. And I don't think that is happening in but a very few rare cases.

The Honorable Tom Chappel: Thank you.

The Honorable James Gordon: Thank you. One thing I'd ask the three of you who are involved with clinical programs to do for us, if you would. And, this is raised by the last question that you just asked, Tom, is, if you would give us some criteria, in writing, by which you refer, especially to conventional MD trained physicians, give us a sense of how those decisions are made. And, even, we'll go more into this when we come to our education, specific panel on education, but we'd appreciate your help and others in the audience as well. What kind of training in conventional, medical diagnosis and therapeutics is required by CAM professions and what else do you think should be required? So, any thoughts about that, we would really appreciate, we could use those in preparing for our next sessions.

Male Participant: Jim, can I make an additional request? What do you folks think the traditional medical student should know about CAM in a very, you know, truncated form, just familiarity.

The Honorable James Gordon: Thank you very much. We are going to take a 15 minute break and we'll start then.

[BREAK]

Female Participant: If there are any Commissioners in the hall, could they come back up to the stage. I am going to run and get the rest of them. And, if the rest of you could take your seats and I'll go ahead and call the first panel up. Would Tommy Lewis, Ralph Forquera, Graham Patrick, Wayne Topping come up please? And, also, if Wendy Weber, Heida Brenneke, Paul Reilley and John Daley, please come up also? And, I would ask the Commissioners to come back up to the stage please. I'm going to go run and get the other ones.

The Honorable James Gordon: Thank you very much. The wonders and horrors of modern technology. Okay, first is Tommy Lewis.

Tommy Lewis: Thank you. Mr. Chair, members of the Commission, my name is Tommy Lewis. I am President of Northwest Indian College located in Bellingham, Washington. Northwest Indian College is known as a tribally controlled college, located in the northwest. Our mission is to serve the northwest Indian tribes with higher education opportunities. There are 32 tribally controlled colleges throughout the country and Northwest Indian College is one of them in this region. I am a Navajo tribal member from Arizona. I recently moved to this area to work with the schools. I want to thank you for this opportunity to share with you, today, how the native American educational system approach to teaching and learning lends the best of the new ways with the old ways from my Indian people.

Earth, each place has its own culture, language, food, medicines, lifestyle and ways of transferring the knowledge from the elders to the newest members of the tribe, whether it is in the United States, South America, Australia or Africa or where there are envisionist people. Each place is different and adds to the magnificent diversity of the world's peoples. The Indian way, in each of our different ways, the basic principles of achieving harmony and peace within ourselves and others with the forces of the Earth and all living things, are what guide our daily lives. Our teachings include knowing about four elements of Earth, air, fire, water. As we learn about each, we learn how they relate to each other and how they are balanced. Throughout the circle of life, we are influenced by time, space and direction.

These are the basic elements of our learning. This planet maintains its relationship with the greater universe through forces that are governed by time. The gifts of this Earth, both living and innate, are interrelated, non-changing in mass, but always changing their form with time. The people have special ceremonies throughout the time cycle honoring the daily blessings, the monthly changes and the completion of the annual cycle fulfilling sacred events on the continuum of time. This is what we teach our children. The indigenous people have their stories of how and where they began. Their places of origin are where they must spend their lives. If they go away for a while, they must return. They must take care of their space, their park of Mother Earth.

We are taught that there is sufficient space for everyone and that everyone is responsible for their space. Our spaces are hogonts [sp.], log cabins, teepees and other structures that are adapted to our lands. We have, around our living spaces, fragrant soil of gardens, pure water for growth, cleanse in wind and air and seeds of life. We balance all of these in our time on Earth. We teach our children to honor the different director, for they each guide our life ways. From the east, morning, we receive the praise and the early life. From the south, noon, we receive the praise and warmth. From the west, the twilight, we receive the honor of the closure of the day. And, from the north, we receive wisdom.

There are a lot of ways that the Native American people can contribute to the world's society. We have sacred ceremonies for healing. We have sacred prayers to heal the mind, body, soul and the spirit. These are all a part of our tradition. These are something that we were brought up with from beginning of time. We also have the Native American church,

using the peyote sacrament, which is a very powerful ceremony to heal the mind, body, soul and spirit. I believe that western society need to understand these and appreciate the way we do things. And, I'm sure we can make a contribution to the bigger world that we all live in.

Thank you very much.

The Honorable James Gordon: Thank you very much. Ralph Forquera.

Ralph Forquera: Good morning. My name is Ralph Forquera. I am the Executive Director for the Seattle Indian Health Board. It is a community health center located here in Seattle. It serves, primarily urban American Indians, Alaskan natives. My presentation is going to be a little bit different, I think, than most of the other people that have presented here because I wanted to talk a little bit about how we are using traditional Indian medicine within the context of our community health setting.

For many urban American Indians, western medicine might be considered alternative or complementary. The majority of urban Indian people we serve, use some form of traditional medicine. Thus, in recognition of this fact, my agency established, back in 1971, a position that we call our traditional health liaison. Seattle King County has about 250 different Indian tribes represented in our service population. So, the ability to provide a single individual to be able to provide all of the different ceremonies and other healing practices of Indian life would just not be something that would be practical. So the position was created, specifically, to act as a liaison between the Indian community itself that is seeking these services and traditional healers in the area that prefer a particular type of tribally specific interventions.

As a GCHO accredited institution, we also chose to take our traditional health person and treat them as any other healthcare practitioner within the agency. So, therefore, we established a group of local Indian leaders that were recognized in the area who established criteria. And, our traditional health person is both credentialled and privileged by the agency to provide certain ceremonial activities, run [inaudible] to a variety of traditional activities on behalf of the patients that we serve.

In 1994 we also established a family practice physician residency-training program in conjunction with the University of Washington and Providence Hospital. And, through that residency program, we also expose our residents to traditional healers and learning a little bit about traditional medicine. Learning also about how to work with patients themselves and asking questions about traditional medicine. In some situations, actually participating in traditional healing activities when it is appropriate. And, it is not always appropriate so it is important they know when they should be there and when they shouldn't be there.

Thank you.

It is important to note that we don't train traditional health practitioners. We can't. These are people that are sanctioned by the tribes themselves and by the communities themselves, people that have acquired skills over a long period of time. Our real purpose is to

try to better integrate an understanding of these two forms of medicine and how they can complement each other and how they can work collaboratively. Traditional health liaison position has been an important piece of our ability to both engage our community, which is very dispersed, very, very difficult to deal with. Engage our community in a way that we can use the western approaches that we think are beneficial and the traditional approaches that we use as a way of trying to address long-term health disparities that exist in our population.

I'm out of time, so, I'll submit some written testimony later that I hope will clarify a little bit more for you the role that we try to incorporate into our agency.

Thank you.

The Honorable James Gordon: Thank you. Graham Patrick. Graham Patrick is not here. Okay. Wayne William Topping.

Wayne William Topping. Mr. Chairman, members of the Commission, I am an instructor in a number of kinesiology [sp.] [inaudible], bio-kinesiology [sp.], brain gem, and I've established 14 courses under the umbrella, wellness kinesiology and have taught these in 21 countries. I am basically an educator, former geology professor, who got more excited by what was happening in holistic health. Recently, I was appointed by the International Kinesiology College based in Zurich, Switzerland, to become one of three [inaudible] instructor trainers for the United States. So, I am shifting more of my emphasis into the United States. Fortunately, I live close to Seattle. I am in Bellingham, also.

Just by way of background, Dr. George Goodhart [sp.], a chiropractor from Detroit, Michigan, established applied kinesiology in the middle '60's using muscle testing to identify how the body was out of balance. And, using techniques drawing from chiropractic, osteopathy and know knowledge of trans-acupuncture system in order to bring the body back into balance. People that have become applied kinesiologists have a license to diagnose. Most of them are chiropractors, some are naturopaths, some are medical doctors and psychiatrists. However, Dr. John Thie [sp.], a chiropractor from southern California became really intrigued with kinesiology, recognized its value for the lay public and packaged a lot of applied kinesiology under the title of touch for health and has been busy training lots of people. There are many, tens of thousands that's been trained as instructors to go out there and teach touch for health. And, a lot of other kinesiology have spun-off from this within a holistic paradigm that is from an energy perspective.

Overseas, there has been an evolution occurring. This training has now happening a lot more through schools, a number of which are government approved, in Australia, United Kingdom and Switzerland, among others. A lot of the other countries are developing extensive programs, 600 to 1,500 hours in duration. And, right now, we are the at the very initial stages of setting up a school, a program in the Seattle, Bellevue area through the Bellevue Massage School to start offering America the same opportunity. So we are working an educational, energetic paradigm where the intent is to balance the body to eliminate stress, relieve pain, improve posture, improve athletic and academic performance. We are not interested in having license, degrees to diagnose. I would have become a medical, sorry, a

naturopath if I'd wanted to do that, but, we need to carve out a niche in the marketplace where there are people there that can be educational, primarily, oftentimes, one on one.

Double-blind studies really don't apply to what we are doing. Where I see the research going best would be if we could get into the rest homes where you have an older population such as we heard about very eloquently from Sheila yesterday. We have people with 29 different medications. We could go in there with very simple techniques and make a significant difference.

The Honorable James Gordon: Thank you. Thank you all three. And, thank you, particularly, for reminding us of the, sort of, gravity of the Indian way and of the connection between health and the world around us and the spiritual world, as well. It felt very good to have that strong reminder. Thank you.

Tom?

The Honorable Tom Chappell: I'm sorry, I lost your name, but I'd like to address my question –

Everyone: Tommy Lewis.

The Honorable Tom Chappell: Yes, Tommy Lewis. Thank you. In your tradition, do you have people who have specific roles that are practicing the traditions for healing? That is my first question.

Tommy Lewis: Yes, there is. These people are gifted.

The Honorable Tom Chappell: Gifted?

Tommy Lewis: And have the ability to understand the symptoms using various ways to connect with The Great Spirit to diagnose the problem and to find ways the individual can come back into balance and to harmony. An illness, a problem, occurs through the human body when something within the spirit is off balance. So, there could be a ceremony. There could be a prayer. There could be some other thing that is needed. It is not always the aspirin. It is not always the x-ray that helps a person.

The Honorable Tom Chappell: And are these, people who are gifted, economically provided for by your culture for their specific role, or?

Tommy Lewis: No.

The Honorable Tom Chappell: No, they just, people just recognize them and go to them in time of need.

The Honorable Tom Chappell: Good. Thank you.

Female Participant: I guess the question is maybe about reimbursement and, sort of, I know that on the Navajo, some of the ceremonies can get quite expensive for the families. And, in a state that is looking at reimbursement for naturopathic medicine and acupuncture, should there be a role, also, for reimbursement of traditional healers that are recognized by their communities? And, that also have to pay electric bills and pay for food if we are covering other types of healing modalities. I'd like to hear from both of you. Has this been addressed in Washington? And, is there reimbursement for traditional healers?

Male Participant: One of the reasons that we decided to credential and privilege our traditional health person was to legitimize them, so to speak. And, Carl has permission now to actually do ceremonial work and other kinds of work in hospitals. And, he is being, we are getting referrals not only from our own providers, but from other providers in the community outside of the Indian community who have worked with us or worked with our traditional person over the years. And, are asking him to come in and do certain kinds of work in hospitals. At this point, we haven't been reimbursed for that. It is kind of a specialist/consultant kind of a position.

Although I had some discussions with Group Health Cooperative a few years ago, there are a couple of physicians that work for Group Health that used to work for us. We train a lot of Group Health doctors. And, we did have some discussions about the possibilities of doing that. I was actually asking them, you know, even if you just paid us \$10.00, it is the idea of legitimizing this as a, I mean, if a doctor is making a referral to us, there is obviously some efficacy in what they are asking them to do. So, we were trying to use the methodologies that medicine seems to understand, credentialing, privileging, those kinds of things, defining the position in a way, as a specialist, consultant, that somebody might be able to, be able to get a handle on enough. What they actually do is very difficult to describe because it is so encased in the culture and in the history of the people themselves. It is not just the individual, it is the family and the community that is involved in this.

So, it is hard to describe it in the way like you would a penicillin shot or other kinds of treatments. But, my experience has been, it is as legitimate as anything else. I can't quantify that. But, I've worked in this field for 20 years and I can tell you that people

[END OF SIDE A]

[SIDE B]

Male Participant: In our agency, anyway, when they get a combination of the western medicine and the traditional medicine in combination, they are healthier, they take care of themselves better, they are more engaged. And, I believe that our providers become better providers when they have the exposure to and the opportunity to consult back and forth in the provision of that kind of service.

Female Participant: I've had the great opportunity of working with the North American Indians in Canada and the United States, and exchanging about Chinese medicine and Native American healing. And, you mention that people are born with special skills. Then, in our discussion, and direction to license and credential and also non-Indian, non-

Natives, interest in healing, you see some problems with that. Can you speak to some of those problems and what needs to be considered? I know, in the Chinese system, there is a tremendous amount of, acupuncture is easy to see, it is a needle, [inaudible] and all the energy concepts that which you people talk about, can you express some of that?

Male Participant: My feeling is, I don't think it is possible, at this point in time, to credential at a national level, or even at a state level, a traditional health person. I believe that that is really something that the community themselves have to accept. Part of the reason that we are able to establish this position was we had a person who happened to be working for me as a drug and alcohol counselor. Who, I found out, was doing these things after hours and on weekends and was extremely well recognized by the community. I've learned over the years, there is a lot of [inaudible] in this business also. You have to be really careful about who you choose to do these kinds of jobs. So, I spent a great deal of time checking out the credentials of this particular individual.

And, one thing that I've learned, in the Indian world, anyway, Indian healers, true Indian healers, know other Indian healers. It is an unwritten society, so to speak, but it exists. And, in checking out Carl, I found him, all over the country, to be a recognized individual. And so, it was possible to create this particular kind of position. I don't think in other places that is replicable. In our particular situation it has worked and it has worked extremely well for us, I believe. But, I don't, again, what they do is not something that you can quantify well enough, I don't think, to create criterion for some kind of a credentialing procedure.

As Dr. Lewis mentioned, this is really something that people were born with. I mean, they are born with this gift and it is recognized and then they are directed in the direction of the people that mentored them, the rest of their lives. They don't just go to school, learn some skills and then go do this stuff. They are constantly being taught. Our traditional person is constantly involved with his mentors. And so, it's not something that, I don't think, I don't think could be easily transferred into that kind of an agenda.

Tommy Lewis: I would agree. It is a lifelong learning process. And it is all about the mind, body, soul and spirit. There is a [inaudible] that goes with it, a connection with a higher power to deliver the message. The knowledge that is needed to understand what is ailing the person, I think that is a gift that the individual has. And to ask to demonstrate this and see how it is done, I think, from an outsider, it would be very impossible. So, you have to be in tune with the Indian community, with that individual's way of life, in order to make that connection.

Female Participant: I hope you will provide us with some written material so that we can take this into consideration with the work of the Commission. I'd appreciate it. Thanks.

Male Participant: Mr. Forquera and Dr. Lewis, what is the line between religion and CAM? If one is regulation CAM, there are certain prerogatives that a government could have. But, the regulation of religion, of course, would be unconstitutional. So, where do we draw the line? Because a lot of what you are describing has deep spiritual implications. And, we

would not want to do anything that would compromise the ability of any group to express their religious beliefs and their heritage.

Ralph Forquera: I don't see traditional Indian medicine as being religious at all. It is spiritual in nature because it is geared, it is based upon a history and culture that's evolved over a period of time, and certain belief systems that have been established. That's different, very different, in my opinion, than religion. So, I don't necessarily see them as being similar at all.

Male Participant: And, is that a view that these people are not seen as spiritual leaders?

Ralph Forquera: They are seen as spiritual leaders, but not as religious leaders.

Male Participant: So, you are distinguishing spirit and religion?

Ralph Forquera: You know, I think, with some tribes, they may be both, I don't know. There is a tremendous amount of variation. But, I know in our particular situation, our traditional people are viewed as providers, as healthcare providers who use a different type of methodology in the provision of the healing that they do. And that is exactly how we've tried to formulate it within the context of our institution. And, as I said, I think in using that approach, we've had a phenomenal amount of success in expanding it beyond the scope of just our institution and into the community. Into the mainstream medical community where providers are beginning to now look at this with the Indian patients that they might be seeing, as a vital part of the treatment practice that they feel will be helpful to this individual.

Male Participant: Dr. Lewis, do you agree with that formulation?

Tommy Lewis: Yes, I agree. This healing is really, boils down to a spiritual connection. Others might classify it as religion, but, in our ways, it is not recognized that way. It is really hard to draw the line, what is religion and what is spirituality. It's a mixture of –

Male Participant: I mean, it's just a blurry line. And, I think, in the quest to legitimate and regulate, we don't want to in any way preclude the expression of these very important things, whether they are spiritual or religious, either way, I think, would be constitutionally protected. So, perhaps you guys could think about that at give us some additional information and formulation of a response. That would be very helpful to us. Thank you.

Male Participant: Mr. Chairman, may I?

The Honorable James Gordon: Go ahead, please.

Male Participant: I'd like to ask one question, which relates to the Native American church. I think that we are at a time, because of a lot of confusion and anxiety and concern in

the culture, people are very concerned about what they call drugs. And, I'm wondering if you can shed some light on the use of plants to assist the transformation of consciousness and assist spiritual development and healing. And, how you would, what lessons you would like to share with us and how you would think that our Commission could address this issue?

Tommy Lewis: I was raised in the very traditional environment. And, my family and relatives all used peyote as a way to understand life and carry on with life.

Male Participant: Could you come a little closer?

Tommy Lewis: And I, it's been said by the medical community that peyote is a drug. It has been tested and went all the way to the Supreme Court through the Native American Religious Freedom Act. Most recently, in 1994, that was declared not the case. So, we are given the opportunity, for the first time in the history of the United States, to use that freely and openly. And, when you use the peyote medicine, it sharpens your senses. It does not, in my experience in taking it, it does not have any kind of ill effect. It just allows me to understand myself, my connection with Earth, my connection with the holy people, understanding the natural process and the connectedness and the wholeness of oneself and with all the natural elements. And, how do I need to become more aware of what I need to do for myself to heal my body, my problems, my weaknesses? So, it is a very powerful ceremony and Native Americans throughout the United States use it. And, in my view, it is one of the fastest growing, Indian religion, in the United States.

Male Participant: And, do you have some thoughts about how the larger society can learn or what we need to do to learn from your experience and your people's experience?

Tommy Lewis: My people, the Navajo people, have always spoke against non-Indians using the peyote because they seem to not understand its real purpose. And there is abuse. People take it as drugs and begin to use it in the different forms. And, that is not the way we use it. That's not how we understand it. So, we are told to use it in the right way, the way it was meant for us to use from the beginning of time. That is the only way we can use it.

Male Participant: Thank you very much.

Male Participant: Dr. Lewis, then, in your tradition, the traditional healer is more a facilitator with these special powers, to enable and empower the person to find alignment and connection and self understanding for self care?

Tommy Lewis: I would agree, yes. They facilitate the ceremonies. And, family members, they all come. Other people who have connection with that individual, all come around to help. So, at the end, it begins, it turns out to be a family healing process, with caring and support from close family members. It allows that individual to really heal and take care of their problems, knowing that they are not in it by themselves.

Male Participant: We have a facilitator, we have someone who is seeking wellness and we have a community of support?

Tommy Lewis: Yes.

Ralph Forquera: But, within the context of that, also, there is some healing that goes on because there is some use of herbs and other kinds of medications that traditional practitioners do, in fact, employ as part of their treatment. So, it is more than just a facilitation.

Male Participant: Okay. Thank you.

The Honorable James Gordon: Thank you. And, Dr. Topping, I know we haven't addressed questions to you, but, I wonder if there is any research on, strictly on the use of brain gem, or the other approaches? We'd appreciate receiving some of that work.

Wayne William Topping: Yes, there is research. That's an area I really didn't cover because in America right now, we have 90% of the worlds use of Ritalin. We have 18-month old children being put on Ritalin which I think is criminal. And, so, I see it as a potential where we can use things like brain gem to come in to show that the problems are because of problems we are tracking. And that research is available.

The Honorable James Gordon: Would you send us that, please?

Wayne William Topping: Yes, I can gather a package of what I know of that is available. And it verifies, well, validifies, kinesiology, particularly in brain gem.

The Honorable James Gordon: Great. Thank you. Thank you, all three, very much.

[Inaudible, whispering amongst a few]

The Honorable James Gordon: We are having a discussion whether it is brain gem or brain jam [laughter]. Wendy Weber, please.

Wendy Weber: Good morning. My name is Wendy Weber and I am a fourth year naturopathic medical student at Bastyr University. I am active on campus, serving on several councils and I've been working in research since coming to Bastyr. Currently, I am the Project Manager on the NIH Echinacea Study Dr. Taylor spoke to you about yesterday. I am graduating in June, 2001 and I'm looking forward to a career in private practice and clinical research. In an effort to pursue this goal, I am writing a grant application for a career development award from the National Center of Complimentary and Alternative Medicine. While I am excited that I now have the opportunity to apply for such a grant, I have come up against several obstacles that I want to share with you.

First of all, I will be one of the first ND's applying for a career development award. Because of this, the NIH is unable to provide me with specific guidance and guidelines in the application process.

Secondly, the NIH recommends that I choose a mentor with experience mentoring researchers that have gone on to be successful independent researchers. At this time, I am unaware of a CAM researcher with this background. This means that I must seek out a mentor from a conventional medical institution. Finding a mentor at these institutions is possible and I've explored returning to Massachusetts General Hospital in Boston to work with a researcher I worked with before attending Bastyr. The difficulty comes in applying for a grant from one of these institutions. Most of these institutions require the grant applicant to hold an academic appointment in order to apply for one of these grants from their institution. I have been told, at this time, that getting an appointment from MGH is not possible. I think it will be difficult for any CAM provider to get an appointment, especially in unlicensed states. And, at this time, Massachusetts does not license naturopathic physicians.

The career development award is designed to train researchers, including funding for education in research design. There excellent training programs available in clinical research. Unfortunately, all of these programs are only available to medical doctors or osteopathic physicians. I have investigated a couple of these programs and found this to be true, including the Robert Wood Johnson program and the Clinical Investigator Training Program at Harvard.

I have three recommendations for you. First, is that you recommend incentives are given to encourage existing clinical research training programs to admit CAM providers interested in research. Or, recommend funding of research training programs at CAM institutions. Second, that you recommend that more research funding go to CAM providers conducting research. And, third, that you recommend licensure for CAM providers in all states so that research can be done by CAM providers in all of these states.

I want to close by telling you that I am just one of many students in the CAM profession interested in conducting research. Thank you for providing me with an opportunity to speak on how you can support CAM providers in the pursuit of research careers.

The Honorable James Gordon: Thank you. And, thank you for your very clear recommendations. Heida Brenneke.

Heida Brenneke: Good morning. Thank you for giving me this opportunity to speak. I am Heida Brenneke, founder and Director of the Brenneke School of Massage. I've been a massage therapist in the state of Washington for 29 years.

I was asked to address what sources of funds exist for the education and training of CAM massage therapists. Before I do that, however, I'd like to speak to the question that you pose, which was, why is it that the state of Washington seems to be so advanced in the area of CAM? I think the credit goes to the many visionary people in various CAM modalities who will have testified by the end of this conference. Who, collaboratively, changed the view of CAM in this state. I'd like to specifically speak to the role of the massage profession. A number of massage therapists in this state began to work in the mid-70's to create state

licensing, followed by revising the state law and then creating astringent educational requirements. Consumers in the states have had 25 years plus to learn about the body mind medicine that massage is and to trust it.

Funding for education and training. Aside from a small number of students, who receive funding through various agencies, 70% of our students receive federal financial aid. Maximum financial aid covers only a portion of the cost of the program. The part-time student has to pay \$260, the full-time student \$420 a month, out of pocket. This is a big chunk for students of modest financial means who have to continue to work full-time while going through school. We'd like to see an increase in financial aid.

Currently, no program exists to fund internships for graduates to work with, for example, the under-served population. A paid internship or having a portion of the financial aid for giving, would benefit both the graduates and the deserved. Funding for research and massage therapy is lacking on all levels. Research is limited and both educators and massage therapists need to be taught how to conduct research projects. Furthermore, many other countries have extensive research on massage therapy, which is not available in translation at this point.

In summary, I'd like to ask your support in the following areas: to increase the amount of financial aid available to students of massage therapy; to fund internships for graduates of massage to work with the under-served, that is helping both populations; to fund research for both educators and providers of massage therapy; and, to fund translations of research down in other countries.

Thank you for your attention.

The Honorable James Gordon: Thank you. Paul Reilly.

Paul Reilly: Good morning. My name is Paul Reilly. I'm a naturopathic physician. I have been in practice for 15 years. Currently, I work in an integrated cancer clinic that is run by Cancer Treatment Centers of America. And, I would like to limit my discussion today to cancer and CAM.

In our center, oncologists work, shoulder to shoulder with naturopaths, with acupuncturists, with psychologists, with nutritionists. And, the model works very well. Currently, cancer is going to effect one out of three people in this country. And, will kill one out of five. Despite 25 years of research, we have not markedly improved the survival for the majority of cancers that effect people in this country. Worse, along the way, the people who are going to be treated will suffer multiple side effects. And, also, 1% to 5% of them will develop a second cancer caused by the very treatment that was designed to help them. CAM therapies can improve this dismal situation. They can increase treatment response rates, reduce side effects and reduce the occurrence of secondary cancers.

For example, in the research, the simple addition of melatonin to conventional radiation and chemotherapy, doubled the responsory in advanced metastatic [sp.] cancer

patients and doubled the one-year survival, with no additional side effects. For another example, adding a mushroom extract to radiation for lung cancer quadrupled the life expectancy of advanced lung cancer patients. These are very inexpensive therapies that can dramatically impact outcomes. Our experience at Cancer Treatment Centers of America confirms these research results. Our patients tolerate their treatment better. And, we often have, so-called, hopeless cases that turned around into remissions and have many years of quality life. The Journal of Clinical Oncology recently reported that two-thirds of cancer patients use some form of CAM therapy. They need help making these choices. Naturopaths and other CAM practitioners can help them make wise choices to maximize the benefit.

The federal government can help in four ways. Number one, I'd like to reiterate the request for increased research. In my supporting literature, I've given about 100 references. But, we need more research to determine benefits. Second, federal insurance should cover CAM therapy when patients are going through cancer treatment in order to save dollars for secondary hospitalizations. Also, educational institutions should be supported the same way, whether they are CAM or they are conventional therapy. And finally, any hospital that accepts federal money should be mandated to accept trainees from all the accredited CAM institutions.

That will answer your question you asked earlier this morning about how do you get understanding between the professions? By working together.

Thank you.

The Honorable James Gordon: Thank you. John Daley.

John Daley: Mr. Chairman, members of the Commission, I want to thank you for the privilege of being able to address you this morning. And, thank you very much for the work you are doing on behalf of CAM.

My topic is what sources of funds exist for the education and training of CAM practitioners. For the past seven years, I have been the Executive Vice President of Bastyr University. This means I am the Chief Operating Officer and therefore familiar with the enormous fiscal challenges facing CAM education research and clinical services. The sources of federal funds, which exist to educate and train CAM practitioners, is far more limited than those available to those in traditional medicine. We seek the elimination of barriers to access federal funds for accredited CAM educational institutions. The public is demanding access to quality CAM. The quality of that care is directly related to the quality of the provider, and, therefore, the education they receive. The best applicants to CAM institutions are not going to ultimately enroll if they cannot afford to do so. At this time, they do not have access to the same loan packages available to traditional medical students.

For example, The Association of American Medical Colleges announced to their members that the Department of Education recently increased the money they could borrow under the Stafford Loan Program to pursue a medical education. Eleven professions were noted as eligible for funds in this expanded Stafford program. But naturopathic medicine and

acupuncture and oriental medicine were not included. The only CAM provider included was chiropractic, a field that this organization defines as a CAM field.

The quality of the CAM professional is also related to their access to residency programs and continuing education. It is important that CAM professionals not be discriminated against as they seek to improve their post-graduate training. Therefore, federal programs that do not now allow, that do not now provide financial support for these activities, should be amended to do so.

The clinical programs at accredited Cam institutions are a vital factor in training their students and in meeting the needs of the public in their local communities. Naturopathic physicians are not reimbursed for services under Medicaid or Medicare. Many elderly and disadvantaged people will rely exclusively on these programs to pay their healthcare expenses and thus their access to CAM is restricted.

The playing field is also not level when it comes to provided loan forgiveness programs for graduates of appropriate CAM fields who are willing to serve in rural and under-served areas after graduation. Extending this program to our graduates would meet their needs and also the needs of those in under-served areas.

Therefore, I have four specific recommendations. Under the Stafford Loan Program include accredited schools of naturopathic medicine and acupuncture and oriental medicine to those authorized to provide increased, unsubsidized loan amounts to students in health professional schools. Number two, require that accredited CAM academic institutions be eligible for inclusion in funding provided by the Health Resources Services Administration, the Healthcare Financing Association and the Bureau of Primary Healthcare to fund residency and continuing education programs for the graduates. Three, seek amendments to current Medicare and Medicaid legislation to include naturopathic physicians and any other appropriate CAM providers as reimbursable providers. And, fourth, extend the federal loan forgiveness program to those willing to serve in rural areas to appropriate CAM graduates.

Thank you.

The Honorable James Gordon: Thank you very much for those suggestions. Joe?

The Honorable Joseph Fins: Dr. Reilly, could you tell me about the patients that are referred to you who have cancer? And, what kind of disclosure is made to them about the availability of Hospice and [inaudible] care services? And, what's that relationship with the naturopathic therapies that you were employing? How does it happen and what's the collaboration?

Paul Reilly: There are two different systems where I see patients. Approximately 50% of my patients are referred by local oncologists who have seen them, their patients, do better when they followed a healthy diet and they eat well and took care of themselves. And they continue under the care of that oncologist as well as see me for naturopathic therapies. The remainder of our patients are self-referrals who come and see an oncologist in our Center

and get all the conventional therapies, whether it is radiation, surgery, oncology care, hospice care, whatever is necessary, but, in addition, they have those other layers of the acupuncture, of the naturopathic therapies. And, I'll tell you, it is very different, in our center, where you will see people sitting and getting chemotherapy, eating their lunch and playing cards and laughing rather than moaning and groaning and racing for the bathroom because of diarrhea or vomiting. That doesn't mean that chemotherapy is [inaudible, someone is coughing], but you can manage those therapies quite well with a combination of wise choices of conventional therapies and wise choices of naturopathic therapies.

The Honorable Joseph Fins: So, do CAM therapies go with an acknowledgment of infinitude and finality and being terminally ill, or is it all about promoting wellness and decreasing side effects? Where is the palliate of care dimension?

Paul Reilly: The palliate of care is part of any whole patient system. And, if they have pain, they get palliate of care. If they are obviously failing, they are advised of hospice services. But that doesn't mean that we would give up on them. Because we have had patients come to us who were told, it is time to go to hospice, and are alive years later, with no evidence of disease. So, we will not give up on a patient, but, at all times, we are in communication about what is a reasonable expectation. And, you balance your treatment for the patient, what they are needing. Some are ready to just fight till the day they go. Others realize, at some point, if they are not doing well. But, we don't give up on patients.

Male Participant: I have a question for you, Dr., regarding your using mushroom and also using melatonin to, in conjunction with conventional treatment. You mention mushroom as a food or it is a [inaudible].

Paul Reilly: Both. We use a shiitake mushroom in the food. The mushroom in this particular study was a coreolus [sp.] mushroom extract that was given in capsule form. And, we also use both tinctures and capsules of the coreolus extract or mitake [sp.] extract or ghanaderma [sp.] extracts as well as dietary mushrooms. And then, the acupuncturists on staff, who are all Oriental medial doctors, will also, sometimes, prescribe specific mushrooms via the Oriental energetic indications.

Male Participant: Melatonin is a food supplement?

Paul Reilly: Melatonin is a food supplement that is generally recognized as a sleep aid. However, there have been, I would estimate, 400 studies using high dose melatonin as a pharmacological agent that have been overwhelmingly positive, turning around failure to respond to tomaxofin [sp.], failure to respond to lupron [sp.] for prostate cancer, failure to respond to chemotherapy. Almost universally, you'll see about one-third of patients who are failing therapy begin to respond when it is used in those doses.

Male Participant: You recommend 5 mg.?

Paul Reilly: For sleep?

Male Participant: Yes.

Paul Reilly: 1, 2, 3 is my general recommendation for sleep.

Male Participant: Thank you. My curiosity.

Paul Reilly: I'll send you my bill.

Male Participant: He can only answer that in Washington.

Paul Reilly: I also recommend Tom's Toothpaste.

[Laughter]

Female Participant: I'd like to direct my question to Heida Brenneke. You talked about wanting additional funding and training. I'm wondering what you believe, what techniques should be incorporated into the massage therapy and translated into law? Things like reflexology, touch for health, [inaudible], what would you see as the complete massage law?

Heida Brenneke: The massage law in the state of Washington is based on Swedish massage. And, it addresses both wellness as well as treatment massage. In most of the schools in the state, you will find that different modalities are taught. [Inaudible], by itself, is not part of massage. It is a whole different system, as halowork [sp.] is. But, most massage schools do train people in various modalities, including foot reflexology, therapeutic touch and so on. They all fall under the same license in the state of Washington.

Female Participant: Wendy, that is so sad and so bizarre, isn't it, that we keep saying, you guys need to do more research, do more research, and then we've created all these obstacles so you can't go do it. So, we took lots of notes about that. But, I'd like to ask you a little bit about your study with Echinacea, if I could, for just a moment. I was curious about the age population that you are using as far as youngest and oldest, which preparation and which dosage form you've chosen?

Wendy J. Weber: Okay. The age group is children ages 2 to 11. They need to be in excellent health, is how the grant is written. The dosing is twice a day dosing. For children ages 2 to 5, it is $\frac{3}{4}$ teaspoon, 3.75 milliliters, and that's twice a day. And, for children 6 to 11, it is 5 milliliters, twice a day. It is an above-ground plant of Echinacea potpourri (??), a non-alcoholic extract.

Female Participant: Is it a juice preparation.

Wendy J. Weber: Yes, it is a juice preparation.

The Honorable James Gordon: Ms. Weber, thank you for bringing that problem to us. I do have a couple of suggestions for you for mentors. One is, our Dr. Cindy Angerhoffer

[sp.] at [inaudible]. She is a Ph.D. pharmacognesist [sp.]. She is also adjunct professor at the University of Illinois at Chicago's College of Pharmacy. She has trained with my second recommendation, Dr. Norman Farnsworth [sp.] at the College of Pharmacy at University of Illinois at Chicago, who just was granted an \$8M grant from NIH for their work on women's, herbs for women's needs. I think both, who have worked together, would be a very, oh, consistent with your orientation and philosophy and have the skills and experience to help.

Wendy J. Weber: Great. The problem still is that Illinois does not license naturopathic physicians. So, I would have a difficult time getting on staff at the institutions that they work at.

The Honorable James Gordon: I see. So –

Wendy J. Weber: To actually apply for the grant, the actual, individual hospitals require that you hold an academic appointment at their institution in order to apply for the grant from NIH. So, NIH does not have this requirement. But, each individual hospital does. So, it makes it extremely difficult for me to apply from an unlicensed state. And there are some wonderful people willing to work with me, it just comes in the actual process of getting that, the appointment that makes it so difficult. So, what I am now looking at doing is applying for the grant here in the state of Washington, instead. But, it means that I can't work with a collaborator that I've worked with in the past that would be an excellent mentor for me in research.

The Honorable James Gordon: I think that is a very useful example for us to have. And if there is any more detail that you'd like to give us, we'd appreciate that.

Wendy J. Weber: I'll be happy to provide that.

The Honorable James Gordon: Paul Reilly, I had a question. You said you gave us a list of 100 references. I don't see them.

Paul Reilly: Yes, I did. It is a 17 page addendum that I turned in at the front desk. Unfortunately, there was only one copy, not 11, but, I can provide the next 10.

The Honorable James Gordon: Terrific. I'd very much like to see that. And, also, to see any of the particular protocols if you are using protocols as well as, sort of, individual prescribing for people that you are using. And, the other question I have is, are you doing some research now at Cancer Treatment Centers on some of these combined, or integrative, approaches?

Paul Reilly: Yes, we are. In fact, we are just starting a, what's called the micro-nutrient intervention trial which will use high-dose antioxidant therapies in conjunction with whatever will be the standard therapy for advanced cancer patients to essentially put to rest the question regarding interference with the effects of chemotherapy.

The Honorable James Gordon: Wonderful. I'd personally, and I think the Commission members would also like to be kept up to date on how you are doing with that work. So, I think, it's an example of taking on a very important question, a critical question, for many people. And, how are you funding the research?

Paul Reilly: Right now, Cancer Treatment Centers of America has a separate affiliate called Cancer Treatment Research Foundation which will be funding this study through donations. Right now we are just recruiting approximately 20-40 patients for the pilot phase. That will last about six months. And, based on the pilot phase, we'll do some tweaking. And then we home to have anywhere from 400-800 patients. It will be a multi-centered trial, not just cancer treatment centers, but, institutions throughout the country that will be doing a double-blind placebo controlled study.

The Honorable James Gordon: That's great. One of the things I'd like to suggest, really, to both, to you, Wendy, as well, is that it is important for us to have these examples. I think it is also important to present these examples and the difficulties to the agencies that are concerned. So, for example, for you, to get in touch with NCAL.

Wendy J. Weber: I have.

The Honorable James Gordon: And, I'm not just speaking to the two of you, and let them know the difficulty. You've done that already?

Wendy J. Weber: Yes, I have.

The Honorable James Gordon: And what have they said?

Wendy J. Weber: You are breaking new ground, go ahead and apply, we'll see what we do with the application.

The Honorable James Gordon: I'm sorry, they what?

Wendy J. Weber: You are breaking new ground, we've never received an application from an ND before. Go ahead and submit and we'll see what happens. We really can't give you any guidance, is what ends up happening.

The Honorable James Gordon: Well, let us know. Okay?

Wendy J. Weber: I will.

The Honorable James Gordon: And, similarly, I think it is important for you, I don't know if you are talking with Jeff White at NCI?

Wendy J. Weber: No, I haven't.

The Honorable James Gordon: No, this is to Paul, really, to Paul Reilly, about the work you are doing. I think it will be important for him to know, as well as for me and for us to know. Jeff White is the Director of the CAP CAM Program, Cancer Advisory Panel. Well, he's the Director of the Office of, what is it called, Office of, the Complementary and Alternative Medicine Office with NCI and is very interested in the research that is going ahead and very interested, also, in the difficulties and the obstacles to undertake.

Paul Reilly: Great. Yeah, I'd love to speak with him.

The Honorable James Gordon: So, one of the ways that we can serve, and I hope to serve all of you, is not only to receive what you want to tell us, and to translate that into legislative recommendations, but also I see this as a sounding board to help you. In the meantime, be presenting the issues to other government agencies, other federal agencies.

Female Participant: Just one brief question to Dr. Reilly. Do you have any quality of life measures that you are using with the patients? You made an observation that the patients that you treat do not appear to be as problematic as in other clinics.

Paul Reilly: Actually, we are just starting an art clinic. I made copies last week, to use the Fact 30 quality of life thing. As an observation, however, most of our patients self-refer because they have other friends who have gone through this and have had similar beneficial experiences. The Center in Seattle here was helped open up by an oncologist who originally started out extremely skeptical and, essentially, by just watching what happened over time, became enthusiastic enough to help open the center and remains one of our primary referral sources because of the objective evidence. But, no, we have not, we do not have a research nurse to do the work at this point. But, I've decided I am just going to start handing them out and some day someone will hopefully collect it.

The Honorable James Gordon: Okay. Thank you. Thank you very much.

Female Participant: Okay. If we could have the following panel come up, please?

Eileen Stretch, Jennifer Booker, Victoria Taylor, Austin McMillin and Susan Rosen. And also, at this time, could we have Sheila Quinn, David Matteson and James Rotchford? Thanks.

The Honorable James Gordon: I wanted to announce, this will be our last panel before lunch. Eileen Stretch, please.

Eileen Stretch: I'm Eileen Stretch, naturopathic physician and medical director for American Whole Health, the leading online and offline provider of integrative health solutions for consumers, practitioners, healthcare organizations and payers.

I'm going to discuss practice guidelines and clinical pathways. By practice guidelines, I mean, how practitioners function as part of a healthcare system, while clinical pathways have to do with the actual diagnosis and treatment of patients.

In CAM, the focus is on the assessment of the individual in his or her unique expression of health and disease that drives the choice of the most appropriate treatment modalities. In conventional medicine, one goal of guidelines has been to minimize variation and patient treatment. In my experiences, the CAM representative on a clinical pathway team on sinusitis, with group health cooperative, it was clear how differently conventional medicine approaches the task of clinical development and the resources it took. We had a team of 10 and spent over a year on the pathway. The goal was a pathway that prescribed treatment for 90% of all patients with a focus on this drug, followed by that drug, followed by that drug. This just doesn't work for CAM because of the inherent conflict between vitalism and mechanism.

A paradigm shift is necessary in the development of clinical pathways that includes multi-modality choices for one patient for one condition. For example, in a patient with asthma, I might make nutritional recommendations, prescribe one or more botanical medicines and may recommend homeopathy or a physical medicine modality. And, in addition, I will recommend lifestyle changes. This type of multi-modality prescribing just doesn't fit the conventional clinical pathway algorithm. This paradigm shift is necessary to honor the distinct knowledge base and philosophical perspective of each CAM profession and still allow for the codification of what we do. In conventional medicine, clinical guidelines have been ritually funded by the federal government, health plans, and various private and nonprofit health agencies. These resources have not been available to CAM.

I recommend your support for CAM professions, specifically in gaining funding from sources such as the Agency for Healthcare Research and Quality to allow the necessary activities to aid each CAM profession in the development of clinical pathways, including the following: benchmarking a best practice – I'm going to skip that part – okay. Practice guidelines have to do with the stewardship of resources, including treatment planning, dosing and outcomes. An example of this at American Whole Health, involves the way in which we manage laboratory costs with naturopathic physicians. We respect the need of ND's to utilize lab testing that is not performed by conventional labs and trust the ND to pick the most clinically relevant test to help diagnose patients. However, we ask the ND to make an informed choice in a way that is economically responsible by limiting not the testing, but the choice of laboratories. Practice guidelines address system issues and may best be developed by inner-disciplinary groups so that the political scientific regulatory and reimbursement aspects of the healthcare system are considered in their development. Again, funding is required.

In working with health plans, in my position at American Whole Health, one of the obstacles that is constantly presented for not including CAM services, is the lack of clinical pathways and practice guidelines by CAM practitioners.

The Honorable James Gordon: Thank you. Thank you for moving through to the text. I appreciate that. Jennifer Booker.

Jennifer Booker: Hello. Mr. Chairman and members of the Commission, I am a naturopathic physician and Chair of Practice Guidelines for the American Association of Naturopathic Physicians. Thank you for this opportunity to speak.

I would like to define practice guidelines, describe how the helpful

[END OF SIDE B]

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10:15 a.m. – 11:45 a.m. [continued]

[SIDE A]

Jennifer Booker [cont.]: Practice guidelines or statements used by healthcare providers and patients to make health treatment decisions. These healthcare or practice guidelines will provide useful and reliable information to healthcare providers and patients about naturopathic medicine. These guidelines can also be used to define appropriate access and delivery of naturopathic healthcare for healthcare systems. We know practice guidelines are a good idea and will help everybody involved in delivery and in receiving healthcare. We also know they cost money to generate. Since the every category of provider law and mandate law in Washington, third-party payers, healthcare policy makers and regulators have made it clear, after many meetings, that they want these guidelines for naturopathic medicine, but no one wants to pay for them.

In the community of conventional medicine, cardiologists have developed cardiac rehabilitation guidelines, which provide a good example of how guidelines are generated. The project was funded at \$2.3M from several sources, including government. They were peer driven and reviewed almost 900 articles. Overall, it was concluded that diet, exercise and lifestyle change were the most effective interventions.

Naturopathic physicians can similarly produce high quality guidelines for diabetes, hypertension, high cholesterol and airway diseases, to name a few conditions of high concern to federal and state health agencies, given the funding. As primary care physicians, we integrate or utilize the tools of what is called alternative medicine, including diet, exercise and lifestyle modification treatments in our practices on a daily basis. I would recommend the federal government help us now with funding to create these guidelines. Help us to produce what everyone, including my own profession, wants: high quality evidence, base practice guidelines that are understandable, and, therefore, useful, for healthcare plans and delivery systems for patients and for government decision-makers. Peer driven and led naturopathic guidelines can extract, grade and organize the scientific literature which studies the modalities used by my profession. Easy to understand guidelines that describe our systematic use of evidence-based naturopathic medicine through the consumer, the payer or the health care educators, and the needs of this White House Commission.

My profession has worked hard over the last four years on a volunteer basis from a pool of already overly busy practitioners. And, we cannot complete such a long and arduous task without funding. Please help us to help you by supporting our efforts to achieve funding and complete practice guidelines for the nations most prevalent and expensive diseases.

Thank you.

The Honorable James Gordon: Thank you. Victoria Taylor.

Victoria M. Taylor: I'm Victoria Taylor, founder of Quality Midwifery Associates and provider of the only statewide quality assurance risk management program in the country for midwives practicing in birth centers and in clients homes. Thank you for the opportunity to speak at this hearing.

While I am here to talk about quality assurance for midwives, most of these elements are applicable to any healthcare provider. When I use the term midwife, I am specifically referring to licensed midwives and certified professional midwives. There are six legs of quality assurance that must be present in any profession for quality assurance and quality improvement to occur on a regular profession-wide basis. National certification and reciprocity for practitioners, nationally accredited educational institutions, outcome data collection and research, state protected confidentiality assurance for peer incident and practice reviews, guidelines and standards of care authored by the profession itself and active professional associations. Of course, the starting point for any quality conversation has to be the legal practice of a profession nationally. Therefore, it is in the public interest to have it be legal for certified professional midwives to practice midwifery in non-institutional settings in every state in the country and we want the Commission to work towards that end.

This is the first step in assuring quality care and safely fulfilling consumer demand for alternatives to basic hospital delivery. The presence of quality care in the midwifery profession is important to all CAM professions because midwifery care itself is frequently a gateway to alternative care modalities and often the consumers first encounter with alternatives to allopathic medical care. When quality is present, the consumer and the profession benefit in many ways. Some of the more obvious ones, safer care, increased consumer satisfaction and decreased risk of lawsuits due to avoidable poor outcomes. Not so readily obvious, quality assurance is the hallmark of and further encourages a learning profession.

In this state, midwives have integrated QAQI practices into their midwifery care. Washington state legislation enables midwives in CAM professions. Collaboration occurs among CAM providers and other organizations and there are three professional associations in the forefront of QAQI for midwives, Midwives Alliance of North America, North American Registry of Midwives and the Midwifery Education Accreditation Counsel.

Here is what midwives need from the Commission. One, adopt the CPM credential granted by the North American Registry of Midwives as a national certification for direct entry midwives with resulting reciprocity of midwifery practice, nationally. Two, recommend that it be legal for certified professional midwives to practice midwifery in out-of-hospital settings in every state. Three, state or federal legislative protection for confidentiality of peer practice and instant reviews for providers who practice in non-institutional settings. Four, recommend that midwives develop practice guidelines and that this be done within their state or national professional associations and not by legislators or other practitioners unfamiliar

with the midwifery process of care. Five, support the collection and reporting of midwifery outcome data at the state and national level through funding of the already existing Midwives Alliance of North America statistical collection database.

Fostering many quality assurance pathways does more than protect the public. It increases consumer satisfaction with healthcare, minimizes risk of lawsuit for the provider and continues the development of professional standards of care.

Thank you for hearing my testimony.

The Honorable James Gordon: Thank you. Austin McMillin.

Austin McMillin: Thank you for the opportunity to testify today. I've been asked to speak on issues of guidelines. And, it is very difficult to provide a detailed discussion in three minutes, but, I'll do my best. Thank you for the work that you are doing with respect to CAM. My background is one of 11 years of private practice in chiropractic care. I've also worked with the Technical Advisory Group with Washington State for healthcare reform. And, in that process, have studied utilization of chiropractic services, their description and value. I have also worked as a participant with the CAM clinician workgroup sponsored by the OIC here in this state, trying to integrate care approaches and develop guidelines and care pathways for practice.

Initially, I'd like to say that the intent of guidelines is to assimilate a knowledge base for the direction of care and for help in decision making. Secondly, and I underscore secondarily, it is a process that helps to work with adjudication of claims and reimbursement of care. However, without a working knowledge of the different forms of care and the descriptions that different providers use, it is very difficult for traditional providers to have an understanding of how and when to use those services and when to [inaudible] for care. I think that is a true challenge of a guideline, is to work on, condition specific approaches, not provider specific approaches so that care can actually be assimilated or integrated one form of care to another. That is an extreme challenge. For example, understanding how and when to refer a patient for acupuncture by a traditional provider is very difficult. I hear complaints about that in my community regularly. Similarly, it is very difficult, aside from monitoring neck pain or back pain, for traditional providers to determine how and when to refer for chiropractic care. And, chiropractors and other alternative care providers often just fall back on saying that what they need to do is send all patients. And, that is really inappropriate, I think.

What I'd like to do is focus on several areas, just very briefly, and rely on written materials that I've submitted for a more detailed discussion. Those areas have to do with problems with guideline development, implementation, altering practice characteristics of providers and then the impacts of guidelines on policy and reimbursement.

As I said, most guidelines are condition specific, rather than provider specific, and that leaves a problem with respect to different provider groups, explaining and determining what it is that they do and explaining that to other providers. There is difficulty integrating the care

pathways and guidelines without such a knowledge base and there needs to be a new paradigm in frame of reference in order to accomplish that. Additionally, there are some providers that lack diagnostic authority. So, they have a very difficult time explaining what it is that they do and the conditions that they actually treat. A few of the guidelines that have been developed have actually incorporated CAM input in the development process. And, there has been cross-professional challenges because of that, many of them quite vocal. CAM providers are actually required to prove what it is that they do. And, that is very, very difficult. I think that is one of the major challenges.

My recommendations to the Commission have to do with improving funding for research. I've heard that said repeatedly here today. And, also, improving cross-professional skills through supporting education, possibly through licensure. And, lastly, realize that guidelines are actually a living document that they do need to be modified and improved over time. And, so, whatever process is put in place, realize that those processes impact state and local policy and we really need to keep our knowledge base current.

The Honorable James Gordon: Thank you very much. Susan Rosen.

Susan Rosen: Hello. I'm Susan Rosen and I'm Co-Chair of the Healthcare Integration Committee for the American Massage Therapy Association, Washington Chapter. I am also one of the founding members of the National Certification Program for Therapeutic Massage and Body Work.

I'm also speaking to guidelines and their use and addressing it specifically for massage therapy. We see them necessary to provide authoritative recommendations, assure appropriate referrals and co-management and facilitate consistency of care. And, we are hoping this will result in clinical effectiveness of our work. We are not primary care providers and we do not diagnose, although we do assess and treat. We need clear communication between the referring practitioners and ourselves and algorithms are a way of cross-professional, cross-disciplinary communication tool. So, they are very important in our instance. We need innovative models of algorithms, multi-factorial that provide significant branches at decision-making points. We also need creative inclusive processes for the development of algorithms that are based on collaboration and consensus. This will honor the distinct knowledge base therapeutic approaches and philosophical perspectives of our field. Algorithms need to reflect the important role that massage therapy plays in a comprehensive healthcare program which is something I don't think has been known about in the past.

I recommend that you strongly support funding through the appropriate federal agencies for a pilot project in Washington State. This project would identify and develop algorithms for the most common muscular skeletal conditions or injuries and stress related disorders for which massage therapy is clinically effective and cost-effective. Practitioners knowledgeable in and representing a wide spectrum in the massage therapy field would work under the guidance of experts and algorithm development.

The pilot project would take place in three stages. Algorithm development, and then the testing of the guidelines out in the field in a wide spectrum of integrated clinics, and then

broad use of the algorithms through education and training of all healthcare professionals, including massage therapists. And the reason I am proposing a pilot project in Washington State is we have over 8,000 LMP's, licensed massage practitioners. Over the past five years massage therapy done by massage therapists has been included in health plans covered benefits. This has resulted in consumer increase, consumer access to massage therapy services, clinical experience by massage therapists in rehabilitation and treatment and clinical data to draw from. We are the only state that has developed two algorithms, which will undergo academic and peer review in the next six months. We are looked to as leaders in the nation.

Just to summarize, all this has been done on a volunteer basis, ultimately, with efforts like these being encouraged and supported financially, we could develop guidelines based on, in an expedient manner, and conditions covered, could then be based on clinical effectiveness and sound research. Thank you.

The Honorable James Gordon: Thank you. Let's begin, Tom, with you.

The Honorable Tom Chappell: No questions.

The Honorable James Gordon: No. Tieraona?

The Honorable Tieraona Low Dog: I'm not sure who this question, maybe Dr. Stretch, that's where it sparked it. Do you, when you are developing guidelines, I mean, do you use some of the family practice guidelines? You gave an example of asthma, which is, sort of, near and dear to my heart, like, pediatric asthma. You know, when you look at guidelines, there is behavioral, there is, certainly, lifestyle, there is the discussion of allergies, not so much nutrition, which could be tweaked by a clever naturopath. And, then, instead of drugs and that though, then there is the whole issue of nutritional supplements and botanicals. But, actually, it seems like sometimes what I hear in these testimonies is that actually there is a lot of overlap, especially with other primary care treatment plans and algorithms. Do you work within those or use those so that you don't have to reinvent the wheel on everything?

Eileen Stretch: Definitely. And, I was involved on the clinician work group, and, specifically on the asthma guideline that we did do as a pilot. And, we looked at many of the guidelines that are out there, currently, in conventional medicine. And, you know, used those, actually, as models to help. But where there is difficulty is because it is so multi-modality. And, in my experience on the guideline team at Group Health, I was included because they thought they wanted to have that CAM perspective. And then, when it actually came down to looking at the evidence, they were, well, we can't really include Echinacea because there weren't enough side effects quoted in the article. The, you know, perfect article, perfect research. But, not included because there have to be bad side effects to any intervention. And so it wasn't included. That is sort of the difficulty I see in the acceptance by health plans of any algorithms that we would put together because they are not, they don't have enough research behind them or there are too many different interventions.

The Honorable James Gordon: Effie?

The Honorable Effie Poy Yew Chow: In the American Massage Therapy Association, how do you choose the kind of massage that is acceptable or what kind of massage are accepted now in the Association?

Susan Rosen: In terms of the Association, specifically, it is a very wide range throughout the field. And then, when we developed the National Certification Program for Therapeutic Massage and Body Work, we basically went through the whole array of massage therapy approaches and body work, not excluding any. And so, that was a very large benchmark, including oriental massage, including reflexology, including, and so, we found that there was a common body of knowledge amongst all of them and that we had something to base an exam on in this case. But, what hasn't been developed are the practice guidelines. And, the practice guidelines would not, necessarily, reflect a specific technique. It would be more of a general approach to that particular condition or that particular set of conditions. And then the techniques would be through a combination of many techniques.

The Honorable Effie Poy Yew Chow: So, like shiatsu and [inaudible].

Susan Rosen: Correct.

The Honorable Effie Poy Yew Chow: Those are all kind of considered, all aspects?

Susan Rosen: Yes. And when we looked at what we actually do, the approach, the theoretical approach may vary, but there is a lot of commonality in the actual hands-on techniques.

Female Participant: Because I'm from Washington State, I have a real-life question for Dr. Eileen Stretch. Our office has opted out of the American Whole Health Network this year because we had trouble with dialoguing with the persons we were directed to about appropriate care. Are you aware of the fact, first of all, that we have two sets of guidelines. We have guidelines reached by consensus on acute low back pain. We have guidelines on subluxation base chiropractic. And, with two sets of guidelines, I'd like to know if you know the difference between the spinal [sp.] adjustment and general manipulation of the spine?

Eileen Stretch: I'm not a chiropractor. And, so, I'll have to say no. I mean, I'm not, I am involved in the naturopathic portion of our company, not the chiropractic portion in terms of being able to answer that specific question.

Male Participant: Well, the difference between a naturopathic manipulation and a chiropractic adjustment?

Susan Stretch: I'm not exactly clear what you are, the difference? I think that they can, there are probably people here who can answer this better because I don't actually do manipulation as a naturopathic physician in my own practice. We, as naturopathic physicians, we are licensed to do manipulation. I don't know that there's, I think it is more in the diagnosis, perhaps in the diagnosis, and application, than in, perhaps, the specific technique.

The Honorable James Gordon: Okay. Linnea?

The Honorable Linnea Larson: A question for Susan regarding massage research. Can you provide the data and the regarding the research published in the past five or ten years which is available to review and to show how effective, how much benefits can get from patients? And, also, have you developed, or your colleague developed a methodology for research? Because, I think it must be hard using double-blind study.

Susan Stretch: That is absolutely correct. I agree with you on that. In terms of providing research, that is part of the first step of what we would do in terms of developing clinical guidelines. We need to look at the existing research. Some of that is starting to be done, both in Canada and the United States, and there are conferences happening annually to this effect, but, it is slow, because, again, of funding and trying to, it takes knowledgeable people in research study to be able to do that. And, we need to get trained in that or need to hire people who can help us learn how to do that. But, some of it has been done. And, Heida Brenneke spoke some to the research in Europe, but it has to be translated. So, there is research out there, whether it is condition-based or specifically done by massage therapists. Sometimes there are nurses who are trained to do, and this is, you know, to do backrubs or to do a 15-minute treatment, they are given very brief training. And that's who's done the research. Again, because of the institutions through which the research is done are usually hospital settings. And, in the past, there haven't been massage therapists on staff. But that is starting to happen now.

The Honorable James Gordon: Thank you.

Susan Stretch: I just want to say, we can provide a list, are you asking for that for this Commission?

The Honorable Linnea Larson: Yes.

Susan Stretch: Okay. So we can provide what we have available to you. We'd be glad to do that.

The Honorable James Gordon: We'd also be interested in the kind of design of, the research design, that you are particularly interested in right now, the protocol. And, also, any algorithms, any, sort of, guidance that you can give us in terms of the way that it might be helpful for us to think about, particularly, about making funding available for care, what kinds of constraints? What kinds of, where should it be open and free? Where should there be constraints, because, inevitably, we are going to be coming up against that? So, if anything you've worked out that you can give us in writing that you've done, would be very helpful. Because, we'll be having a whole session on funding of services in the Spring, so, you can help us prepare for that. Thank you very much, all of you.

This will be the final group of the morning. And, Sheila Quinn is first.

Sheila Quinn: Good morning. Before Michelle starts timing me, I just wanted to let the Commissioners know how much conversation I've heard among the participants about the opportunity this hearing has afforded us to listen to each other and to celebrate, together, the accomplishments that have happened here in the northwest. It is a unique experience for us and an incredibly valuable one. So, I just wanted to say, thank you.

The Honorable James Gordon: Thank you.

Sheila Quinn: Commissioners and colleagues, patient safety, reimburseability and professional collaboration all require accountability in healthcare. But, no single activity or process guarantees accountability and there is no easy definition. I believe accountability is present when the consumer or patient has confidence in the safety, efficacy and cost-effectiveness of the treatment, and the competence and accessibility of the provider, and has recourse or opportunity for redress if something goes wrong.

In most countries, healthcare regulation is the responsibility of the central government. But here, each state regulates independently. A very imperfect world in which to establish an adequate baseline level of accountability. So, we must incorporate a whole array of activities to enhance safety, efficacy and cost-effectiveness. Perhaps the deepest level of accountability emerges from convincing research and data collection. What is really working, who is delivering it and who is benefiting from it. whether or not a state decides to regulate botanical medicine, for example.

The research that demonstrates the safety and efficacy of certain herbs, creates confidence on the part of patients and providers and the confidence drives a demand for greater accessibility.

Credible professional credentials from board examinations, accredited education, and competent specialty training provide vital information for providers and patients, even in the absence of good laws. Although there are many regulatory models, we tend to think of licensure as a single guarantor of accountability. However, licensing laws may lack essential requirements such as testing or disciplinary action. They are subject to stakeholder pressure and entrenched bias. Even the best laws must change to accommodate evolving knowledge and practices. So, even regulation is an imperfect solution.

Reputable professional groups often lead the way in setting and implementing credible standards for professional behavior through position papers, practice guidelines, and many similar activities. Even state regulators rely on the standards and opinions of professional association to help determine the specifics of licensing laws and rules and regulations.

There is research to indicate that patients achieve significantly better outcomes with providers trained in whole systems than with providers trained in modalities only. This research needs to be replicated. And, if confirmed, disseminated widely.

Recommendations: One, CAM professional associations and institutions willing to work on strengthening accountability models should have access to funding and expert assistance to guide them.

Two, CAM providers, educators and researchers must be systematically included in funded research and in high-level policy decisions because they bring the expert knowledge about whole systems and current practices to the table.

Three, national credentialing, testing and standard setting efforts should be encouraged and funding assistance provided as a vital counterbalance to our uneven regulatory climate.

I will submit an expanded version of this testimony, electronically, for your review. Thank you very much.

The Honorable James Gordon: Thank you. David Matteson.

David Matteson: Greetings and thank you. You've asked the question how has this happened in Seattle? And, Dr. Gordon, you've asked the question, how will all this get sorted out? So, a few observations and some recommendations.

As President of Pacific Solutions, I've had a 20-year focus on vision leadership, idea diffusion, organizational development, social change, public policy. And so, it is within that context that I make these observations. First, we've been talking about all the moving parts of this issue. And, what's the big picture? What's the nature of the whole of which these parts collectively comprise, organizationally, socially, culturally speaking? And the first observation is, this is about people. People trying to figure out our collective understanding and decide our collective actions about healthcare. Whoa, that was weird. Sorry. [Laughter] My son's computer. [Laughter] So, and the fact it is about people, it is about relationships. And so, how will the collective, we, establish a set of relationships that allow productive discussions and aspire out of the box thinking? It's only been through the creation of these relationships and the structured discussions that the people of Washington have come to see, accept and understand and value their interdependence.

So, without going through too much detail, the quick history that hasn't been told here this morning, I think it is important, is how some of this has happened. In the early '90's, we had a rare experimental moment. We had a strong legislative, democratic legislature, a White House that wanted to try some serious out of the box thinking on healthcare. We've passed an outrageous healthcare reform bill. A couple of years later the democrats lost control of the legislature. Republicans came in and gutted it, almost completely. There is vestiges, including things like the every category provider statute that didn't get gutted. But the other thing that's a vestige, it is critical, is the relationships that we all developed while the healthcare commission that was created held extensive hearings, subcommittees, sub, sub, subcommittees. And we all got to know each other. Small groups started banding together. And, what you see today is these groups coming back together after many years of knowing each other in a variety of settings.

So, recommendations, at the risk of being too bold in addressing such a experienced group about leadership and design, I suggest that you create a strategy that is better matched to the need. I fear that without taking a resource allocation model, sort of a utility model to the issues of healthcare, is not recognized, and this is a social movement, and not a technical question. There is some wonderful work that is being done at Harvard by Ron Heffits [sp.], the recently established Center for Public Leadership. I strongly encourage you, perhaps, to talk with Ron and get some of his perspective. His book, Questions Without Easy Answers, provides a really interesting leadership framework that is well-suited to this.

The other suggestion I have is that you look at this as a social movement. And, for direction on some of that, I suggest you look at some of the work of someone like Parker Palmer, at the Fetzer [sp.] Foundation.

And, without going through everything, I would leave my last recommendation, which is, please don't ingrain the language problem. The word CAM, complementary and alternative medicine, in my opinion, is a transitional term. And, whatever you do in your ultimate recommendations, figure out a way to get rid of that.

Thank you. [Applause]

The Honorable James Gordon: Great. Thank you. James Rotchford.

James K. Rotchford: Hello. I'm James Rotchford. I'm President of the Medical Acupuncture Research Foundation. I'm a medical doctor. And, the Medical Acupuncture Research Foundation is an arm of the American Academy of Medical Acupuncture. We are nearly 2,000 physicians who have really led the way in integrating acupuncture and to standard medical practices over the last 15 years or so.

A lot that I could talk to you about, I wanted to emphasize, you know, I gave you some handouts and details of what AMA has been doing or, more specifically, Mark's been doing. I call your attention, specifically, to the work that has happened as of today. We've published, online, a database of acupuncture references that will be available to the public. It is at acures.com, over 12,000 citations, many of which are annotated by experts in acupuncture, which, I really hope will further the progress in terms of research of acupuncture.

I wanted to talk to the Commission about many things, but I thought I'd focus, I just have a couple of minutes here, about how to approach research in this area. And, I have to speak specifically about acupuncture, that is my background. But, I think it is applicable to all areas of complimentary medicine. And rather than getting into the specifics, because that gets fairly heady and analytical, and it is just before lunch and we are tired, I thought I would talk, kind of, in analogies.

My basic recommendation to the Commission is to approach this problem in a very American way. That is, we set down rules of participation as best we can. And then we

attempt to be as inclusive as best we can. And then, we let the contest or the election determine the winners. Okay. That is basically an American way, I think.

In football, we don't determine the winner based on a reputation, how far the quarterback can throw, how many yards the team achieved. There is certain rules, this is what it takes to win the game. And I think, collectively, we can agree in terms of outcomes, how best or why those outcomes are achieved, sometimes. But, we can at least agree on outcomes that we are all looking for. I'd like to emphasize that. More to the point, we need to promote outcome research based on reliable and valid outcome measures. One caveat I would give is not, to be careful about outcomes based on one particular model.

Example, we said osteoarthritis, we are going to see if acupuncture works for osteoarthritis. Well, acupuncture might help the pain, it may help the disability, does it really help acupuncture? Will the x-ray change? Maybe not. But does that really matter. I mean, do we want to be really evaluating osteoarthritis or are we wanting people to have less pain and more mobility. I think we have to be careful of how we define the problem.

So, that is basically within my comments for today. Thank you.

The Honorable James Gordon: Thank you. Questions.

Male: Yes, this is for Sheila Quinn. You gave us a little write-up here. You mentioned ethical practices and trust in ethics. Where is the place of futility in all this? In medicine we talk a lot about medical futility and not misrepresenting things that won't work as working. What is the place of futility in CAM, an informed consent, if we haven't yet discerned what the limits of our knowledge are? And, how do we talk to patients and not misrepresent what is being done, but not deprive them of hope, medical futility?

Sheila Quinn: I don't think that differs a great deal among all the professions because even conventional medicine shows estimates of only 15% to 20% actual proof of clinical effectiveness on the practices that are most common. So, I think all, that's, where I do think ethical behavior and training in ethical behavior comes in. I think it is incumbent upon every practitioner to know not only the limits and their scope of practice, but, how to communicate what we know about effectiveness.

Now, I think that research, to me, is a somewhat limited term, which is why I put data and research, because I think there is a lot of data available that doesn't come under the rubric of research as we know it in western science. There is data that has come down from thousands of years of effective use. There is the lack of information. It was really interesting to me, somebody said they couldn't use something that didn't show side effects. Well, an herb that has been used for thousands of years and hundreds of years in recorded history and no significant side effects have emerged, has a lot of data behind it, about, perhaps, not, the maximum research model of effectiveness, but, lack of toxicity and lack of side effects.

So, I think there is a whole range of information but I didn't have time to address everything. And one of the things that I didn't get to address was pragmatic observation,

which provides data directly to the practitioner and the provider who are experiencing these therapies together. I don't think there is anything more powerful than having a personal experience of healing. And, no research project can really address the practitioner and the patient's joint experience in a healing situation. And yet, we don't have a way to wrap that into the information that is available.

So, it is a complex question, no easy answers. And, I think we just have to struggle with it in every profession.

Female Participant: I would just like to make a comment and an observation to Sheila Quinn. I believe that you were the first person here to make a statement regarding the imperfection and lack of guarantees given by licensure. And that there may be a qualitative and perhaps quantitative difference between licensure and the certification set-up by [inaudible]. Could you explain a little teeny bit about that, or, correct me if I'm wrong?

Sheila Quinn: I have been in the down and dirty arena of political efforts to obtain in licensure. And so, I have seen, firsthand, the kinds of trade-offs that are made due to stakeholder pressure and turf battles. It is really clear to me that in no way does the political arena resemble decision making that takes into account research, utility, cost-effectiveness, ethical behavior. It takes into account tremendously, money, and political expertise. So, it has made me not skeptical of licensure, which I think can provide a platform from which other accountability models can be strengthened and developed, but, I certainly don't think it is the only answer.

The Honorable Effie Poy Yew Chow: Question to Dr. Rotchford. What is the training of medical doctors for acupuncture to become part of the Association?

James K. Rotchford: The Association has developed guidelines consistent with the World Health Organizations Guidelines. There are 200 hours, supplemental hours, for licensed physicians. The Academy has also developed a certification program so that if a physician really wants to become certified in medical acupuncture beyond those basic requirements, they've established those guidelines as well.

The Honorable Effie Poy Yew Chow: Does it take into the consideration of the laws of the five element, the ancient theories of energy and [inaudible] and so forth?

James K. Rotchford: Yes. And I might just add that our Association is very diverse in terms of styles and models from a very, very strict neuroanatomical [sp.] model described to acupuncture. The very esoteric, I would call, spiritual, maybe even shamanistic [sp.] approaches to acupuncture. We are a diverse group. We come together as physicians and, I guess, with that commonality too, that it works. And, I think I want to push that to the Commission. It is emphasizing as much what works as the model.

The Honorable Effie Poy Yew Chow: Joe Helm [sp.] is related with this, Dr. Joseph Helm?

James K. Rotchford: Joseph Helms was the initial president of the American Academy of Medical Association, yes.

The Honorable Effie Poy Yew Chow: Thank you.

The Honorable James Gordon: Tom?

The Honorable Tom Chappell: David, on the question of the paradigm relationships, interrelationships, and interdependence, you are addressing the question of vocabulary. I would be interested in some of the key words that you think stand out for you as you think about this new paradigm and this new orientation to health. What are the key words that you might offer us?

David Matteson: Well, I think I am better versed in what words don't work.

The Honorable Tom Chappell: Okay. [Laughter]

David Matteson: There is an emerging use of the word integrative. But even that one depends on which end of the conversation you start from, depends on how you participate in the conversation. And, I fall back, more and more, on the question of what is health? Are we building a health system? Are we trying to fix the delivery system?

And, to me, in most of the work that I have done through decades worth of working on public policy dispute resolution and development, it really, the most critical part of any process like this is framing the correct question. Because most disputes get resolved when you get everybody focused on the same question or agreeing on the same questions in the right order. And, I think that that is one of the great challenges.

Terminology will be evolutionary. And, you know, if you get into the Margaret Wheatley [sp.] things, that organizations and systems will organize themselves, it is how you hold the conversation so that the system will agree on the essence of the principles, and, in many terms, the essence of the language that will emerge. I don't think you can, what I've discovered is, no matter how hard we try, you cannot legislate meaning into language. It bubbles up. People use it the way they want and it is getting more complex when you look at the number of new words and the vernacular on a daily basis.

So, we could attempt to give you some suggestions about that, but my notion is that that's something that will emerge out of the evolution of the process, that the good work of this Commission, it's a little bit like Bill Shore's work on the Cathedral Within. What do you do if you are building a cathedral that takes 200 years to build and you are the mason laying the foundation? How do you stay enthusiastic about the process when your entire lifetime you are not going to see anything, not a single gargoyle? So, to me, that is really, part of what your job all is, as a Commission, is to set a framework that allows the conversation to move forward. Not to try and find a specific set of answers by which the rest of us are going to fall in line behind.

The Honorable James Gordon: Great. Thank you. Thank you very much for those words. And, we welcome yours and other peoples suggestions, comments, as you watch the process unfold. And we welcome your contributions to it.

Thank you very much. We are going to adjourn for lunch. We will come back promptly at 1:05 and we'll begin with the final panel and then we'll have the

[BREAK]

Female Participant: Mitch Stargrove, Bradford Weeks, David Butters and Christopher Huson.

The Honorable James Gordon: Okay. We are going to begin now. We invite those of you who are eating to continue eating. There is an apple historical precedent including your member of the symposium where very high-class talk and eating went on at the same time. So, we'll begin. Mitch Stargrove.

Mitch Stargrove: Hello. Good Afternoon, I'd like to thank the Commission for allowing me to present testimony today. My name is Mitchell Stargrove. I am a naturopathic physician and acupuncturist with a private practice in Beaverton, Oregon. I'm also the founder and Chief Medical Officer of Integrated Medical Arts Group, Incorporated, a market-leading electronic publisher of information on CAM therapies and herbal interactions.

Thanks to the advent of the Internet, consumers are educating themselves -

The Honorable James Gordon: Could you move closer to the mike?

Female Participant: [Inaudible]

Mitch Stargrove: Closer? Okay. Thanks to the advent of the Internet, consumers are educating themselves about CAM so fast that their physicians have had a hard time keeping up. Consumers want to know which therapies and supplements can complement their conventional treatments. Or, when used preventatively, will mitigate potential disease risk. Their quest for a full spectrum of care from Advanced Medical Technologies to Complementary Approaches has never been more active.

Most consumers indicate that they want their doctors to advise them on the use and risks of these alternative options. Unfortunately, today, due to the lack of knowledge among conventional physicians about these therapies, we find consumers turning to a wide variety of information resources with friends and family topping the list. Today, information available to the public about what has interchangeably been termed natural or complementary, and, more recently, integrative medicine is fragmented, inconsistent and incomplete.

Unlike conventional medicine, which has always been founded on scientific medicine, CAM incorporates healing modalities from around the world, many of which predate the

emergence of mechanical or western medicine in the early 1900's. Despite this information void, CAM continues to be among the fastest growing healthcare approaches, worldwide.

Looking forward, however, CAM must cross the threshold into mainstream practice and to drive that

[END OF SIDE A]

[SIDE B]

Mitch Stargrove: Community, must take active measures to unify, validate and standardize the information resources available to the public. We must transform our system from two competing forms of medicine to one integrative form of whole person care, which recognizes a common framework of scientific evidence and quality of care.

At IMA, we have defined three initiatives that can help us reach this goal. First, promoting communication between patients and their healthcare providers about the use of alternative therapies. Second, educating practitioners and consumers about the efficacy of and research on natural medicine. And, third, facilitating collaboration among various types of professionals in the healthcare delivery system. All of our work attempts to address these initiatives.

First, IMA has developed a comprehensive CAM database, the integrative [inaudible] information system, or IBUS. This is the first and most comprehensive CAM database to be developed by uniting clinical practice and scientific evidence. But, in order for such databases to succeed, they must first earn the trust of doctors, practitioners and patients alike by clearly communicating the level and limitations of scientific and clinical research behind all of the information. And, by providing tools to confirm the validity of the clinical options they offer. IBUS begins to address these issues by incorporating a patients and visits module for recording outcomes of multi-factorial clinical interventions. These functions need to be improved and extended onto the Internet as a patients records and outcomes research and data gathering tool.

Recent media scrutiny of the popular -

The Honorable James Gordon: It's time. Time.

Mitch Stargrove: Okay.

The Honorable James Gordon: Do you want to make a concluding sentence, or?

Mitch Stargrove: I would just say that we've also been working on drug/herb, drug/nutrient interactions and have setup a database on the Internet for people to report such interactions events, interactionreport.org. The rest of my testimony is provided, written.