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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. business card	Jerri Fredin (partial) (1 page)	nd	b(6)
001b. testimony	to WHCCAMP Town Hall Meeting, Jerri Fredin (partial) (1 page)	10/30/2000	b(6)
002. resume	Victoria Taylor (partial) (1 page)	nd	b(6)

COLLECTION:
Federal Records
White House Commission on Complementary and Alternative Medicine Policy [WHCCAMP]

OA/Box Number: 43238

FOLDER TITLE:
WHCCAM Seattle Testimony [October 30-31, 2000] [4]

2011-0568-S
kc883

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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[001a]

#63

JSF

Jerri Spalding Fredin

(b)(6)
SEATTLE, WASHINGTON 98125
(b)(6)

White House Commission on Complementary & Alternative Medicine Policy

Testimony : Town Hall Meeting Seattle, WA, October 30, 2000

I am **JERRI FREDIN of SEATTLE** and have been an alternative health care activist since 1980.

Today I am speaking on behalf of a statewide volunteer organization, *Citizens for Alternative Health Care*, or CAHC.

My testimony focuses on the question, "*How can access to safe and effective CAM practices and interventions be improved?*"

Currently the #1 barrier to CAM practices and interventions in Washington is the law that grants supreme authority to our state's medical disciplinary board, with no provision for checks and balances. Therefore, to improve access to safe and effective CAM practices and interventions, we must change that law.

Many of us in CAHC know conventional physicians who would like to include safe and effective 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 (the *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. Glenn Warner of Bellevue. When Dr. Warner appealed to the King County Superior Court for a reversal of the board's decision — a decision made by just three board members who were neither oncologists nor CAM practitioners — Superior Court Judge Robert Lasnik, 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 that 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.*

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 can benefit both CAM and conventional physicians.

Draft copies of all five of CAHC's proposed amendments have been submitted to your commission.

We seek your support in our endeavor.

Thank you for permitting me to testify.

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[0016]

WRITTEN TESTIMONY

for the

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

October 30, 2000
Seattle, WA

Attached is a copy of the Final Draft for our Health Care Amendments for changing laws governing our state's medical disciplinary board (the Medical Quality Assurance Commission).

The "checks and balances" amendment, referred to in my oral testimony on October 30th, is on the next to the last page and reads:

> "A physician subject to a disciplinary decision by the commission shall have the right of appeal to the state judicial system, and a decision by such court shall affirm or overrule a decision of the commission subject to RCW 34.05.574." (RCW 34.05.574 spells out how judicial courts, as a form of checks and balances to state commissions, can overrule or affirm state commission decisions.)

The above sentence strikes out the following sentence, which excluded the Medical Quality Assurance Commission from any checks and balances:

> "The disciplining authority shall make the final decision regarding disposition of the license unless the disciplining authority elects to delegate in writing the final decision to the presiding officer."

The "checks and balances" amendment also requires that no longer can a panel of only three members legally revoke the license of a medical doctor. The amendment reads:

> "For matters of license revocation, a panel of the whole, consisting of regular members who have been appointed by the governor and are serving, must be convened. See RCW 18.71.015,paragraph 5."

Jerri Spalding Fredin, testifying for Citizens for Alternative Health Care
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FINAL DRAFT: HEALTH CARE AMENDMENTS

AN ACT Relating to Health Care; amending RCW 18.71.015, 18.130.180, and 18.130.050.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

RCW 18.71.015 is amended to read as follows:

The Washington state medical quality assurance commission is established, consisting of thirteen individuals, licensed to practice medicine in the state of Washington under this chapter, at least two of whom shall be physicians, a significant portion of whose practices include Integrative treatments, also known as Complementary and Alternative Medicine (CAM), two individuals who are licensed as physician assistants under Chapter 18.71A RCW, and four individuals who are members of the public, at least two of whom are consumers of Integrative treatments. Each congressional district now existing or hereafter created in the state must be represented by at least one physician member of the commission. The terms of office of members of the commission are not affected by changes in congressional district boundaries. Public members of the commission may not be a member of any other health care licensing board or commission, or have a fiduciary obligation to a facility rendering health services regulated by the commission, or have a material or financial interest in the rendering of health services regulated by the commission.

The members of the commission shall be appointed by the governor. Members of the initial commission may be appointed to staggered terms for four years. The governor shall consider such physician and physician assistant members who are recommended for appointment by the appropriate professional associations in the state. In appointing the initial members of the commission, it is the intent of the legislature that, to the extent possible, the existing members of the board of medical examiners and medical disciplinary board repealed under section 336, chapter 9, Laws of 1994 sp. sess. be appointed to the commission. No member may serve more than two consecutive full terms. Each member shall hold office until a successor is appointed.

Each member of the commission must be a citizen of the United States, must be an actual resident of this state, and, if a physician, must have been licensed to practice medicine in this state for at least five years.

The commission shall meet as soon as practicable after appointment and elect officers each year. Meetings shall be held at least four times a year and at such place as the commission determines and at such other times and places as the commission deems necessary. A majority of the commission members appointed and serving constitutes a quorum for the transaction of commission business.

The affirmative vote of a majority of a quorum of the commission is required to carry any motion or resolution, to adopt any rule, or to pass any measure of ordinary business of the commission. Except as stated below, [t]he commission may appoint panels consisting of at least three members. A quorum for the transaction of any business by a panel is a minimum of three members. A majority vote of a quorum of the panel is required to transact business delegated to it by the commission, with the exception of revocation of a physician's license. In order to revoke a physician's license, a majority of the regular commission members must concur with the decision to revoke.

Each member of the commission shall be compensated in accordance with RCW 43.03.265 and in addition thereto shall be reimbursed for travel expenses incurred in carrying out the duties of the commission in accordance with RCW 43.03.050 and 43.03.060. Any such expenses shall be paid from funds appropriated to the department of health.

Whenever the governor is satisfied that a member of a commission has been guilty of neglect of duty, misconduct, or malfeasance or misfeasance in office, the governor shall file with the secretary of state a statement of the causes for and the order of removal from office, and the secretary shall forthwith send a certified copy of the statement of causes and order of removal to the last known post office address of the member.

Vacancies in the membership of the commission shall be filled for the unexpired term by appointment by the governor within 60 days of the start of the vacancy.

The members of the commission are immune from suit in an action, civil or criminal, based on its disciplinary proceedings or other official acts performed in good faith as members of the commission.

Whenever the workload of the commission requires, the commission may request that the secretary appoint pro tempore members of the commission, except as stated below, [w]hen serving, pro tempore members of the commission have all of the powers, duties, and immunities, and are entitled to all of the emoluments, including travel expenses, of regularly appointed members of the commission; however, pro tempore members shall not participate in license revocation decisions.

RCW 18.71.010 Definitions (Also for chapter 19.130 RCW)

The following terms used in this chapter shall have the meanings set forth in this section and in RCW 18.130.020 unless the context clearly indicates otherwise:

(2) The following terms shall have the following meanings, unless the context clearly indicates otherwise.

(a) "Integrative" or "Complementary" health care, also known as "Complimentary" 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.

(b) "Conventional" health care shall mean those methods of diagnosis, treatment, or interventions that are offered by most licensed physicians as generally accepted methods of routine practice.

Chapter 18.130 RCW, Regulation of Health Professions-Uniform Disciplinary Act:

RCW 18.130.050 Authority of Disciplining Authority is amended to read as follows:

The disciplining authority has the following authority:

(1) To adopt, amend, and rescind such rules as are deemed necessary to carry out this chapter;

(2) To investigate all complaints or reports of unprofessional conduct as defined in this chapter and to hold hearings as provided in this chapter;

(3) To issue subpoenas and administer oaths in connection with any investigation, hearing, or proceeding held under this chapter;

(4) To take or cause depositions to be taken and use other discovery procedures as needed in any investigation, hearing, or proceeding held under this chapter;

(5) To compel attendance of witnesses at hearings;

(6) In the course of investigating a complaint or report of unprofessional conduct, to conduct practice reviews;

(7) To take emergency action ordering summary suspension of a license, or restriction or limitation of the licensee's practice pending proceedings by the disciplining authority;

(8) To use a presiding officer as authorized in RCW 18.130.095 (3) or the office of administrative hearings as authorized in chapter 34.12 RCW to conduct hearings. ((The disciplining authority shall make the final decision regarding disposition of the license unless the disciplining authority elects to delegate in writing the final decision to the presiding officer;)) A physician subject to a disciplinary decision by the commission shall have the right of appeal to the state judicial system, and a decision by such court shall affirm or overrule a decision of the commission subject to RCW 34.05.574.

(9) To use individual members of the boards to direct investigations. However, the member of the board shall not subsequently participate in the hearing of the case;

(10) To enter into contracts for professional services determined to be necessary for adequate enforcement of this chapter;

(11) To contract with licensees or other persons or organizations to provide services necessary for the monitoring and supervision of licensees who are placed on probation, whose professional activities are restricted, or who are for any authorized purpose subject to monitoring by the disciplining authority;

(12) To adopt standards of professional conduct or practice ((;)) for Conventional and Integrative treatments.

(13) To grant or deny license applications, and in the event of a finding of unprofessional conduct (see RCW 18.130.180, paragraph 4) by an applicant or license holder, to impose any sanction against a license applicant or license holder provided by this chapter;

(14) To designate individuals authorized to sign subpoenas and statements of charges;

(15) To establish panels consisting of three or more members of the board to perform duties of ordinary business under this chapter. For matters of license revocation, a panel of the whole, consisting of regular members who have been appointed by the governor and are serving, must be convened. See RCW 18.71.015, paragraph 5.

(16) To review and audit the records of licensed health facilities' or services' quality assurance committee decisions in which a licensee's practice privilege or employment is terminated or restricted. Each health facility or service shall produce and make accessible to the disciplining authority the appropriate records and otherwise facilitate the review and audit. Information so gained shall not be subject to discovery or introduction into evidence in any civil action pursuant to RCW 70.41.200(3).

RCW 18.130.180 Unprofessional Conduct.

(4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. The use of ((a nontraditional treatment)) an Integrative or Complementary treatment, as defined in RCW 18.71.011 by itself shall not constitute unprofessional conduct, ((provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed;)) unless by competent evidence, the Commission can establish that the treatment has a safety risk greater than that of the prevailing treatment. The absence of a prevailing treatment, alone, shall not establish unprofessional conduct. The Commission shall not revoke or deny a license to a person, nor find a licensed health care provider guilty of unprofessional conduct solely because of that person's use of an Integrative therapy as defined in RCW 18.71.011 or because that person's therapy departs from Conventional practice as defined in RCW 18.71.011.

(5) Qualified health professionals licensed under this chapter shall have the right to use any Conventional and/or Integrative treatment they determine appropriate to achieve the best therapeutic outcome. Patients have the right to be treated by a qualified health care provider licensed under this Chapter for any health problem or illness with any Conventional or Integrative treatment that the patient requests. Health care providers have the duty to provide written information to the patient as to the proposed course of treatment, including substances to be used and known side effects.

#65

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A Guide On The Complaint Process

Washington State Department of Health

Washington State Department of Health
Health Professions Quality Assurance Division
1300 Quince Street S.E.
P. O. Box 47860
Olympia, WA 98504-7860

Internet address: http://www.doh.wa.gov

DOH Pub 657-002 (2-00)

#64

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

Statement by Don Sloma, MPH, Executive Director, Washington State Board of Health

Welcome to the Northwest, and thank you for the opportunity to share some background on Washington state government's interest in complementary and alternative medicine.

I do not speak today for my current employer, but as the former lead staff to our State Senate's Health and Long Term Care Committee. In that capacity, I worked on our state's 1993 Health Services Act. This was proto-type legislation for President Clinton's ill-fated National Health Security Act. Our bill differed from the federal effort in many ways, not the least of which being that ours actually became law until many of its provisions were repealed in 1995. But two provisions survived that now serve as a statutory base for CAM integration here. These are

1. the "any category of provider" law, and
2. a Health Personnel Resources Plan, including its connection to a health training scholarship and loan forgiveness program.

Others can speak to the specific provisions of these laws as well as how they have been interpreted. I am here to share with you how they got into our state's law books.

Prior to the health reform debates of the early 1990s, Washington enjoyed a good, but quiet reputation in national health policy circles as an interestingly progressive province. We had done a few interesting things like pass comprehensive HIV/AIDS legislation and create a separate state health department. And we had authorized licensure of naturopaths, acupuncturists, chiropractors, midwives and others who did not enjoy such official recognition elsewhere. But few knew that state government had actually examined and debated the value of these "alternative medicine" professions in some detail through the state legislature's Sunset process during the 1980s, and found little reason to reject or limit them. By the end of the 1980s, despite some suspicions in some quarters of established Medicine, these professions were well established here as safe, well-disciplined parts of our health community.

The 1990s brought concern about the medical financing crisis here and around the nation. Double digit inflation, poor health outcomes, increasing rates of uninsurance and underinsurance and so forth. The litany has become as familiar and accepted now as twenty five year old .com millionaires who commute to work on skateboards and pay cash for all their medical care. Then, as today, decrying our nation's health care financing mess was a great way to win elective office. Actually fixing it, was a poor way to stay there.

But never mind. In 1993, our state's political leadership resolved to address the health care financing issue comprehensively. Armed with the recommendations of a "blue ribbon" Health Services Study Commission, our state became the first in the nation to establish the complex series of statutory mandates and regulations that came to be known as health reform. The scheme required all employers and individuals to purchase insurance coverage for a state determined "decent" minimum package of health services. (Optional supplements would also be available) All coverage was to be purchased only from state certified health plans. Minimum benefits, provider network adequacy, quality standards, market conduct standards, risk pooling arrangements and more aspects of these private managed care insurance carriers were to be regulated by the state. In exchange for meeting these standards, a certified health plan would be entitled to sell in a guaranteed market of all of our state's residents, since

universal financial participation by employers and state residents was also mandated. (Those of marginal means were to receive public subsidies to participate as consumers.) In other words, for a time, state policy in Washington defined a closely regulated universal access, private market for the bulk of health care.

We were mindful that such a bold step could create many problems, including the two that led to the provisions you are interested in. For one thing, this closely regulated market could devastate any licensed health care provider whose services were excluded from it. For another, an adequate number of many types of health personnel, especially primary care providers, would be needed. Accordingly, the legislation contained provisions that

1. required every certified health plan to include in their network every category of provider whose scope of state licensed practice included treatment for a condition covered by the minimum benefits package, and
2. established a state health personnel resources plan, which would identify shortage areas and professions (especially primary care providers) and make appropriate recommendations for work force development.

When Congress rejected President Clinton's health reform effort, our state's effort was doomed. Technically, this was because our state's effort hinged upon federal action to suspend the ERISA exemption of employers from state regulation of employer sponsored health benefits plans. Without that, our reform could not ensure a broad enough market, so the rest was simply untenable, financially as well as politically. A major repeal and retrenchment effort began here in 1995. And it may not be over yet.

However, because of some sloppy lobbying by the business community and the insurance industry in 1995 when they orchestrated the repeal of much of our health reform law, the "any category law" was retained. Despite numerous political and legal assaults, the law remains, applying now to any condition covered by a health plan that happens also to be covered by our state's Basic Health Plan.

The health personnel resources plan (HPRP) functioned well during its first few years, but ultimately it too was sacrificed to the reactionary forces that took hold in the wake of our 1993 efforts. Before it was repealed however, the HPRP defined "primary care" providers to include naturopaths, thus making them eligible for our state's health scholarship and loan forgiveness program. The repeal of the HPRP did not undo this, and several naturopaths have benefited from that program. More importantly perhaps, this effort to define a health care provider work force that did not exclude these CAM providers seems to have legitimized some CAM providers as partners with MDs in ways that had not been seen before.

So, our state's now largely defunct health care reform scheme left in its wake two bases for the growth of CAM in our state. But these bases were established less as carefully considered policies to endorse CAM and promote its integration than as a result of care to avoid systematically excluding CAM as an already accepted form of medicine from a system intended to regulate all health interventions. The reasons for this acceptance were tied up both in the state's already established acceptance of CAM practitioners as licensed providers, and in the political activism of CAM associations in an environment full of the will to act on health financing issues much more broadly.

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Complementary And Alternative Health Professions Regulated In The State Of Washington

Health Profession	First Licensed In Washington State	Scope Of Practice As Currently Defined In Washington State Statutes	Number Currently Licensed
Acupuncturist	1985	Acupuncture means a health care service based on an Oriental system of medical theory utilizing Oriental diagnosis and treatment to promote health and treat organic or functional disorders by treating specific acupuncture points or meridians. Acupuncture includes the following techniques: a) Use of acupuncture needles to stimulate acupuncture points and meridians; b) Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; c) Moxibustion; d) Acupressure; e) Cupping; f) Dermal friction technique; g) Infra-red; h) Sonopuncutre; I) Laserpuncture; j) Point Injection therapy (aquapuncture); and k) Dietary advice based on Oriental medical theory provided in conjunction with techniques under a) through j). (RCW 18.06.010)	568
Chiropractor	1974	(1) Chiropractic is the practice of health care that deals with the diagnosis or analysis and care or treatment of the vertebral subluxation complex and its effects, articular dysfunction, and musculoskeletal disorders, all for the restoration and maintenance of health and recognizing the recuperative powers of the body. (2) Chiropractic treatment or care includes the use of procedures involving spinal adjustments, and extremity manipulation insofar as any such procedure is complementary or preparatory to a chiropractic spinal adjustment. Chiropractic treatment also includes the use of heat, cold, water, exercise, massage, trigger point therapy, dietary advice and recommendation of nutritional supplementation except for medicines of herbal, animal, or botanical origin, the normal regimen and rehabilitation of the patient, first aid, and counseling on hygiene, sanitation, and preventive measures. Chiropractic care also includes such physiological therapeutic procedures as traction and light, but does not include procedures involving the application of sound, diathermy, or electricity. (3) As part of a chiropractic differential diagnosis, a chiropractor shall perform a physical examination, which may include diagnostic x-rays, to determine the appropriateness of chiropractic care or the need for referral to other health care providers. The chiropractic quality assurance commission shall provide by rule for the type and use of diagnostic and analytical devices and procedures consistent with this chapter. "Massage" and "massage therapy" mean a health care service involving the external manipulation or pressure of soft tissue for therapeutic purposes. Massage therapy includes techniques such as tapping, compressions, friction, Swedish gymnastics or movements, gliding, kneading, shaking, and facial or connective tissue stretching, with or without the aids of superficial heat, cold, water, lubricants, or salts. Massage therapy does not include diagnosis or attempts to adjust or manipulate any articulations of the body or spine or mobilization of these articulations by the use of a thrusting force, nor does it include genital manipulation. (4) Chiropractic care shall not include the prescription or dispensing of any medicine or drug, the practice of obstetrics or surgery, the use of x-rays or any other form of radiation for therapeutic purposes, colonic irrigation, or any form of benipuncture. (5) Nothing in this chapter prohibits or restricts any other practitioner of a "health profession" defined in RCW 18.120.020(4) from performing any functions or procedures the practitioner is licensed or permitted to perform, and the term "chiropractic" as defined in this chapter shall not prohibit a practitioner licensed under chapter 18.71 RCW from performing medical procedures, except such procedures shall not include the adjustment by hand of any articulation of the spine. (RCW 18.25.005)	1,993
Massage Therapist	1975	"Massage" and "massage therapy" mean a health care service involving the external manipulation or pressure of soft tissue for therapeutic purposes. Massage therapy includes techniques such as tapping, compressions, friction, Swedish gymnastics or movements, gliding, kneading, shaking, and facial or connective tissue stretching, with or without the aids of superficial heat, cold, water, lubricants, or salts. Massage therapy does not include diagnosis or attempts to adjust or manipulate any articulations of the body or spine or mobilization of these articulations by the use of a thrusting force, nor does it include genital manipulation. (RCW 18.108.010)	8,731

Health Profession	First Licensed In Washington State	Scope Of Practice Defined In Washington Statutes	Number Currently Licensed
Midwife	1917	Any person shall be regarded as practicing midwifery within the meaning of this chapter who shall render medical aid for a fee or compensation to a woman during prenatal, intrapartum, and postpartum stages or who shall advertise as a midwife by signs, printed cards, or otherwise. Nothing shall be construed in this chapter to prohibit gratuitous services. It shall be the duty of a midwife to consult with a physician whenever there are significant deviations from normal in either the mother or the infant. (RCW 18.50.010)	116
Naturopathic Physician	1919	Naturopathic medicine or naturopathy is the practice by naturopaths of the art and science of the diagnosis, prevention, and treatment of disorders of the body by stimulation or support, or both, of the natural processes of the human body. A naturopath is responsible and accountable to the consumer for the quality of naturopathic care rendered. The practice of naturopathy includes manual manipulation (mechanotherapy), the prescription, administration, dispensing, and use, except for the treatment of malignancies or neoplastic disease, of nutrition and food science, physical modalities, homeopathy, certain medicines of mineral, animal, and botanical origin, hygiene and immunization, common diagnostic procedures, and suggestion; however, nothing in this chapter shall prohibit consultation and treatment of a patient in concert with a practitioner licensed under chapter 18.57 or 18.71 RCW. No person licensed under this chapter may employ the term "chiropractic" to describe any services provided by a naturopath under this chapter. "Nutrition and food science" means the prevention and treatment of disease or other human conditions through the use of foods, water, herbs, roots, bark, or natural food elements. "Manual manipulation" or "mechanotherapy" means manipulation of a part or the whole of the body by hand or by mechanical means. "Physical modalities" means use of physical, chemical, electrical, and other noninvasive modalities including, but not limited to heat, cold, air, light, water in any of its forms, sound, massage, and therapeutic exercise. "Homeopathy" means a system of medicine based on the use of infinitesimal doses of medicines capable of producing symptoms similar to those of the disease treated, as listed in the homeopathic pharmacopeia of the United States. "Medicines of mineral, animal, and botanical origin" means medicines derived from animal organs, tissues, and oils, minerals, and plants administered orally and topically, excluding legend drugs with the following exceptions: Vitamins, minerals, whole gland thyroid, and substances as exemplified in traditional botanical and herbal pharmacopoeia, and nondrug contraceptive devices excluding interuterine devices. The use of intermuscular injections are limited to vitamin B-12 preparations and combinations when clinical and/or laboratory evaluation has indicated vitamin B-12 deficiency. The use of controlled substances is prohibited. "Hygiene and immunization" means the use of such preventative techniques as personal hygiene, asepsis, public health, and immunizations, to the extent allowed by rule. "Minor office procedures" means care incident thereto of superficial lacerations and abrasions, and the removal of foreign bodies located in superficial structures, not to include the eye; and the use of antiseptics and topical local anesthetics in connection therewith. "Common diagnostic procedures" means the use of venipuncture to withdraw blood, commonly used diagnostic modalities consistent with naturopathic practice, health history taking, physical examination, radiography, examination of body orifices excluding endoscopy, and laboratory medicine which obtains samples of human tissue products, including superficial scrapings but excluding procedures which would require surgical incision. "Suggestion" means techniques including but not limited to counseling, biofeedback, and hypnosis. "Radiography" means the ordering but not the interpretation of radiographic diagnostic studies and the taking and interpretation of standard radiographs. (RCW 18.36A.020 and 030)	471

#72

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

Testimony by: Sheila K. Rhodes MA, Director of Social Services, Mt. Baker Care Center, 2905 Connelly Ave. Bellingham, WA 98225. (360-734-4181).

Summary: Herbal remedies offer safe alternatives to standard prescriptive practices in long term care facilities and an inpatient drug treatment program. One herbal tea eliminates urine odor; another prevents urinary tract infections. A third herbal tea has been used successfully for ten years in an inpatient drug and alcohol detoxification center in lieu of drugs to ameliorate symptoms of withdrawal. Herbal remedies are less expensive. Yet physicians are unwilling to authorize their use. They rightfully want to know what impact the teas have on other medications they prescribe for their patients. There is no readily accessible document, such as the **Physician's Desk Reference** to which they can refer for information nor were they taught about CAM in medical school.

Specifics: In particular, one herbal tea comprised of equal parts of chickweed, alfalfa and peppermint successfully eliminates urine odor among elderly patients without harmful side effects. The tea improves digestion and cools the urine. A second herbal tea called Waterfall Tea reduces the instance of kidney infections. Comprised of uva ursi, cornsilk, pipsissewa, catnip, lemongrass, nettles and marshmallow root, this tea has low level antibacterial qualities which flush the urinary tract system and reduces the likelihood of recurring UTIs. Our doctors presently prescribe low level antibiotics continuously for elderly patients with chronic UTIs. Continuous use of antibiotics adversely affects the productive flora in the intestines and leads to yeast infections. A third herbal tea made up of peppermint, scullcap, lemon balm, valerian root, passion flower, and cramp bark has been used successfully for ten years at St. Joseph Hospital Detox Center to reduce spasms, nausea and insomnia related to withdrawal. Patients released from the center continue to use the tea on their own because they have found it also helps reduce their craving.

1.Coordinated Research and Development to Increase Knowledge of Complementary and Alternative Medicine Practices and Interventions.
Question: How can we more effectively integrate the CAM and conventional research communities to stimulate and coordinate research? Answer: Recognize the validity of CAM. Use European research as a basis for US research to confirm long held assertions. Call upon recognized seats of CAM learning such as our local Bastyr College to link reputable sources of information. Encourage conventional research communities to work with CAM researchers by offering research grants in this area of inquiry. Lean on the national sources of research funding to designate funds for this purpose.

2. Guidance for Access to, Delivery of, and Reimbursement for Complementary and Alternative Medicine Practices and Interventions.
Question: Do you have ready access to CAM practices and interventions? Answer: Yes, in my community of Bellingham, Washington, there is a plethora of CAM practices and interventions. The challenge is in knowing how to use them wisely.
Question:How can access to safe and effective CAM practices and interventions be improved? Answer: If our health care coverage systems are ever going to support CAM, we need a review system by which we as consumers and health providers can determine who/what is reputable and who/what is not. The community grapevine in this instance is less reliable than it might be because of the element of historical folklore that impacts CAM.
Question: What types of CAM practices and interventions should be reimbursable through federal programs or other health care coverage systems? Answer: All CAM practices and interventions which have been validated by solid research and proven effective should be reimbursable. Eventually, reimbursers will discover that health care provision is less expensive if CAM practices and interventions are incorporated. Case in point: chiropractors and naturopaths were not covered by insurance in this state a few years ago. Today, their use is encouraged by my HMO. In fact, I am able to schedule up to 10 visits to a chiropractor per year without seeing my primary care physician (PCP) for a referral. To see any allopathic specialist I still must first obtain a referral from my PCP.

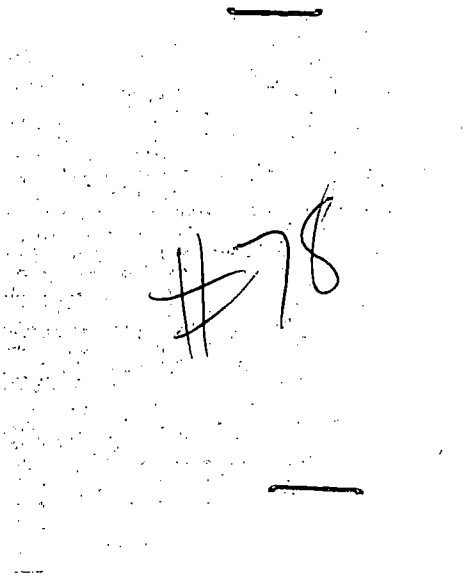
3. Training, Education, Certification, Licensure, and Accountability of Health Care Practitioners in Complementary and Alternative Medicine.
Question: What training and education should be required of all health care providers to assure access to safe and effective CAM practices and interventions? Answer: Naturopaths receive the same basic medical training as allopathic physicians but the latter do not receive naturopathic training. Expand the syllabus in medical schools in the nation to incorporate teaching in CAM and the training in how to access and incorporate CAM in their practice of medicine. No one can be expected to know it all, but all can be expected to know how to find out what is useful.
Question: Are performance standards or practice guidelines needed to ensure the public will have access to the full range of safe and effective CAM practices and interventions? Answer: Absolutely. The challenge will be to find ways to accept the existing performance standards established for each form of CAM. Each is unique and based on, in some cases, centuries of practice.

4. Delivery of Reliable and Useful Information on Complementary and Alternative Medicine to Health Care Professionals and the Public.
Question: How can useful, reliable, and updated information about CAM practices and interventions be made more accessible? How would you like to receive such information? Answer: The way to make them more accessible is to

use existing resources and expand them. For example: for herbal and homeopathic remedies, include them in the **Nurse's Desk Reference (NDR)** and the **Physician's Desk Reference (PDR).** These are "bibles" in daily use in every nursing facility and doctor's office. Future medical texts can include an array of treatment modalities.

Question: As a consumer, what kinds of information about CAM practices and interventions are most needed and important to you? Answer: I want to know how the herbal remedies I use interact with any medications I take. I want to know in what order I should be taking them. Presently, I am learning by experience. I have severe varicose veins in one leg. For recurring bouts of phlebitis, my physician prescribed warfarin and aspirin along with heat and elevation. The medications caused gastric distress. An herbal specialist recommended tincture of horse chestnut, which I now use in lieu of warfarin/aspirin. I also drink green tea. Now the only time I risk an attack of phlebitis is after a contusion to the area. However, I discovered that I needed more information about my self healing program when I bled unusually from a minor surgery conducted in my doctor's office.

Question: As a health care provider, what kinds of information about CAM practices and interventions are most needed an important to you? Answer: The roadblocks to introducing CAM into nursing home protocol are physician ignorance/resistance and consumer unwillingness to try any CAM which is not endorsed by the PCP. Another roadblock is lack of coverage by insurance providers. What is most needed is a thorough understanding by the medical community of how CAM can be incorporated into conventional medical practice. The most immediate help would be to expand the **NDR and PDR** to cover herbal and homeopathic remedies. Britain publishes a reference manual that has done this. Next, place emphasis on CAM in future medical refresher courses. All physicians must accrue a certain number of continuing education hours. You validate CAM by making it required learning.


#78

Homeopathy in the United States

Jennifer Jacobs, MD, MPH, Department of Epidemiology, University of Washington, Seattle

I am a conventionally trained family physician who has been using homeopathy in my practice for nearly 25 years. I also do clinical research in homeopathy at UW. I have seen many patients helped by this practice, without the high cost and dangerous side effects of conventional medications. I believe that the best way for homeopathy and other CAM modalities to be integrated into the health care system is to train physicians like myself to use it in their medical practices.

Homeopathy is the primary CAM modality being used in Europe. In the US, the use of homeopathy has increased five-fold in the past 10 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 specific license in homeopathy. Homeopathy is practiced by a wide variety of licensed providers including MD's and DO's, PA's and 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, one for the medically licensed, one for naturopaths, and one that is open to all. Some health insurance companies offer optional coverage for homeopathy, but most patients pay out of pocket.

Homeopathy is not taught in any US medical schools, although it is often included in courses on CAM and it is taught in naturopathic schools. Most practitioners study homeopathy in postgraduate 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 US are few, due to the generic nature of the medicines, which cannot be patented. The NIH has funded several homeopathic studies and is now requesting new proposals for funding. Currently, I am heading up a study of homeopathy for hot flashes in breast cancer patients funded by the Department of Defense at Providence Medical Center in Seattle.

Actions that can improve access to homeopathy include:

1) Establish Departments of CAM in medical schools and residency programs where homeopathy can be taught
2) Cost effectiveness research to document the 15% cost savings of homeopathic physicians in France
3) Reimbursement policies that allow adequate time for homeopathic consultations
4) Inclusion of homeopathy in low-income clinics
5) Hospital privileges for homeopathic physicians
6) 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 in more depth at a later meeting.

#79

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BASTYR UNIVERSITY

SPIRITUALITY HEALTH AND MEDICINE

Professional Certificate Program 2000

Thank you to the committee for holding these hearings.

My name is Paul Reilly. I am a naturopathic physician in practice for 15 years.

I currently work in an integrated cancer clinic where oncologists work shoulder to shoulder with naturopathic physicians and acupuncturists. I will limit my discussion to day to cancer.

Cancer will affect one American in three and cause the death of one in five. Despite 25 years of the war on cancer we have not significantly improved survival for the vast majority of cancers. 50% of those diagnosed with cancer will eventually die of their disease. Along the way they will suffer from multiple treatment-caused side effects and even worse, 1% will develop a treatment-induced secondary cancer.

CAM therapies can improve this dismal situation. They can increase response to treatment, reduce side effects, and prevent recurrences. For example the simple addition of melatonin to treatment for advanced cancers doubled response rates and 1 year survival over treatment without melatonin. Adding mushroom extracts to radiation quadrupled survival in advanced lung cancer patients.

Our experience at CTCA has confirmed these research results. Our patients have better quality of life and we see enough so-called "hopeless cases" turn around to convince us that CAM therapies are essential ingredients in cancer care.

The Journal of Clinical Oncology recently reported that 2/3 of cancer patients are using some form of CAM. They need help making good choices. NDs with their rigorous science-based training in natural therapies are uniquely qualified to provide the link between conventional oncology and CAM.

The federal government can help cancer patients in four ways:

1. RESEARCH DOLLARS: Provide increased funding to research CAM therapies in the field of oncology.

2. PATIENT CARE DOLLARS: Medicare, Medicaid, and all federal insurance programs should mandate coverage for CAM services during oncology care.

3. EDUCATIONAL DOLLARS: Support accredited CAM school to the same degree as all other medical training institutions, especially through supporting fledgling research departments.

4. EDUCATIONAL OPPORTUNITIES: Mandate that any hospital or medical institution which receives federal support permit students from all accredited health care schools, including CAM schools, to have access to training at those institutions. The cross-pollination of ideas will improve care for everyone.

Making changes such as this can speed the integration of cancer care and thus improve the lives of millions of Americans suffering from cancer.

Thank you.

#98

101

Testimony of Dr. Jennifer Booker, Naturopathic Physician
White House Commission on Complementary and Alternative Medicine Policy
Oct. 31, 2000

My name is Jennifer Booker. I am a Naturopathic Physician and Chair of Practice Guidelines for the American Association of Naturopathic Physicians. Thankyou for this opportunity to speak. I will define Practice Guidelines, describe how they help fulfill the needs of this White House Commission and President Clinton's Executive order, and will urge this commission to support funding for this project.

Evidence based practice guidelines are statements used by health care providers and patients to make health care treatment decisions. These health care or practice guidelines will provide useful and reliable information to health care provides and patients about naturopathic medicine. These guidelines can also be used to define appropriate access and delivery of naturopathic medicine for health care systems.

We know practice guidelines are a good idea and will help everybody involved in delivery and in receiving health care. We also know they cost money to generate. Since the "every category of provider" mandate law, third party payers, health care policy makers and regulators in the state of WA 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 2.3 million 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 profession, wants. High quality evidence based practice guidelines that are understandable and therefore useful for health care plans and delivery systems, for patients and for government decisions makers.

Peer driven and led Naturopathic medicine 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 evidenced based Naturopathic medicine serves the consumer, payer and 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.

Jennifer Booker N.D.
6326 Martin Way E., Ste. 205
Olympia WA 98516

Email: jenniferbooker@earthlink.net
Tel.: 360-491-2111

Chair: Practice Guidelines, American Association of Naturopathic Physicians

5700 SW Spokane Street
Seattle, WA 98116

White House Commission on Complimentary and Alternative Medicine
Town Hall Meeting, Seattle, October 31, 2000

I'm Victoria Taylor, President 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 the client's home. (Attachments 1 and 2)

Thank you for the opportunity to speak about quality assurance at this hearing.

While I am here to talk about quality assurance for midwives, most of these elements are applicable to any health care provider. When I use the term 'midwife' I am specifically referring to Licensed Midwives and Certified Professional Midwives, however, in Washington State, this term includes Certified Nurse-Midwives as well.

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:

1. National certification and reciprocity for practitioners
2. Nationally accredited educational institutions
3. Outcome data collection and research
4. State protected confidentiality assurance for peer, incident and practice reviews
5. Guidelines and standards of care authored by the profession itself
6. Active professional association(s)

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 for healthy pregnant women.

The presence of quality care in the midwifery profession is important to all CAM providers because Midwifery care itself is frequently a gateway to alternative care modalities and often the consumer's first encounter with viable 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.

What midwives need from this commission:

1. Adopt the CPM credential and NARM standardized testing as national certification with resulting reciprocity of midwifery practice nationally.

2. Recommend that it be legal for Certified Professional Midwives to practice midwifery in birth centers and at the client's home in every state.

3. State or federal legislative protection for confidentiality of peer, practice and incident reviews for providers who practice in non-institutional settings.

4. Recommend that risk guidelines for consultation and referral, practice guidelines and content of care documents be developed by midwives and that this be done within their state or national professional associations and not by legislators or other health care practitioners unfamiliar with the midwifery process of care.

5. Support the collection and reporting of midwifery outcome data at the state and national level through funding of the already existing MANA statistical collection database.

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

Thank you for hearing my testimony.

BACKGROUND

QA/QI practices of Washington State midwives:

- Engage in midwifery practice site reviews and peer reviews
- Collect practice outcome data and report results annually (Attachment 2, pg3)
- Obtain CEU's for attending annual midwifery association conferences and other educational offerings
- Use Federal and Washington State rules and regulations (Attachment 3), the Midwives' Association of Washington State (MAWS) Standards for the Practice of Midwifery (Attachment 4), and midwifery journals as a guide to scope of practice
- Use MAWS Practice Guidelines for Risk Screening and Indications for Consultation and Referral for Out-of-Hospital Birth (Attachment 5)
- Submit a Current Plan for Consultation, Emergency Transfer and Transport to the Department of Health annually
- Develop and refer to their policy and procedure manual and protocol manual to guide clinical actions, communicate with other health care providers and further define scope of practice.
- Use written informed consents and client handouts to educate their clients and as an adjunct to discussion of possible tests or treatments.

Washington State rules and regulations (Attachment 3) **in support of midwifery care:**
(The first three rules and regulations apply to every licensed CAM provider).

- ✓ Confidentiality protection for participants in peer reviews in a non-institutional setting:
  Coordinated Quality Improvement Program RCW 43.70.510, RCW 70.41.200, Title 42, 34.05.482 and WAC 246-50

- ✓ Inclusion of every category of health care provider in basic health plan services:
  Every Category of Provider RCW 48.43.045

- ✓ Clear, strongly worded outline of elements of informed consent, written or oral:
  Informed Consent RCW 7.70.060

- ✓ Health care plans prohibited from restricting women's access to type of women's health care provider of their choice by asking for prior physician referral:
  Women's Health Care Services RCW 48.42.100

- ✓ Midwifery education and scope of practice for non-nurse midwives:
  Midwifery RCW 18.50 and WAC 246-834
  Legend Drugs and Devices WAC 308-115-250
  Use of Epinephrine and Magnesium Sulfate in Midwifery care

- ✓ Availability of medical malpractice insurance at physician level coverage ($1million/$3million):
  JUA for Midwifery and Birthing Centers Malpractice Insurance RCW 48.87 and WAC 284-87

What fostered collaboration among CAM providers, across public and private agencies and organizations.

- Collaboration was not engendered by any single activity or circumstance.
- The long-term presence of Seattle Midwifery School and its teaching relationship with Bastyr University faculty and students certainly laid the groundwork for cooperation among midwives and naturopathic physicians.
- Midwifery care itself is a gateway to alternative care.
- Midwives are committed to accountability for quality assurance within the midwifery profession and that strengthens our credibility with other providers. This is manifested in several ways:
  - A strong midwifery professional association
  - Midwives active in improving their individual practices and the midwifery profession
  - Midwifery association documents supporting quality care and defining scope of practice
  - Active participation by individual midwives in the legislative process.
- Active Office of the Insurance Commissioner - brought together CAM providers for a series of meetings to assist in the development of guidelines within each profession.

National professional associations that support quality and accountability in direct entry midwifery care.

1. The Midwives Alliance of North America (MANA), a national professional association with strong support for a variety of educational approaches to midwifery training.

2. The North American Registry of Midwives (NARM) developed and administers a national midwifery exam and issues the Certified Professional Midwife national certification, which is accepted in many states, including Washington, as the state-licensing exam.

3. The Midwifery Education and Accreditation Council (MEAC), accredits direct entry non-nurse midwifery educational institutions.

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b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[002]

Victoria M. Taylor, LM, CPM

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homemidwif@aol.com

Objective: To consult with and educate midwives in using risk management and quality improvement principles in the design and delivery of midwifery services regardless of setting, route of education or scope of practice. I am committed to the following for midwives: Quality improvement is not just what we do, it is who we are.

Professional Experience

Quality Midwifery Associates (QMA)
Seattle, WA
1995 to present

Owner and principal in a company specializing in the design and implementation of quality assurance and risk management programs for midwives in independent practice. Design and administer Professional Liability Reviews and site visits for all midwives who purchase malpractice insurance through the Joint Underwriting Association of Washington State. Assist in development of content of midwifery care documents, grievance process and quality assurance program at the request of the Midwives' Association of Washington State. Design and deliver courses on writing policy and procedure manuals and protocol manuals. Consult with other state midwifery organizations on the formation of their quality improvement programs. Worked with Providence Hospital in the initial development of hospital-privileging guidelines for Licensed Midwives in Washington State. Co-developed and delivered Non-Pharmacological Pain Relief Guideline for the Office of the Insurance Commissioner Complimentary and Alternative Provider/Managed Care meetings in 1998 and 1999. Guest lecturer addressing the business aspects of midwifery and quality assurance/risk management mechanisms for Seattle Midwifery School, Bastyr University, Portland Naturopathic College and Oregon School of Midwifery. Professional liability review workshop leader at Midwives' Association of Washington State and Midwives Alliance of North America annual conferences.

Home Midwifery Service
Vancouver, Washington
1993 to 1996

Owned and operated metropolitan midwifery practice delivering full scope maternity care for healthy pregnant women requesting home birth as an option. Actively promoted the availability and use of doulas for labor support and assisted in the formation of Doulas of Vancouver. Clinical Manager of Arlington Birth Center, Washington, while the owner was completing course work toward her CNM.

Bickson, Pitcher, Seeton & Co.
Toronto, Canada
1989 to 1991

Worked as a management consultant and coach to executives and managers of Fortune 500 Companies in Canada and the United States. Helped design and lead courses as well as provided coaching that enabled people to produce breakthroughs in their personal effectiveness and in achieving quantifiable bottom line financial results.

W.E. Foundation
Sausalito, CA
1987 to 1989

Keeler Motor Car Company
Latham, NY
1984 to 1987

Southeastern Otsego Health Center
Worcester, NY
1981 to 1982

Washington Hospital Center
Washington, DC
1978 to 1981

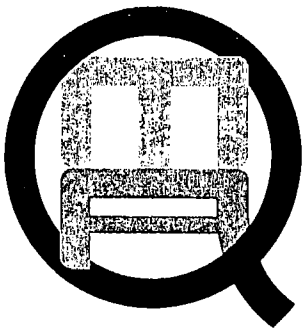
Maternity Center Associates
Bethesda, MD
1975 to 1981

Professional Associations

- *Board of Directors, Seattle Midwifery School*
- *Member: American Society for Quality*
- *Member: Midwives Alliance of North America, Midwives' Association of Washington State, National Association of Childbearing Centers, and Citizens for Midwifery*
- *Participant in numerous medical, midwifery, communication, business, and quality and risk management courses*
- *Produced educational events and courses for 50 to 100 people*

Education

- *Seattle Midwifery School, Seattle, WA; Licensed Midwife 1993, Certified Professional Midwife 1998*
- *Montgomery College, Takoma Park, MD; RN Degree, Phi Theta Kappa, 1978*
- *Howard University, Washington, DC; 1975-76 Toward BSN*



QUALITY
MIDWIFERY
ASSOCIATES

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PROFESSIONAL LIABILITY REVIEW SUMMARY

The Professional Liability Review (PLR) is a type of midwifery practice review that focuses on risk management and quality of care. This review was developed by Quality Midwifery Associates (QMA) in conjunction with the Midwives' Association of Washington State in order to meet the need of midwives in Washington for a comprehensive on-site practice review. The on-site PLR, using the National Committee on Quality Assurance accreditation standards as a guide, is designed to be conducted every third year. A Professional Liability Review is required of all midwives who purchase professional liability insurance through the Joint Underwriting Association (JUA) of Washington State. Washington Casualty Company and the Board of the JUA use the results of the review in determining eligibility for continued professional liability insurance coverage. The cost of the PLR in Washington for midwives in the JUA is covered by the midwife's annual premium.

The PLR is conducted when the following criteria are met:

- The Joint Underwriting Association (JUA) of Washington State and/or a professional liability insurance carrier contracting with QMA requests a formal review of the midwife's practice to meet the conditions for obtaining or continuing professional liability insurance; and/or,

- The individual midwife, electing to pay directly for the review, requests a formal risk management audit; and,

- The midwife agrees to release to Quality Midwifery Associates (QMA) information that QMA deems pertinent; and,

- The midwife agrees to hold QMA, its employees, directors, officers, contractors and agents harmless from any claims the midwife may have relating to QMA Professional Liability Reviews, and any reports and recommendations made by QMA relating thereto.

Victoria Taylor, LM, CPM
Revised: April 2, 1998; June 1, 1999; April 8, 2000

PR 1.0 FORMS

PR 1.1 Confirmation of Review Letter

PR 1.2 Self-Evaluation Tool (SET) consisting of the following forms and checklists:

- **1.2.0** Site Review Schedule Request
- **1.2.1** Document Checklist
- **1.2.2** Policy and Procedure Manual
- **1.2.3** Equipment
- **1.2.4** Medications
- **1.2.5** Supplies
- **1.2.6** Office/Clinic Site
- **1.2.7** Annual Statistics
- **1.2.8** Medical Record Review - single chart
- **1.2.9** SET Forms Checklist
- **1.2.10** Requirements for the Conduct of the Site Visit
- **1.2.11** Protocol Manual
- **1.2.12** Medical Record Review - 5 Chart Compilation
- **1.2.13** Recommendations Worksheet

PR 1.3 Post Review Evaluation of the PLR and the site reviewer

PR 2.0 THE REVIEW and THE REVIEWER

When requested as outlined above, a site review shall be performed by QMA. The Self-Evaluation Tool will be mailed to the midwife to be completed and returned fourteen (14) business days before the site visit. A QMA reviewer will review the SET before beginning the site visit to verify that the information, documents and data provided are current, complete and within the timeline specified for the review. The site reviewer, utilizing the SET previously submitted by the midwife under review, will then recheck items while on site for accuracy.

A minimum of five charts shall be randomly selected by the reviewer from the charts of clients delivered within the timeline specified for the review and shall include those reflecting significant morbidity or mortality. Additional charts may be reviewed at the discretion of the reviewer.

A succinct on-site verbal report shall be given at the conclusion of the Professional Liability Review. During the conference the site visitor shall review anticipated findings of fact regarding the midwife's quality related systems, risk management and midwifery practices, and records. The summation conference verifies the reviewer's findings and clarifies any inconsistencies in information with the midwife. The reviewer shall also inform the midwife if she expects to make further recommendations. The reviewer does not make a determination nor provide conclusions regarding the midwife's Professional Liability Review status or eligibility for malpractice insurance.

Victoria Taylor, LM, CPM
Revised: April 2, 1998; June 1, 1999; April 8, 2000, October 5, 2000

The senior reviewer at Quality Midwifery Associates is Victoria Taylor, CPM, a RN with OB hospital and physician office experience and a Licensed Midwife who was in private midwifery practice until 1996. She received training in conducting accreditation site reviews through the National Association of Childbearing Centers, has researched QA/QI issues since 1993, studied the accreditation review process designed by the National Committee for Quality Assurance and is a member of the American Society for Quality.

PR 3.0 DATA COLLECTION

Annual birth outcome statistics are to be made available before the site-visit and each year between site visits as requested. The data submitted for midwifery care provided in an out-of-hospital setting must include:

PR 3.1 Total number of undelivered clients in practice at start date
PR 3.2 Number of new clients accepted during the specified time
PR 3.3 Number of clients transferred/left AP for non-medical reasons
PR 3.4 Number of undelivered clients
PR 3.5 Number of delivered clients
PR 3.6 Number of clients transferred for medical reason antepartum
PR 3.7 Number transported to hospital intrapartum
PR 3.8 Reasons for maternal transport intrapartum
PR 3.9 Number transported to hospital postpartum
PR 3.10 Reasons for maternal transport postpartum
PR 3.11 Number of neonates transported; emergent/non emergent
PR 3.12 Reasons for neonatal transport
PR 3.13 Number of cases of neonatal mortality
PR 3.14 Number of cases of neonatal morbidity
PR 3.15 Number of cases of maternal mortality
PR 3.16 Number of cases of significant maternal morbidity

PR 4.0 PROFESSIONAL LIABILITY REVIEW REPORTS

A confidential copy of the report and any recommendations prepared by the site visitor, if a site visit was performed, or prepared after credentials, statistics and document review and update, shall be submitted to the JUA or a contracting professional liability insurance carrier, or to the midwife contracting as an individual, within 30 days of the review. A confidential copy of all reports and correspondence shall be kept in the midwife's file at the offices of Washington Casualty Company unless otherwise noted.

PR 5.0 MIDWIFE FILE

Midwives must agree to make the requested materials available to QMA for risk management purposes fourteen (14) business days before the scheduled PLR. The PLR recommendations are based on information received from the midwifery practice and do not necessarily address all areas needing improvement. The responsibility for risk assessment and undertaking improvements rests solely with the midwife under review.

Victoria Taylor, LM, CPM
Revised: April 2, 1998; June 1, 1999; April 8, 2000, October 5, 2000

PR 6.0 MIDWIFE APPEALS PROCESS

In Washington and states with a JUA, the midwife undergoing a Professional Liability Review may request that the Joint Underwriting Association reconsider any decisions and/or recommendation(s) of the professional liability insurance carrier that she/he feels are unfair or with which she/he is otherwise in disagreement. In the remaining states the appeals process will be consistent with the laws and arrangements of that state.

Victoria Taylor, LM, CPM
Revised: April 2, 1998; June 1, 1999; April 8, 2000, October 5, 2000

RCW Index

7.70.010-030	Actions for Injuries Resulting from Health Care
7.70.060	Consent Form – Contents – Prima facie evidence – Failure to Use
7.71	Health Care Peer Review
18.36	Naturopathy
18.50	Midwifery {includes **18.130** – Uniform Disciplinary Act; regulation of health care professionals}
18.79	Certified Nurse Midwives; Advanced Registered Nurse Practitioners
26.28.10	Age of Majority
26.44.030	Abuse of Children; reports – duty and authority to make
43.70.510; 70.41.200; Title 42; 34.05.482	Coordinated Quality Improvement Program
48.43.045	Every Category of Provider
48.42.100	Womens Health Care Services
48.87	Midwives and Birthing Centers – Joint Underwriting Association
49.17	Washington Industrial Safety & Health Act
70.02.030-120	Medical Records
70.24.090-095	Control and Treatment of Sexually Transmitted Diseases
70.24.310-330	Rules for AIDS Education and Training
70.42	Medical Test Sites
70.54.220	Practitioners to Provide Information on Prenatal Testing
70.58.070-080	Vital Statistics
70.58.320-322	Reports of Sentinel Defects
70.83.010-030	PKU & Other Preventable Heritable Disorders
70.95K	Biomedical Waste

WAC Index

246-100-016	Communicable Diseases; confidentiality
246-100-021	Communicable Diseases; responsibilities of health care providers
246-100-071	Communicable Diseases; reporting to Health Department
246-100-076	Communicable Diseases; reportable diseases and conditions
246-100-186	Communicable Diseases; health care facilities
246-100-200(2)	Communicable Diseases; health care providers duties
246-100-207	Communicable Diseases; HIV testing
246-100-208	Communicable Diseases; HIV counseling
246-329	Childbirth Centers
246-338-020(2b)	Medical Test Site Rules
246-338-030	Medical Test Site Rules; waiver
246-338-050	Medical Test Site Rules; proficiency testing
246-338-080	Medical Test Site Rules; quality assurance
246-420	Sentinel Birth Defects
246-490-039	Vital Statistics; certificates in pencil not allowed
246-50	Coordinated Quality Improvement Program
246-650-020	Newborn Screening; performance of screening tests
246-680	Prenatal Tests – Congenital and Heritable Disorders
246-834	Midwives
246-836	Naturopathic Physicians
284-87	JUA for Midwifery and Birthing Centers Malpractice Insurance
308-115-250	Legend Drugs and Devices
468-300-700	Preferential Loading – Ferry System
Protocols	Use of Epinephrine and Magnesium Sulfate in Midwifery
Policy	Opthalmic Agents Approved for the prevention of Opthalmia Neonatorum in the Newborn (1981)

ATTACHMENT A - 476

MIDWIVES' ASSOCIATION OF WASHINGTON STATE

QUALIFICATIONS FOR PROFESSIONAL MEMBERSHIP

1. ACTIVE LICENSURE TO PRACTICE MIDWIFERY OR NURSE-MIDWIFERY IN THE STATE OF WASHINGTON.

2. COMPLIANCE WITH LEGAL REQUIREMENTS IN WASHINGTON STATE FOR THE PRACTICE OF MIDWIFERY OR NURSE-MIDWIFERY.

3. COMPLIANCE WITH THE STANDARDS OF PRACTICE AS DEFINED BY THE PROFESSIONAL ORGANIZATIONS, THE MIDWIVES' ASSOCIATION OF WASHINGTON STATE (MAWS) OR THE AMERICAN COLLEGE OF NURSE-MIDWIVES (ACNM).

4. CURRENT CERTIFICATION IN NEONATAL RESUSCITATION BY THE AMERICAN ACADEMY OF PEDIATRICS AND THE AMERICAN HEART ASSOCIATION FOR ALL MEMBERS PRACTICING IN AN OUT-OF-HOSPITAL BIRTH SETTING.

REVISED: AUGUST 1995

Midwives' Association of Washington State

Standards for the Practice of Midwifery

I. Practitioner

Midwifery Practice:

1.1 Occurs within the parameters of Washington state law.

1.2 Includes maintenance of currency of practice as evidenced by continuing education contact hours as required by the Midwives' Association of Washington State (MAWS) or the American College of Nurse-Midwives (ACNM).

1.3 Demonstrates knowledge, clinical skills and judgment as described in the MAWS Core Competencies for Basic Midwifery Practice or the ACNM Core Competencies for Basic Nurse-Midwifery Practice.

1.4 Fosters the delivery of safe, satisfying and economical maternity services and may extend to certain areas of gynecology, family planning and well baby care according to individual licensure.

1.5 Includes participation in a state sanctioned quality assurance/improvement program for the evaluation of midwives within the setting in which the practice occurs and within legal requirements.

1.6 Seeks consultation for medical conditions outside scope of practice and makes appropriate referrals.

1.7 Elicits client feedback to evaluate and modify clinical services.

1.8 Uses the MAWS or ACNM clinical practice mechanism for introducing new/unconventional clinical practices.

Revised: August 1995

2. ENVIRONMENT

MIDWIFERY PRACTICE:

2.1 MAINTAINS A SAFE ENVIRONMENT BY HAVING THE APPROPRIATE EQUIPMENT AVAILABLE INCLUDING THAT NEEDED TO ASSESS MATERNAL, FETAL AND NEWBORN WELL-BEING; EQUIPMENT AND SUPPLIES TO MAINTAIN CLEAN AND/OR ASEPTIC TECHNIQUE; ANTIHEMORRHAGIC AGENTS; AND, EMERGENCY RESUSCITATION EQUIPMENT.

2.2 ARRANGES FOR 24 HOUR CLINICAL COVERAGE FOR THE MIDWIFERY PRACTICE.

2.3 INCLUDES RISK FACTOR ASSESSMENT FOR INITIAL AND CONTINUING MIDWIFERY SERVICE FOR EACH CLIENT.

3. DOCUMENTATION

MIDWIFERY PRACTICE:

3.1 INCLUDES COMPLETE, ACCURATE, LEGIBLE, UP-TO-DATE AND CONFIDENTIAL RECORDS OF THE CLINICAL CARE PROVIDED BY THE MIDWIFE FOR EACH CLIENT. THESE SHALL BE MADE AVAILABLE TO APPROPRIATE HEALTH CARE PERSONNEL UPON CONSULTATION OR TRANSFER OF CARE. OTHER RECORDS, AS REQUIRED BY LAW, MAWS AND/OR ACNM SHALL BE MAINTAINED AS WELL.

3.2 INCLUDES A SET OF ESTABLISHED, WRITTEN PRACTICE GUIDELINES THAT ARE CONGRUENT WITH THE SCOPE OF PRACTICE AND STATE REGULATIONS FOR THE MIDWIFERY PROFESSION. PRACTICE GUIDELINES SHALL CONTAIN A CLEAR, WRITTEN PLAN FOR REFERRAL, CONSULTATION, HOSPITAL ACCESS AND TRANSFER.

4. CLIENT RELATIONS

MIDWIFERY PRACTICE:

4.1 PROVIDES INFORMED CONSENT AND UPHOLDS CONSUMERS' RIGHTS TO INFORMATION AND SELF-DETERMINATION.

4.2 PROVIDES ACCURATE INFORMATION REGARDING THE SCOPE OF MIDWIFERY PRACTICE, FINANCIAL CHARGES, MEDICAL CONSULTATION ARRANGEMENTS AND THE RIGHTS AND RESPONSIBILITIES OF THE CLIENT.

4.3 FOCUSES ON CHILDBEARING AS A FAMILY-CENTERED LIFE EXPERIENCE AND ENCOURAGES THE ACTIVE PARTICIPATION OF FAMILY MEMBERS IN CARE AS APPROPRIATE.

4.4 INCORPORATES EDUCATION IN CLINICAL CARE AS APPROPRIATE.

4.5 STRESSES CONSUMERS' RESPONSIBILITY FOR ACTIVE PARTICIPATION IN THEIR OWN HEALTH CARE.

4.6 PROVIDES AN AVENUE FOR RESOLVING CLIENT GRIEVANCES.

5. COMMUNITY RELATIONS

MIDWIFERY PRACTICE:

5.1 OCCURS AUTONOMOUSLY/INDEPENDENTLY AS A PROFESSION AND IS INTERDEPENDENT WITH OTHER PROFESSIONALS AND COMMUNITY RESOURCES IN ORDER TO REFER CLIENTS AND MEET THEIR MEDICAL, PSYCHOSOCIAL, ECONOMIC, CULTURAL OR FAMILY NEEDS.

5.2 RECOGNIZES THAT, FOR THE PROTECTION OF THE MOTHER AND INFANT, OR MIDWIFE/MIDWIFERY PROFESSION, IT IS THE RIGHT OF THE MIDWIFE TO REFUSE OR DISCONTINUE HER/HIS SERVICES, AND THE RESPONSIBILITY OF THE MIDWIFE TO MAKE THE APPROPRIATE REFERRALS FOR CONTINUATION OF CARE.

Midwives' Association of Washington State
c/o Seattle Midwifery School • 2524 16th Ave South, Room 300 Seattle, WA 98144
(206) 860-4120

PRACTICE GUIDELINES FOR RISK SCREENING AND INDICATIONS FOR CONSULTATION AND REFERRAL FOR OUT-OF-HOSPITAL BIRTH

Licensed Midwives and Certified Nurse Midwives are specialists in the normal childbearing cycle. When problems arise which deviate significantly from the normal prenatal, intrapartal or postpartum course, midwives consult with a physician regarding the client's care or, in some cases, refer the client to a physician.

Evaluation of the childbearing woman is an on-going process which begins during the initial prenatal consultation and continues through the completion of care in the postpartum period. Risk screening is the assessment of conditions which may indicate a deviation from normalcy and the identification of those conditions which require physician involvement. In making this assessment, a midwife relies on her training, skill, and clinical judgment. There are only a few conditions which are absolute contraindications to out-of-hospital birth. There are other conditions which individually or cumulatively may indicate a trend toward abnormality.

This document is representative and not an exhaustive list of the conditions that a midwife may encounter. This document is not meant to replace the clinical judgment or experience of the midwife. There may be variations based on agreements between individual midwives and their consulting physician. New clinical practices may be undertaken in adherence to the Midwives' Association of Washington State's *Mechanism for Introducing New/Unconventional Clinical Practice,* or the American College of Nurse Midwives' *Guidelines for the Incorporation of New Procedures into Nurse Midwifery Practice.*

I. Pre-existing Conditions

The following maternal conditions existing prior to the current pregnancy require that a physician be consulted and may require physician referral:

1. Cardiovascular Disease/Hypertension
2. Pulmonary Disease/Active tuberculosis/asthma if severe or uncontrolled by medication
3. Renal Disease
4. Hepatic Disorders
5. Endocrine Disorders
6. Significant Hematological Disorders
7. Collagen-Vascular Diseases
8. Neurologic Disorders
9. Cancer
10. Infectious Diseases; the treatment of which is beyond the midwife's scope of practice
11. Current alcoholism or abuse
12. Current drug addiction or abuse
13. Current severe psychiatric illness
14. Isoimmunization
15. Previous C-section with classical incision
16. Inadequate home environment/support structures for mother and infant
17. Other significant deviations from normal as assessed by the midwifery staff

IV. Postpartum Conditions

The following maternal conditions arising during postpartum require that a physician be consulted and may require physician referral.

1. Seizure
2. Significant hemorrhage not responsive to treatment
3. Sustained maternal vital sign instability
4. Uterine prolapse
5. Lacerations, repair of which is beyond midwife's level of expertise
6. Development of any of the conditions listed previously
7. Other significant deviations from normal as assessed by midwifery staff

V. Neonatal Conditions

The following conditions arising in a neonate require that a pediatric physician be consulted and may require referral.

1. Persistent respiratory distress
2. Persistent cardiac irregularities
3. Central cyanosis or pallor
4. Prolonged temperature instability
5. Prolonged glycemic instability
6. Seizure
7. Apgar score less than 7 at five minutes of age
8. Birth weight <2000 grams
9. Significant clinical evidence of prematurity
10. Significant jaundice or jaundice prior to 24 hours
11. Loss of >10% of birth weight/failure to thrive
12. Major apparent congenital anomalies
13. Birth injury requiring medical attention
14. Other significant deviations from normal as assessed by midwifery staff

II. Antepartum Conditions

The following conditions arising during current pregnancy require that a physician be consulted and may require physician referral:

1. Labor before the completion of 37 weeks gestation
2. Presentation other than vertex at term
3. Multiple gestation
4. Significant bleeding
5. Gestational Diabetes Mellitus uncontrolled by diet
6. Severe anemia
7. Evidence of PIH or pre-eclampsia
8. Documented IUGR
9. Thrombophlebitis
10. Known fetal anomalies or conditions affected by site of birth, with an infant compatible with life
11. Fetal demise after 12 completed weeks gestation
12. Abnormal fetal NST
13. Abnormal ultrasound findings
14. Isoimmunization
15. Documented placental abnormalities, or previa
16. Post-dates pregnancy (>42 completed weeks)
17. Positive HIV antibody test
18. Parent(s) ill prepared for out-of-hospital birth
19. Inability of client and midwife to come to an agreement regarding plan of care
20. Development of any of the conditions listed previously
21. Other significant deviations from normal as assessed by the midwifery staff

III. Intrapartum Conditions

The decision to transport at any time during labor or the postpartum period will be based on any serious deviations from the normal course of events. The following conditions arising during labor require that a physician be consulted and may require physician and/or hospital referral. It should be noted that in some intrapartum situations, because of time urgency, it may not be prudent to pause management long enough to seek physician consultation before management is given.

1. Abnormal fetal presentation
2. Maternal fever
3. Hypertension with or without additional signs or symptoms of pre-eclampsia
4. Thick meconium stained fluid with delivery not imminent
5. Persistent and/or severe fetal distress
6. Significant abnormal labor pattern in active labor
7. Abnormal bleeding
8. Maternal seizure
9. ROM > 24 hours with unknown or GBS+ status
10. Prolapsed cord
11. Anaphylaxis
12. Active genital herpes in labor
13. Adhered placenta or retained without bleeding
14. Client's desire for pain medication, consultation or referral
15. Development of any of the conditions listed previously
16. Other significant deviations from normal as assessed by the midwifery staff

A Summary Discussion of Clinical Practice Guidelines and the Impact on Complementary and Alternative Care Providers

Austin McMillin, DC
Private Practice
Tacoma, Washington

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

It is an honor and privilege to be invited to briefly offer my views regarding clinical practice guidelines and their impact on complementary and alternative care providers and care delivery. CAM services are clearly in demand in the health care marketplace, and thus far traditional care delivery and reimbursement systems have been struggling to determine how best to include CAM services into those systems. I am grateful to the members of the commission for their time and investigative commitment to help improve the role of complementary and alternative care delivery nationally.
The foundation for my comments includes 11 years of clinical experience in private practice; five years of work done with the State of Washington as a technical advisor for health care reform, with concurrent related studies of chiropractic procedures, descriptions, and value; private consulting regarding CAM services in the insurance arena; consulting work regarding the development and implementation of multidisciplinary practice guidelines; and participation in the Washington State Complementary and Alternative Medicine Clinician Workgroup where guidelines were a primary issue.

The primary intent of clinical guidelines is to integrate and assimilate the knowledge base about given conditions to improve overall patient care and successful outcomes of intervention. Secondarily, guidelines help to influence claim adjudication. They are intended to influence clinical decision making; however, it is difficult for traditional providers to make decisions about the appropriateness of CAM services, or integrate them into guidelines without a working knowledge about assessments and services in those settings. Without such knowledge, how is a traditional allopathic provider to know when to suspect that his patient might have problems with Chi that an acupuncturist may help, or a spinal subluxation that a chiropractor may help? The inability to determine how and when to refer patients cross-professionally into a CAM environment, coupled with lingering skepticisms, often results in no referral at all. This problem is much less prevalent with care coordination from CAM providers into allopathic settings. Theoretically, true multidisciplinary practice guidelines would facilitate proper referrals and care coordination between CAM and traditional provider groups.

Although good in their intent, guidelines pose several significant problems for CAM providers. These relate to the guideline development process, implementation, altering practice patterns of health care providers in general, and the impact of guidelines on policy and reimbursement. I believe that the Federal government can be instrumental in improving overall patient care by taking positive action in these areas.

Problems relating to guideline development:

Various clinical practice guidelines have been developed, revised, and redeveloped over the years in an effort to describe and improve care pathways for patients. The design of these care pathways has been necessarily condition-specific rather than provider-specific, and the vast majority have been put forth from traditional allopathic groups.

The first major problem lies within differing perspectives about the conditions for which guidelines are being developed, beginning with how each profession arrives at a diagnosis/impression. The most obvious example is apparent when comparing the diagnostic impression of acupuncturists as compared to traditional medical diagnoses. Not only are the assessment methods radically different, but reporting of the final impressions are not even remotely similar. It is challenging at best to discuss integrated guidelines of care with any meaning without developing new, common frames of reference that can be understood and agreeable to all providers. Without such a framework, guidelines are reduced to symptom management guidelines that are provider- specific and lack true integration of the range of care alternatives. Further, some CAM provider groups lack diagnostic authority under their scope of practices, and therefore have less direct influence over guideline recommendations relating to their professions. There is also a strong emphasis on health and wellness with CAM groups in general, and these concepts fall outside of condition-based guideline development.

With those guidelines that have been proposed, few have included CAM providers in the process of guideline development. As such, CAM procedures have been either been neglected entirely or inadequately represented within those pathways. There also has been a history of vocal cross-professional challenges to care pathways that recommend CAM-type procedures, such as in the case of the AHCPR Guidelines for the Treatment of Acute Low Back Pain in Adults. Further, opponents of one set of guidelines are free to develop care pathways that more adequately support their respective position. Treating providers are left wondering which guidelines are the more appropriate to follow.

Once invited to participate, CAM groups are often asked to "prove" their approach, ultimately as judged by the traditional medical profession.. Often the threshold for the level of evidence is quite high and overly rigid, excluding all but the most stringent study data. This is especially problematic for CAM providers. It is typical for them to be asked for randomized, controlled studies (RCTs) citing the efficacy of CAM procedures for them to be considered for inclusion. Studies of such magnitude have largely been lacking for CAM interventions, largely attributable to poor funding and research inexperience. Further, research is always subject to design imperfections and slanted interpretation. As evidenced by the CAM

Clinician Workgroup here in Washington State, CAM providers are solidly committed to working at improving the level and quality of information regarding their approaches, and interfacing with the traditional medical system. Absent RCT quality data, CAM providers have encouraged the use of other available information, such as case studies, clinical expertise, and concensus to develop "seed" pathways to encourage best practice strategies.

Guidelines overly slanted toward RCT bias while excluding other viable sources of practice information may be viewed as controversial and met with resistance by the various provider communities. In opposition are guidelines with an over reliance on theory or misrepresentation of available data, leaving them overly generalized leaving no clear influence on decision making or adjudication, and also ultimately controversial. For one reason or another, there is a lack of universal support for those guidelines that have been developed to date. Even though guideline development is a long, arduous, exhaustive, and expensive process, those in disagreement with the end result can abandon existing guidelines and create their own.
At the federal level, strong support of true multidisciplinary best practices (e.g.; those that are effective, have good outcome, are cost effective, and enjoy high patient satisfaction) will positively influence the guideline development process nationally. Resisting endorsing those with poor design or those that have neglected the input from stakeholders is an effective start. Improved funding to CAM provider groups earmarked for research would also be highly beneficial, as would support for multidisciplinary research efforts. It would also be beneficial to support ongoing task forces/agencies with diverse and unbiased multidisciplinary provider participation in guideline and practice recommendation development.

Problems relating to the logistics of implementation:

Currently, guidelines are developed, posted by supporting associations or constituents, and possibly posted at the National Guideline Clearinghouse. In rare cases, copies of Guidelines are made available to members of select professions, but not all groups effected by the guideline itself. They are simply made available. There is no actual plan of implementation into the provider community.

As clinical information becomes increasingly accessible and clinical problems, including those managed in CAM settings, are more highly scrutinized, practice guidelines will need to be rapidly modified to keep pace with new developments and greater levels of understanding. Intuitively, practice recommendations need to rely contemporary thinking, yet there is no reliable process in place to ensure that guidelines are regularly revisited once created. Additionally, given all of the possible conditions for which practice guidelines could be conceivably developed, dissemination to all stakeholders becomes potentially monumental.

I would encourage either Federal support to commit agency resources to multidisciplinary guidelines development, such as that formerly in place under the

Agency for Health Care Policy and Research, or support for guideline development privately in academia. The range of CAM provider input is vital. Either avenue could avoid political slowing of guideline development processes and revisions. Efficiency of information dissemination could be achieved through electronic exchange, and "packaging" multiple guidelines together in care pathway algorithms. Ultimately, base guidelines and revisions need to be disseminated to all stakeholders.

Lastly, there should be some process to accumulate actual provider feedback over time in an effort to improve initial recommendations and reduce undue burden on providers.

Problems relating to altering past practice patterns:

There is ample evidence to suggest that the practice patterns of individual care providers is difficult to change. Just because a guideline is published does not necessarily mean that it will have any subsequent impact on patient care delivery. The chiropractic profession saw this first hand after the publishing of the AHCPR Guidelines for Acute Low Back Pain in Adults. Given the high statistics of presentations to physicians for low back pain in the general population, one would have expected there to have been a sharp rise in the volume of referrals to chiropractic providers for care including spinal manipulative or adjustive therapy, and rehabilitative exercise and reactivation. Yet most chiropractors saw little if any change in incoming medical referrals.

Failure to modify practice behavior regarding CAM services is thought to be attributable to case management habits, poor education about CAM providers and services, and mistrust due to lack of communication or personal relationship building.

Although Federal influence may not be able to build personal relationships, it may help promote an environment with will facilitate improved interprofessional relations. Funding for education at both the pre-doctorate and post-graduate levels is an important first step, especially as it relates to interprofessional interaction with CAM groups by traditional allopathic providers. Advancing interprofessional skills can be accomplished by integrating protocol and communication strategies within competency and licensure testing. Additionally, developing incentives to promote "best practice" care pathways that include CAM options and allow patients to pursue CAM care if it is their preference will help open the door to more appropriate use of CAM services once "best practice guidelines" have been developed.

Challenges relating to policy and reimbursement:

By far, one of the greatest dilemmas is how to successfully use guidelines to set policy and reimbursement strategies. The Federal government clearly sets precedent in this area, as state and private institutions look to action and policy set at the national level as their template for local policy. In working with the Technical Advisory Group for Washington State Health Care Reform RBRVS Steering Committee, we frequently received reports of national policy prior to considering

what to do with our local policy decisions. The private payer community also looks to national policy to design coverage and reimbursement limitations.

Because of the influence the Federal government has over the rest of the adjudication and administration arenas, great care need to be exercised when supporting specific guidelines. Full explanations need to be offered regarding guideline selection, interpretation, and use.

Perhaps even more fundamentally, strong support at the Federal level for equitable benefits and coverage consistent with CAM scopes of practice is vital. Even if guidelines are developed showing favorable integration and use of CAM services, access will be limited or even discouraged with continued poor and inequitable reimbursement policies.

Of the guidelines that are present today, many have been used by the payers and policymakers to override the clinical judgment of the provider, as though the guideline has predicted ever practice presentation permutation. There have also been attempts at suggesting that guidelines imply a standard of care, and that practices outside the guideline should be subject to punitive action, despite the fact that clinical guidelines capture only the most common encounters and fail to capture the range of more complicated "outlier-type" presentations. An example that applies to my own profession again can be shown with the AHCPR Guidelines for Acute Low Back Pain in Adults. In that guideline, recommendations are made for acute back pain, most case of which are said to resolve in 6 weeks. The guideline cautioned against major signs of greater problem, and failed to make specific recommendations for those cases that, in fact, did not resolve according to the guideline. It is exactly these unresolved. Case that are so costly to our society. It also failed to comment on recurrences, which are common. And after guideline publication, intermediate level complicating factors, referred to as "yellow flags" were put forth with no integration into the initial guideline. It was not helpful that the commissioning agency was eliminated in the interim. Providers were left to manage for themselves without guidance.

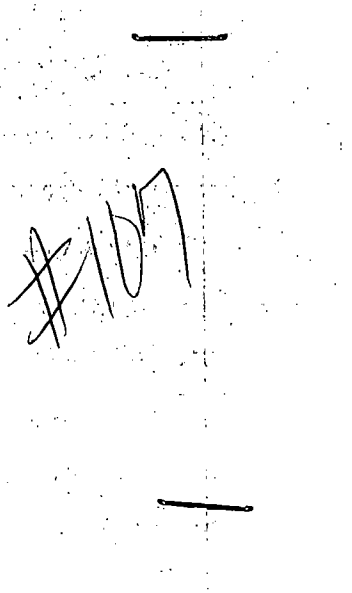
It would be extremely beneficial for the Federal government to support fair and equitable coverage of services for all providers, and ensure equal reimbursement for services of essentially the same nature. Finally, it should be acknowledged that policy is often difficult to change once set, and therefore caution and formal process should be exercised in all policy development processes.

#105

Sheila Quinn
Town Hall Meeting, Seattle, WA
October 30-31

ACCOUNTABILITY in an IMPERFECT WORLD

- DATA/RESEARCH
  Controlled clinical trials, bench research, outcomes research, patient satisfaction measures, utilization data, cost effectiveness data, health services and field research, best cases data
- CREDENTIALS
  Professional education, accreditation, testing for board exams and certification, specialty training, continuing education
- GOVERNMENTAL REGULATION
  Certification, registration, licensure, peer review, scope of practice, public health laws, OSHA laws
- PROFESSIONAL SELF-REGULATION
  Association eligibility criteria, peer review for complaints, position papers, expert consensus, continuing education, specialty training, practice guidelines, clinical standards, quality improvement plans
- TRUST AND ETHICS
  Patient-provider relationship and communication; ethical practices training and ethics review processes
- PRINCIPLES AND PHILOSOPHY
  Significantly better patient outcomes with providers trained in whole systems than with providers trained in modalities only (acupuncture research)
- FREQUENCY OF PROVIDER USE OF DIAGNOSTIC AND TREATMENT TECHNIQUES
  Higher frequency generally improves provider performance and patient outcomes for certain procedures and services.
- PROFESSIONAL LIABILITY RECORDS
  Malpractice claims, licensing board complaints, state association complaint history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MEDICAL
ACUPUNCTURE
Research
FOUNDATION

Comments by the President: James K. Rotchford, MD MPH
To the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP)
Seattle Town Meeting: October 31st 2000

MARF Background (Please see attached detailed information sheet)

1. Research arm of the American Academy of Medical Acupuncture an organization of over 1700 licensed physicians who have integrated medical acupuncture into their clinical practices.

2. Has played an important role as advocate to research regarding acupuncture:

a. Has convened several major research conferences.

b. Annual Research contest
i. $10,000 in awards

c. Instrumental in establishing annotated bibliography of acupuncture references. It's work was instrumental in the formulation of the bibliography for the1997NIH consensus conference on Acupuncture.

d. Published grant resources available for those interested in research in Acupuncture.

e. Advises AAMA members interested in research endeavors.

3. Online **MARF Database of Acupuncture References**
a. WWW.ACUBRIEFS.COM
i. Over 12,000 citations
ii. Many of the references from generallly non-indexed journals have annotated abstracts
iii. Monthly annotated abstracts of current literature published in subscription free newsletter. Visit **www.acubriefs.com**

RESEARCH STRATEGIES:
1. Emphasize outcome studies.
a. We are too ignorant of specific mechanisms involved.
b. Specific Mechanisms are not what we need to initially pursue.
c. Process and Context may be defining issues.
d. We might find consensus with regard to what constitutes a favorable outcome. Outcomes/observations should drive process/theoretical models, not vice versa.
2. How one defines the problem has implications on what solutions will be found.
a. Example Osteoarthritis
3. Problem with definitions
a. imprecise: Acupuncture

(Over)

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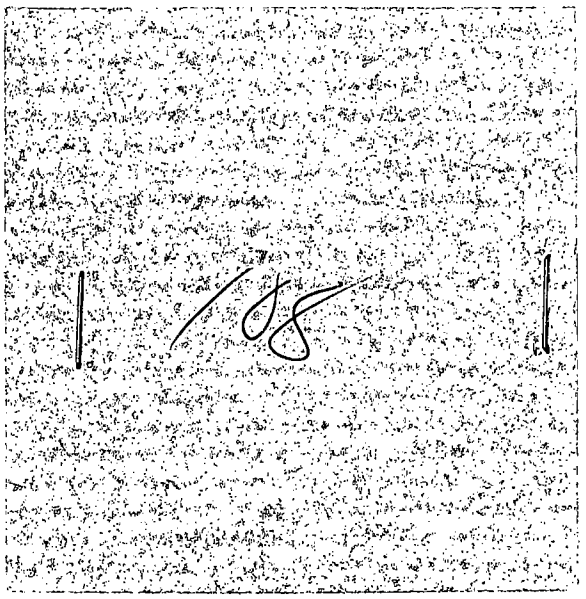
b. confounding: Placebo Effect
c. adverse event: Subjective/contextual especially in non-linear models of medicine.

4. Recommend randomized studies comparing head to head different alternative and complementary approaches as adjunctive to standard medical care with regard to common presenting "symptoms". My "belief" is that all the interventions are best in the context of patients benefitting from the best of all worlds if evidence supports such. Also medical doctors are more likely to make objective diagnoses that would enhance the eventual interpretation of the data. Also medical doctors are more likely to be part of large institutions where such studies could be done.

Example: All adult patients presenting to outpatient clinics for knee pain would be randomized to standard western medical care and physical therapy, standard care and practitioner of acupuncture, standard care and practitioner of homeopathy, standard care and practitioner of naturopathy, standard care and practitioner of chiropractic. This study would be preceded by pilot studies to assure that there is no major variation amongst outcomes of practitioners within each group. If significant variations present, practitioners would be selected based on their background, style of practice, and likelihood of being helpful. No practitioner would be required to do anything specifically. They could choose to see the patient daily if they felt the condition warranted it and was part of their standard of care. On the other hand if the patient went to see let's say the chiropractor and the chiropractor felt there was nothing they could do for the individual's knee then OK. Outcomes at 4, 8, 26, and 52 weeks would be evaluated using reliable and valid outcome measures for pain and disability. Direct costs as well as indirect costs to patients would be included eg: Number of visits, extra travel, etc.. I think compliance is an important variable as well.

Once we get a better idea of what works then we can start to design studies which start to answer why?

JK Rotchford, MD, MPH
President of MARF



Good ~~morning~~ afternoon. I'd like to thank the Commission for inviting me to present testimony today. My name is Mitchell Stargrove, I'm a naturopathic physician and acupuncturist with a private practice in Beaverton, Oregon. I'm also the Founder and Chief Medical Officer of Integrative Medical Arts Group, Inc., a market leading electronic publisher of information on CAM therapies and herbal interactions.

Thanks to the advent of the Internet, consumers are educating themselves about CAM so fast that their physicians have 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 evidence, CAM incorporates healing modalities from around the world, many of which pre-date the emergence of mechanical or western medicine in the ~~late 1800's~~ early 1900's. Despite this information void, CAM continues to be among the fastest growing health care ~~places~~ approaches worldwide. Looking forward however, CAM must cross the threshold into mainstream practice, and to drive that change we in the CAM 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 integrated form of wholeperson 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:

1. Promoting communication between patients and their health care providers about the use of alternative therapies;
2. Educating practitioners and consumers about efficacy of and research on natural medicine; and
3. ~~Promoting~~ Facilitating collaboration among various types of professionals in the health care system.

All of our work attempts to address these initiatives. First, IMA has developed a comprehensive CAM database, the Integrative BodyMind Information System, or *IBIS*. 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* 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. IBIS begins to address these issues by incorporating a Patients and Visits module for recording outcomes of multifactorial clinical interventions. These functions need to be improved and extended onto the Internet as a patient records and outcomes research data-gathering tool.

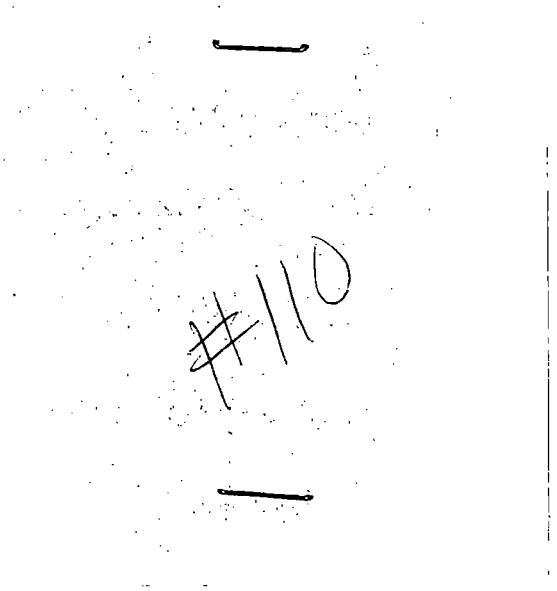
Recent media scrutiny of the popular herb Saint John's Wort and its interactions with some protease inhibitors used to treat HIV is a prime example of the pitfalls of incomplete and inconsistent information resources in the CAM space. To answer this concern IMA has created, and is continuing to develop a database of interactions and adverse reactions involving herbs and nutritional supplements. The database, called simply *Interactions*, represents a thorough compilation of data on drug-herb and drug-nutrient interaction, designed to help both practitioners and consumers determine areas of concern, assess the relative strength of relevant literature, and the practical implications of the potential interactions. It's imperative that this database, and others like it, continuously grow in size and substance as we extend our research and stay current with the scientific and medical literature.

A critical path to spur this expansion is through events reporting. In researching the medical literature on interactions we found that too many citations were based on very small studies, individual case reports, and downright erroneous or incomplete data. As a result, we built a tool that enables patients and practitioners to report interactions and adverse events involving herbs and nutritional supplements. We've launched a parallel website at InteractionReport.org to provide access to resources on interactions issues, tools for reporting potential events, and an archived Q&A forum. We have since invited academic institutions, organizations of health care professionals, and natural products businesses to join a consortium around this resource.

In order for the emerging paradigm of integrative medicine to take root, it is essential that we raise the standard of information available to doctors, practitioners and patients, to the same level of consistency, accuracy and integrity found in conventional Western medicine.

Through IBIS and Interactions, we have begun this process, working to provide up-to-date, scientifically-based clinical information to enable health care providers to understand and implement elements of natural medicine practice. Furthermore, sophisticated tools must be developed to gather and analyze data to help us determine efficacy and refine clinical practice. Likewise, we must build resources, such as InteractionReport.org, to help gather new information on interactions and adverse reactions and promote communication and collaboration around these pivotal issues of safety and effectiveness.

Information is the key to proving the medical arts of CAM should stand next to, not behind, conventional Western practice.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Good afternoon. My name is David Butters. I am a chiropractor and I have practiced in the Seattle area for over 25 years. I appreciate the opportunity to offer some brief remarks at this meeting and wish to thank the Metropolitan King County Commission for the invitation to be here.

Our population has voiced its desire for a new approach to health care with its unprecedented embrace of what has come to be known as "alternative care". I see three key advantages for the public in an expanded health care system with significant alternative care elements in this country:

1. The definition of health in America has changed and this change has resulted in the evolution of mind-body-spirit related health care. We have an opportunity to fashion a system for the 21st century and beyond that embraces the needs of this new definition. If the health care system fails to address these needs it will be set aside as an anachronism of the 20th century.

2. Health care must be delivered in an atmosphere of fiscal responsibility. Cost effectiveness must be examined in the context of quality of life as opposed to a dose specific view of health care and its outcomes. The cost replacement value of alternative care must be evaluated and understood.

3. Policy making in health care in America must reflect the spectrum of health care providers and of health care consumers. Health care in the 21st century will be a balanced equation not a continuum of the patriarchal model we have known in America.

I am concerned about the future of health care in the United States as you are but as a result of my role in health care delivery as an "alternative provider" I think I can offer you some cautions regarding pitfalls that lie before you, please consider:

1. The thought that health care equals the practice of medicine and that other systems and approaches can be reduced to a subset of medicine is folly. For all the good biomedicine has accomplished it has failed to meet the needs of health care consumers. For example, if spinal adjusting or acupuncture are added to the armamentarium of medicine without understanding the systems that form the foundation for each approach, it will be a waste of time failing to capture the greatest good offered by either system.

2. The public is calling for recognition of different systems of health care and the delivery of that care by the most qualified within each system. A general surgeon could perform a heart by-pass but would you want to receive it from a generalist or a specialist? Alternative care providers have developed unique skills in applying specialized forms of care that should unquestionably be provided by the most qualified persons available.

3. Policy discussions must include providers of alternative care. Relying on medical physicians, who generally do not understand and appreciate the interface of various forms of alternative care, in which they are not primarily trained will simply result in a "same song, different verse" outcome.

On behalf of the men and women who long to have a greater opportunity to assist in the improvement of the human condition in America and on behalf of the persons who desire that improvement in their lives I thank you.