#115

Testimony Submitted

by

Brian C. Fennen, LAc, OBT, QME

to the

White House Commission
on
Complementary and Alternative Medicine Policy

October 31, 2000

Town Hall Meeting
Seattle, Washington

Brian C. Fennen, L.Ac., QME, CMT

October 31, 2000

Thank you Commissioners. After hearing all of the testimony the past two days, I am excited and fearful all at once. Some look at official recognition as validation and support, others look at it as assimilation and servitude.... when resistance may be a futile gesture.

I have previously submitted specific recommendations, and will further revise and amend them, based upon further input from others and testimony given at this forum.

I am here today to represent acupuncture and Oriental medicine, as well as massage therapy. Officially, I am representing the **American Association of Oriental Medicine (AAOM)** and the **Council of Acupuncture and Oriental Medicine Associations (CAOMA)**. Unofficially, I am representing the **Associated Bodywork and Massage Professionals (ABMP)**.

I have prepared a brief packet for you.

First, you will find a spreadsheet summary of licensing or certification of various CAM professions in the US. ***CAM Therapist - Licensing by State***.

Next, you will see a map, (***Massage Therapist Licensing - Status by State***), and spreadsheet summary (***Massage Therapy - Licensing by State***) and map (***Number of Massage Therapist Licensed in the United States***) of the status of massage therapy licensing in the U.S . This is as up to date as you will find. As you can see, twenty-nine states plus D.C. have massage therapy laws, and the most commonly-accepted standard for licensing, certification, or registration, is 500 hours.

Next, I have included a copy of the ***Regulation of the Massage, Bodywork & Somatic Therapies Profession***, published by the ABMP. This document summarizes their perspective regarding massage therapists reservations and support for licensing and regulation. Keep in mind that regulating the various forms of massage and bodywork is like regulating cats. You can declaw, defang, and neuter them, but most will still not give up their free spirits and beliefs in their independence.

Both the ABMP and the American Massage Therapy Association (AMTA) are well-respected organizations that represent the bodywork and massage profession well, and you will find them to be a wealth of information and opinions.

Next, I have included a summary of the new Minnesota law allowing for the regulation of unlicenced CAM practitioners (***Minnesota H.F. 3839***). I believe this could be a successful model for many CAM therapists. This law holds them to certain professional standards, including informed consent procedures, without setting unnecessary or burdensome educational or examination standards.

2436 Foothill Blvd., Suite D, Calistoga, CA 94515
tel: 707-942-9380 fax: 707-942-8242 email: brianf@sonic.net

Next, I have included a map of ***Acupuncture Licensing in the United States***. This map indicates that some states still require referral or supervision by a physician before treatment. This map does not indicate the wide variety of licensing standards and scopes of practice that exist. We have Registered Acupuncturists who practices only acupuncture with a referral, Licensed Acupuncturists who may or may not use herbs, and primary care Doctors of Oriental Medicine, who practice acupuncture, herbal medicine, and manual therapy without any need for a referral.

Next, I have included a brief information packet from the American Association of Oriental Medicine. The AAOM supports full-scope licensure of Oriental medicine practitioners as primary care professionals in all fifty states. Currently, the majority of licensees fit this category, but it will probably take another decade to make this a universal standard.

The AAOM is in the midst of preparations for its annual Convention in Alexandria, Virginia on November 10-12, and was unable to complete comments for the Commission at this time. We invite you to visit our convention, where there will not only be seminars for our members, but public meetings held by the national Certification Commission, Accreditation Commission, Council of Colleges, Teachers Association, Council of State Presidents, and, of course, the AAOM's own House of Delegates.

Lastly, I have included a copy of the California State Oriental Medical Association's "***Peer Review Manual.***" The issue of safety, responsibility, liability, and oversight has come up a few times at these hearings. Peer review is the commonly-accepted model used for accountability in the various health professions and in hospital and clinical settings. This is the first-level mechanism to deal with breeches of ethics or standards of practice. These could include minor injuries sustained during treatment, as those are given risks, and not necessarily violations of laws and regulations. Flagrant scope of practice violations, sexual assault, or severe bodily harm are licensing or criminal matters, and are not suitable for simple peer review, and must be referred to the appropriate governmental agencies. The accompanying documents, also published in 1995, the "Standards of Care," and "Scope of Practice," are still under revision, and I could not provide draft revisions to you at this time. We expect them to be published by early next year.

I would be glad to address the issues of standard medical training for Oriental medicine practitioners, and vice versa, or the issue of herb-drug and herb-herb interactions, or direct you to experts who can answer those questions better.

Thank you for your time. Our hearts and spirit are with you in this endeavor.

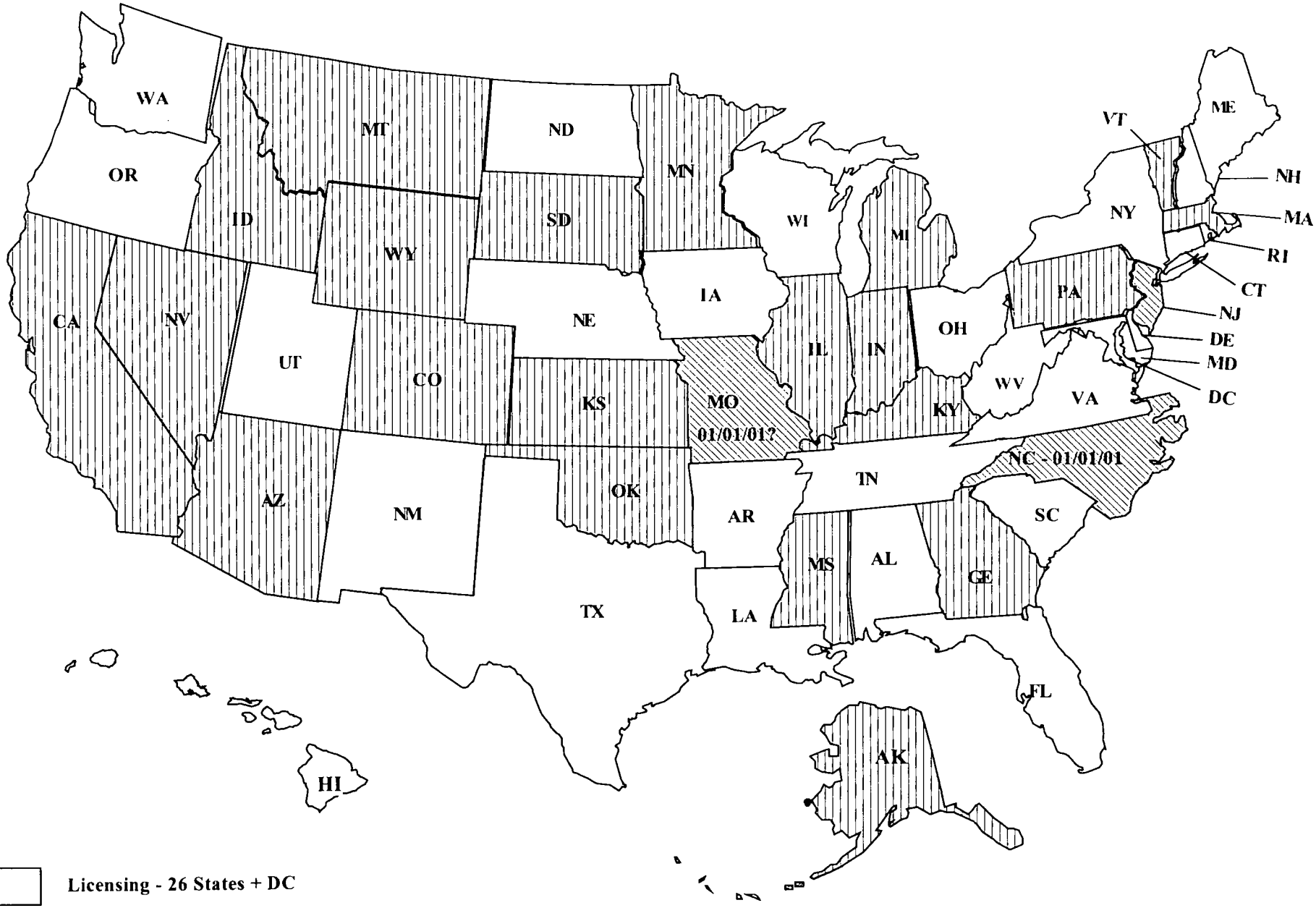
Brian C.Fennen, LAc, OBT, QME
Council of Acupuncture and Oriental Medicine Associations
American Association of Oriental Medicine

2436 Foothill Blvd., Suite D, Calistoga, CA 94515
tel: 707-942-9380 fax: 707-942-8242 email: brianf@sonic.net

CAM Therapist - Licensing by State

ALABAMA					✓	✓				✓		
ALASKA	✓				✓			✓		✓		
ARIZONA	✓				✓			✓				
ARKANSAS	✓				✓	✓				✓		
CALIFORNIA	✓				✓							✓
COLORADO	✓				✓							✓
CONNECTICUT	✓				✓	✓		✓			✓	
DELAWARE	no				✓	✓					✓	
DISTRICT OF COLUMBIA	✓	✓			✓	✓				✓		
FLORIDA	✓				✓	✓				✓		
GEORGIA	no			1/1/02 ?	✓					✓		
HAWAII	✓				✓	✓		✓				
IDAHO	✓				✓					✓		
ILLINOIS	✓	✓			✓					✓		
INDIANA	no			1/1/02 ?	✓						✓	
IOWA	✓	✓*		*	✓	✓				✓		
KANSAS	no				✓					✓		
KENTUCKY	no				✓					✓		
LOUISIANA	✓		✓		✓	✓				✓		
MAINE	✓				✓	✓		✓		✓		
MARYLAND	✓				✓	✓				✓		
MASSACHUSETTS	✓				✓					✓		
MICHIGAN	no				✓							
MINNESOTA	✓				✓					✓		
MISSOURI	no			1/1/02 ?	✓		1/1/01			✓		
MISSISSIPPI	no				✓					✓		
MONTANA	✓				✓			✓		✓		
NEBRASKA	no				✓	✓				✓		
NEVADA	✓				✓						✓	
NEW HAMPSHIRE	✓				✓	✓		✓				
NEW JERSEY	✓	✓			✓		1/1/02 ?					
NEW MEXICO	✓				✓	✓				✓		
NEW YORK	✓				✓	✓					✓	
NORTH CAROLINA	✓				✓		1/1/02 ?			✓		
NORTH DAKOTA	no				✓	✓				✓		
OHIO	no			1/1/02 ?	✓	✓				✓		
OKLAHOMA	no				✓					✓		
OREGON	✓				✓	✓		✓		✓		
PENNSYLVANIA	✓		✓		✓							
RHODE ISLAND	✓				✓	✓				✓		
SOUTH CAROLINA	✓	✓	✓		✓	✓						
SOUTH DAKOTA	no				✓					✓		
TENNESSEE	no			1/1/02 ?	✓	✓				✓		
TEXAS	✓	✓*			✓	✓				✓		
UTAH	✓				✓	✓		✓			✓	
VERMONT	✓				✓			✓			✓	
VIRGINIA	✓	✓			✓	✓						✓
WASHINGTON	✓				✓	✓		✓			✓	
WEST VIRGINIA	✓				✓	✓				✓		
WISCONSIN	✓				✓	✓					✓	
WYOMING	no				✓							
TOTAL	50	7	3	6	51	27	3	11	0	31	9	3

* Iowa - Independent Licensing status effective 8-5-00. All "Registered Acupuncturists" required to comply with "Lincensed Acupuncturist" standards by Nov. 1, 2000.
* Texas - Allows patients to sign attestation to having been evaluated by a physician within the past six months. Acupuncturist not required to verify information.



Licensing - 26 States + DC

Licensing Pending Implementation - MO / NC/ NJ

No Licensing - 21 States

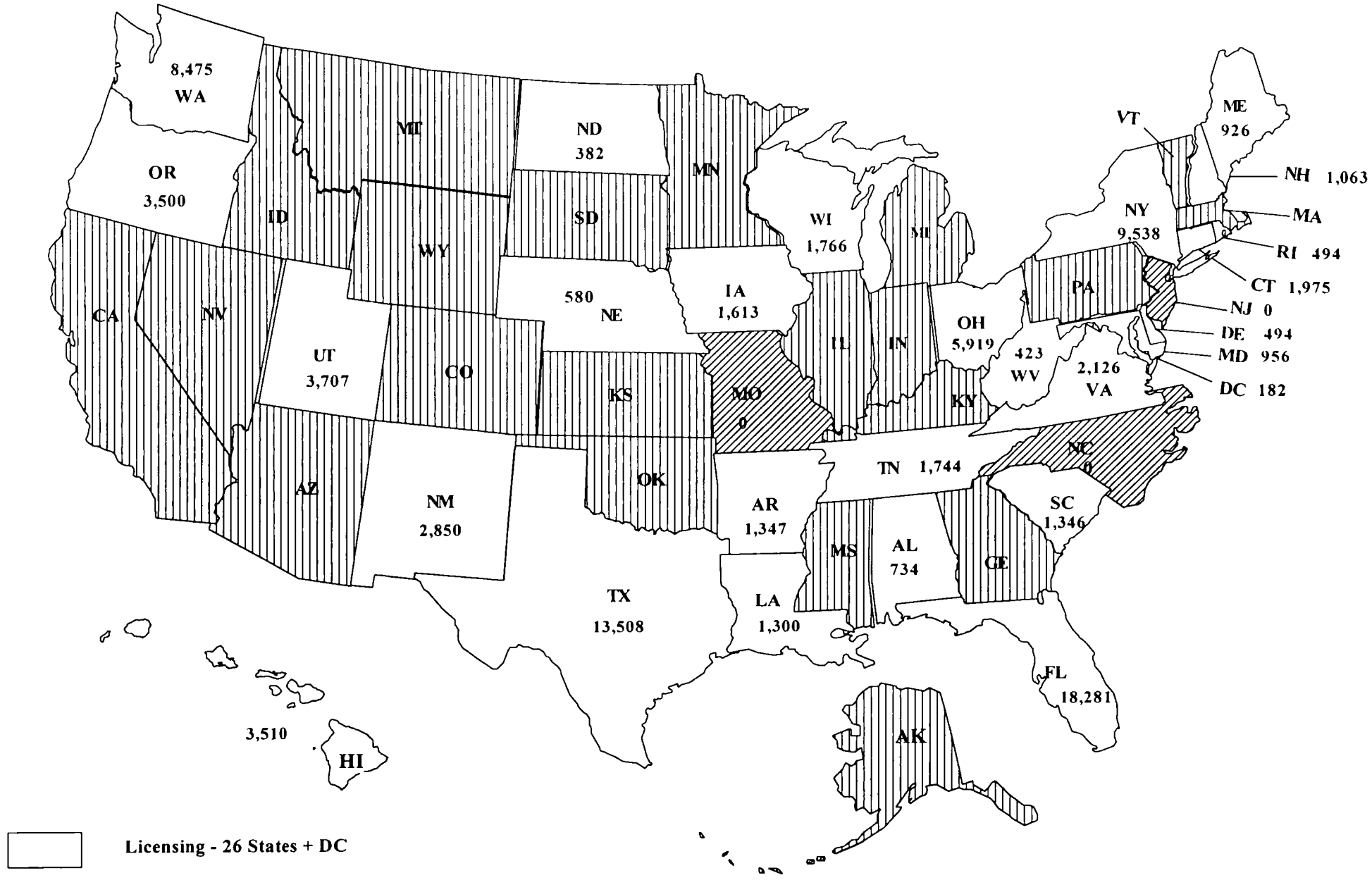
MO - Regulations are being drafted. Expect to issue first licenses in early 2001.
NJ -Regulations are being developed. No estimated date for licenses yet. Mid-2001?
NC - Applications issued. No licenses yet. License required by 01/01/2001.

Massage Therapist Licensing - Status by State

AcuMap revised 08/24/00 by B.Fennen

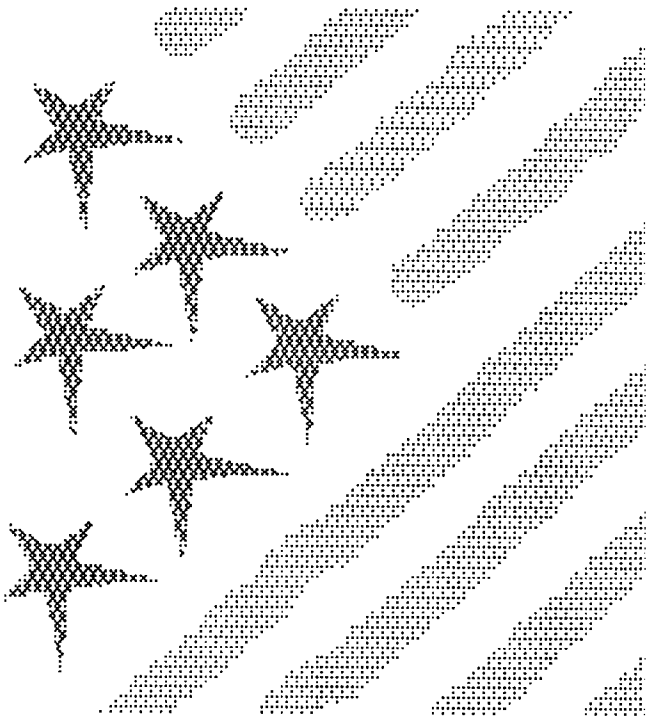
Massage Therapy - Licensing by State

State	Laws Passed	Regulation on File	Number of Licensees		Title Granted	Licensed or Certified	Facility License	Education (hours)	Written Exam	Practical Exam	NCETMB Approved
ALABAMA	1996	yes	734		Massage Therapist	License	yes	650	Yes	No	Yes
ARKANSAS	1951	yes	1,347		Massage Therapist	License	no	500 (in-class)	Yes	or NCETMB	No
CONNECTICUT	1993	yes	1,795		Massage Therapist	License	no	500	Yes	No	Required
DELAWARE	1993	no	124		Massage / Bodywork Therapist	License	?	500	Yes	No	Required
DELAWARE	1993	no	370		Certified Technician	Certificate	?	100	Yes	No	Yes
DISTRICT OF COLUMBIA	1994	no	182		Massage Therapist	License	?	500 or Exam	or 500 hrs	No	Yes
FLORIDA	1943	yes	18,281		Massage Therapist	License	yes	500	Yes	No	Yes
HAWAII	1947	yes	3,510		Massage Therapist	License	yes	570	Yes	No	No
IOWA	1992	yes	1,613		Massage Therapist	License	no	500	Yes	No	Required
LOUISIANA	1992	yes	1,300		Massage Therapist	License	yes	500	Yes	Verbal	Yes
MAINE	1991	yes	926		Massage Therapist	License	no	500 or NCETMB	Yes	No	Required
MARYLAND	1996	no	956		Massage Therapist	Certified	?	500	Yes	No	Yes
MINNESOTA		-	*0*		*may require registration in future*	*none*	*?*	-	*N/A*	*N/A*	*N/A*
MISSOURI -Early 2000?	*1998*	*no*	*0*		*Massage Therapist*	*License*	*no*	*grand-fathering*	*Yes*	*No*	*not yet*
NEBRASKA	1958	yes	580		Massage Therapist	License	no	1000	Yes	Yes	Required
NEW HAMPSHIRE	1980	yes	1,063		Massage Therapist	License	no	750	Yes	Yes	Required
NEW JERSEY - Mid 2000?	*1998*	*no*	*0*		*Massage Therapist*	*License*	*no*	*500 or exam*	*or 500 hrs*	*No*	*Yes*
NEW MEXICO	1991	yes	2,850		Massage Therapist	License	no	650	Yes	No	Required
NEW YORK	1967	yes	9,538		Massage Therapist	License	no	1000	Yes	No	Yes
NORTH CAROLINA - 01/01/00	*1998*	*no*	*0*		*Massage Therapist*	*License*	*no*	*500*	*Yes*	*No*	*Yes*
NORTH DAKOTA	1959	no	382		Certified Massage Therapist	License	?	750	Yes	Yes	No
OHIO	1916	yes	5,919		Massage Therapist	License	no	600	Yes	No	No
OREGON	1971	yes	3,500		Massage Therapist	License	no	500	Yes	Yes	No
RHODE ISLAND	1979	yes	494		Massage Therapist	License	no	500	Yes	No	Required
SOUTH CAROLINA	1996	yes	1,346		Massage & Bodywork Therapist	License	no	500	Yes	No	Required
TENNESSEE	1995	yes	1,744		Massage Therapist	License	yes	500 or NCETMB	or 500 hrs	No	Yes
TEXAS	1985	yes	15,508		Massage Therapist	Registration	yes	300	Yes	Yes	No
UTAH	1981	yes	3,707		Massage Therapist	License	no	500 (approved)	Yes	No	Yes
VIRGINIA	1996	yes	2,126		Massage Therapist	Certification	no	500	Yes	No	Yes
WASHINGTON	1976	yes	8,475		Massage Therapist	License	no	500	Yes	No	Required
WEST VIRGINIA	1997	no	423		Licensed Massage Therapist	License	?	500	No	No	Yes
WEST VIRGINIA	1997	no	0		Provisional LMT	License	?	250	No	No	Yes
WISCONSIN	1998	no	1,766		Licensed Massage Therapist	License	?	600	?	?	Yes
TOTAL			90,559		Total of 90,559 is up 17% from 77,459 in 1999						



Number of Massage Therapists Licensed in the United States

AcuMap rev. 08/24/00 by B.Fennen



REGULATION OF THE MASSAGE, BODYWORK & SOMATIC THERAPIES PROFESSION

A perspective from Associated Bodywork and Massage Professionals

The practice of therapeutic massage in the United States dates back at least 100 years. During the 1890s, massage was routinely available at YMCAs and YWCAs, among other settings. Practitioners have offered massage services ever since, but the profession really started to grow 30 years ago. During the past 10 years, growth of the field has been explosive.

Today, an estimated 140,000 to 160,000 people in the United States practice massage, bodywork or somatic therapy. The nearly 800 state-recognized massage therapy schools in the U.S. graduate approximately 50,000 trained students each year. It is estimated that only 10% of Americans have experienced a professional massage, but that number grows each year.

The field of massage practitioners is amazingly diverse and certainly is not represented by any one voice. The two large, broad membership associations in the field are Associated Bodywork & Massage Professionals (ABMP) and the American Massage Therapy Association (AMTA). While these associations have somewhat different membership qualification requirements, each requires a significant minimum number of hours of education in massage therapy and agreement by members to adhere to a code of ethics. Together they represent about one-fourth of practitioners in the United States. Numerous other smaller associations exist, generally focused on a particular modality (a specialized practice or technique, often an approach like Rolfing or Feldenkrais developed by a founder after whom the approach is named); these typically have 300 to 1,200 members. Many others in the profession fiercely guard their independence, aren't interested in being organized, and abhor regulatory and licensing excess.

A number of full-time practitioners earn $40,000 to $60,000 per year; however, many individuals in the field use massage as a second career or part-time avocation. Many practitioners find working on weekends or just on family and friends to be quite fulfilling. As a result, median income from the practice of massage therapy today appears to be under $20,000. This part-time, second career element of the massage profession is often overlooked when regulation is developed and implemented. The financial burden created by excessive regulation may be costing the profession its most valuable resource – its members. Licensure or examination fees that exceed $100 may drive numerous part-time practitioners underground or out of the profession altogether.

The American public and progressive health insurers appear increasingly interested in holistic approaches to good health, embracing sound nutritional and exercise practices alongside traditional medicine. The practice of Swedish massage and certain centuries-old Oriental bodywork modalities have become increasingly accepted as legitimate alternative or complementary medicine. Indeed, certain modalities within the broad headings of bioenergetics, acupressure and somatic therapy, which stresses mind/body connections, are on the leading edge of alternative and complementary medicine with regard to healing and retraining injured muscles.

While acceptance of massage by the medical community is growing, many traditional medical practitioners remain unconvinced of the connection. As a result, and also because of general health care cost pressures, many health insurers still will not reimburse clients for massage therapy services. Indeed, even within the profession, com-

peting factions promote massage as either deserving a place alongside traditional medicine or as wellness and relaxation care that should be enjoyed but should not be assumed to relate to medical practice. Some view massage as medical treatment, some as an essential part of promoting health through wellness practices, and others as simply a pleasant personal service.

WHAT DOES THE GOVERNMENT HAVE TO DO WITH THIS?

The answer is far from clear, beyond a broadly accepted government role in approving massage training schools to ensure that they deliver to the public the services they advertise. Some states go a step farther to ensure that school curriculums meet certain standards in order to be approved or licensed.

Twenty-nine states (and the District of Columbia) have chosen to extend their reach even further by regulating individual massage practitioners. In the 29 licensing states, you must be approved by the state to practice massage, bodywork or somatic therapies (or at least use certain protected titles). Most of these states have a minimum training requirement of 500 hours; the range is from 300 to 1000. Most of these licensing laws have been implemented during the past 10 years, though Ohio's dates back to 1917. California, which has the largest concentration of therapists, has no statewide massage regulation. Inconsistent regulation is the only reasonable way to describe the current patchwork of approaches.

WHY HAVE SOME STATES CHOSEN TO ENGAGE IN SUCH REGULATION?

Some appear to have done so out of zeal to regulate professional activity broadly. Where this remains the sole motivator, the current trend to sunset certain government activities may lead to termination of jurisdiction over the massage profession.

The other historical cause for state intervention in this field derives from the hijacking of the term massage by prostitutes. The phrase "massage parlor" has become a euphemism for prostitution in some cities and regions. Legislative attempts to eradicate prostitution led to the initiation of regulations affecting the activities of legitimately practicing massage, bodywork and somatic therapists. Some massage therapists welcomed such regulation as a means of distinguishing their activities and educational training from those corrupting the term massage. Others find state involvement unhelpful, expensive, bureaucratic and unknowledgeably intrusive. They see absolutely no history of public harm from receipt of professional massage therapy services and, therefore, no cause for state intervention.

THE CASE FOR NO REGULATION

Public protection is a legitimate reason for government regulation. Legislating professionalism or competency is not. When in doubt, one should be skeptical about claimed benefits of government involvement and protection.

A question asked of all professions that seek licensure (or have it thrust upon them) is "does the practice of this create a public danger or harm?" If the answer is yes, regulation of the practice is deemed necessary for public safety purposes. Does massage fit this description? No evidence has ever been presented that indicates that the practice of massage creates a public danger if unregulated.

Professional associations appropriately have jurisdiction over entry, minimum training standards, conduct, ethical standards of practice, and expulsion of members. Problems occur when professional associations become lazy at these tasks and look to state or local governments to do this work for them. Unfortunately, certain professional associations purportedly representing the interests of the profession have been the defining force in certain jurisdictions in creating barriers to entry into the field and have used the state legislatures as their tool.

For three primary reasons, state mandated regulation does not serve the interests of the industry or the public it serves:

The diverse field of massage, bodywork and somatic therapies does not lend itself to cookie-cutter regulation. In its legislative form, "massage" is a generic term. In actuality, there are more than 50 different modalities and techniques which, legislatively, fall under the umbrella of massage. Practitioners of many of these techniques do not consider themselves related to massage. Creating regulation for massage can give rise to complex definitional challenges.

Proponents of regulatory massage practitioners are mostly well-motivated by a desire to promote sound training and professional conduct. Too often, however, they underestimate side effects of regulation – excessive fees on practitioners to support the regulatory apparatus thereby discouraging people from entering the field, driving others underground which will limit consumer information and choices, raising consumer costs, and limiting practitioner incomes and mobility. The unwitting result can be less rather than greater professionalism.

SELF REGULATION

The case for self-regulation respects a market approach to economic and political activity. In this model, consumers have central responsibility for choosing among alternative service providers. As professions mature, skilled and educated practitioners find it in their interest to organize, to embrace standards of practice and codes of

ethical conduct, and to take other actions to distinguish themselves from less committed practitioners. They educate the consuming public about distinguishing features of their capabilities and services. Over time, skilled practitioners thrive and less committed colleagues leave the field.

In the positive version of this model, strong practitioners "self-regulate" through internally adopted standards, continuing education requirements and codes of conduct. This is the model that implicitly applies today in states without regulation and is interwoven on top of state regulation that sets forth minimum requirements in the other 29 states.

The status of self-regulation of the massage therapy profession today can be characterized as imperfect but evolving. The two large umbrella organizations have solid standards and codes of conduct. They are adding members at an even faster rate than the growth rate of the profession as a whole. In their individual ways they provide leadership and direction to the profession.

In addition, the National Certification Board for Therapeutic Massage & Bodywork (NCBTMB) was created for the purpose of advancing the profession, foremost by developing a uniform national exam (the National Certification Examination for Therapeutic Massage and Bodywork or NCETMB) to certify practitioners. That exam has been in use since 1992. Approximately 36,000 practitioners have passed the exam and currently are certified (a significant number of them also are members of ABMP or AMTA). To maintain that status, they must subscribe to a code of ethics, earn a certain number of continuing education credits, and become recertified every four years.

The National Certification Exam appears to provide an adequate test of basic "academic" information a massage therapist needs to know. It does not, however, test hands-on proficiency in touch. Also, no single version of this test, which is all there is at this point, can address skills in the wide variety of modalities practiced under the broad banner of massage, bodywork and somatic therapies. Nonetheless, the exam has been approved by the National Commission for Certifying Agencies and potentially offers an additional foundation piece toward self-regulation of the profession. The certification credential also may help persuade certain members of the medical profession and the general public that they can have confidence in certified practitioners.

In actuality, the presence of the NCETMB has raised the opportunity of a more seamless level of regulation throughout the United States. The critical qualification for practitioners appears to be completion of a 500-hour program from a school that has been approved to operate by the state department of post-secondary education. This is used as primary qualification for taking the NCETMB. As a method of recognizing the developing nature of the profession, it makes sense that accepting the NCETMB as an alternative method allows for the flexibility that the field's growth necessitates, while separating legitimate professional massage therapy practitioners from prostitutes masquerading under the massage banner.

In ABMP's view, these two approaches (500 hours and the NCETMB) are excessive when combined. It is a very costly exercise to require both methods as fare for entry. While the allure of the NCETMB to regulators is duly noted, it is redundant and only penalizes entrants to the profession where they can afford it least – in the pocketbook. The NCETMB can be a helpful alternative, but does not merit a role as a mandate to practice.

FAIR STATE REGULATION WHERE REGULATION IS NEEDED

If problems related to massage are sufficient as to warrant government regulatory involvement, then that involvement should come at the appropriate level and should be fair and unbiased.

State level regulation is far superior to local regulation. Otherwise, the problem being addressed – usually prostitutes masquerading as massage practitioners – simply gets exported to the next jurisdiction. A classic current example is non-smoking ordinances applied to restaurants. However meritorious the motives behind such legislation, particular municipalities which pass such rules find that both sales taxes and dining choices for their residents decline. Further, most states have greater resources available than do municipalities to define and administer regulation of professions. Training schools also prefer uniform state requirements for practitioners to the alternative of trying to design a curriculum to match diverse local requirements.

Adherence to several key principles will go a long way toward assuring comprehensive, fair, and unbiased state regulation of the practice of massage:

- A comprehensive definition of what is encompassed by massage, bodywork and somatic therapies, so that each of the broad array of modalities is treated equally, avoiding "cookie-cutter" legislation under the Swedish massage umbrella.

- Reasonable educational standards for state certification of practitioners – a curriculum encompassing 500 hours of classroom work is adequate as a minimum requirement.

- Recognition of classroom work from any training institution approved by the state department of higher or post-secondary education.

- Reciprocity for work completed at an out-of-state training school (transcript review if necessary) including national or international

institutes such as those connected with Rolfing, Rosen Method, Feldenkrais, etc.

• A provision which allows an individual to practice, absent completion of the education requirements, if he or she can demonstrate to a state board of experts both physical skills and knowledge of anatomy, physiology, and the limits of appropriate practice.

• No organization-specific language, or distinction between for-profit or not-for-profit form of organization, in considering which training institutions to approve or which membership organizations to recognize.

• No requirement that a practitioner must belong to any particular professional organization. Practitioners are qualified or not qualified; their choice of professional affiliation should not determine their eligibility to practice.

• A tone to regulations which keeps them from becoming overly clinical or medicalized. Both massage practitioners and clients take pride in the heart and sense of connection provided by a skilled touch experience and don't desire to see this legislated away via mandated bureaucratic procedures.

In defining minimum education requirements, a fine balance exists between ensuring appropriate curriculum coverage and excessive hour-counting. The most frequently employed current standard is 500 hours. Thorough training in anatomy, physiology, appropriate touch techniques, the appropriate depth of touch for different muscle groups and client condition, ensuring client privacy, ethics, and business practice can be accomplished within a 500-hour curriculum. Standards that build to 1,000 or 2,000 hours or which require a practitioner to have a college degree indicate a guild mentality – trying to close the door to new practitioners or an attempt to enhance training institution revenue.

A trend in several states which recently have passed new laws regulating massage practitioners has been to require those individuals to be nationally certified as evidenced by passing the National Certification Exam sponsored by NCBTMB. Such a requirement, at least at this stage of the exam's development, is highly discriminatory. It simply does not fairly test individuals whose training has been in certain modalities other than Swedish massage. One size does not fit all. The test does not require any measure of tactile skill, of demonstrated proficiency in skilled touch.

Where an appropriate minimum education requirement exists as part of state standards, the National Certification Exam becomes superfluous as a **requirement** to practice, and an unneeded financial barrier to entry. Qualifying educational institutions will at least require students to demonstrate practical abilities, as well as book knowledge. Offering passage of the NCETMB as an **alternative** way of qualifying to practice is reasonable, and can help someone in the circumstance of relocating to a regulated state.

HELP IN DRAFTING OR CHALLENGING REGULATORY REQUIREMENTS

There seems a right and a wrong way to go about adopting state regulation of massage practice. First, it is important to take the pulse of massage practitioners and the general public to determine whether regulation is really needed. Where a clear consensus emerges on the appropriateness of regulation, then by far the preferred approach is forming a broad coalition of practitioners. Such a coalition should include members of both ABMP and AMTA, representative smaller associations organized around particular modalities, and training school administrators and teachers.

ABMP stands ready to participate in any such effort, through both contributing the expertise of its national staff and by locating practitioners in the affected state who wish to contribute to the process. We also can modify a model legislative template we have drafted to provide a proposed starting document for interested legislators. Alternatively, we will help legislators make the case that further regulation of therapeutic massage in their state is not needed or that the inequitable portions of their current state law should be revised. To take advantage of this offer of assistance, please contact:

Mr. Les Sweeney, Executive Vice President
Associated Bodywork & Massage Professionals
1271 Sugarbush Drive, Evergreen, CO 80439
Tel: 800/458-2267; Fax: 303/674-0859
E-mail: les@abmp.com
Web site: www.abmp.com

Associated Bodywork & Massage Professionals is a professional membership association founded to provide massage and bodywork practitioners with valuable services and information. ABMP is growing rapidly and currently includes over 32,000 women and men in its ranks. ABMP is dedicated to promoting ethical practices, protecting the rights of practitioners, and educating the public as to the benefits of massage and bodywork. Its membership is present in all 50 states and several other countries. Services provided through membership in the association include professional liability insurance, professional resource publications, an international referral service, regulatory interaction, and program accreditation through the Integrative Massage & Somatic Therapies Accreditation Council (IMSTAC).

ASSOCIATED Bodywork & Massage® PROFESSIONALS

Massage & Bodywork Regulations

Local Government Regulations

The regulation of the massage, bodywork and somatic therapy profession in the United States began in 1916 with the state of Ohio. By 1990, 12 more states began regulating massage. In the last seven years, the number of states with statewide regulation for massage therapists has almost tripled. As of August 1999, 29 states and the District of Columbia have statewide regulations. Numerous cities and counties in unregulated states have regulatory ordinances for massage practitioners. The regulatory environment is constantly changing; information provided here is current, effective August 1999. If you live in an unregulated state, you are encouraged to contact the city or county clerk in your area to obtain a copy of any local ordinances you may be required to comply with in order to practice.

Education requirements in regulated states vary from 300-1,000 hours of instruction. The nationwide standard is typically 500 hours. Most states administer a written or practical exam in addition to the educational requirement. Many states accept the national certification examination for the written examination or for grandfathering purposes.

If you plan to practice in a state with no statewide licensing or registration, we recommend you contact the city or county clerk's office in the specific area you wish to practice to see if there are any local regulations governing the practice of massage, bodywork and somatic therapies. You will want to inquire if there are specific regulations for a therapist/technician license, if a business license if required, if there are any Department of Health regulations with which you must comply, and/or if there are any city or county zoning requirements regarding where you may establish a practice. Be sure the school you attend meets the requirements of the area in which you plan to practice. If you discover an ordinance or law that you feel is discriminatory with regard to specific organizations, non-acceptance of equivalent training or simply antiquated and degrading, contact the ABMP Legislative Services Department at 800/458-2267, ext. 626, for assistance. Many local ordinances have not been updated in years and most local governments are very proactive provided you keep a positive, patient attitude.

ABMP has had great success in assisting its members with the modification of local ordinances. When you find that your ordinance is in need of alteration, you should obtain the name of the city council members, the address, phone and fax numbers for city hall, the name, address, phone and fax numbers of the city attorney and most importantly a copy of the local ordinance. Once ABMP receives this information and pertinent information on any other contacts you may have at city hall, we can move forward with your request for assistance. ■

Terms you should know

Licensure
Requires a State Board of Examiners
Requires everyone in the state who practices the profession to be licensed
Requires specific educational requirements and/or examination
Provides protection for title usage, i.e.,the term massage

Certification
This refers to government,state, county or city regulations,not private certification programs
Administered by an independent board
Certification is voluntary, but would be required by anyone using the protected title, i.e.,massage therapist
Requires specific educational requirements and examination
Provides title protection

Registration
This refers to government,state, county or city regulations,not private certification programs.
Administered by the State Department of Registry or other appropriate state agency
Registration is voluntary
Does not necessarily require specific education
Does not provide title protection

Exemption
Exemption from an existing state and/or municipal regulation
Practitioners who meet specified educational requirements could be exempted from meeting current requirements
Does not provide title protection

Minnesota H.F. 3839
Alternative Health Care Freedom of Access Act

This legislation protects the unlicensed practice of complementary and alternative health practices, but holds practitioners accountable to certain professional standards of enforcement. CAM practitioners are looking at this as a model for future legislation in many states.

Signed by Governor Ventura on May 11, 2000

Creates the Office of Unlicensed Complementary and Alternative Health Care Practice within the Health Department.

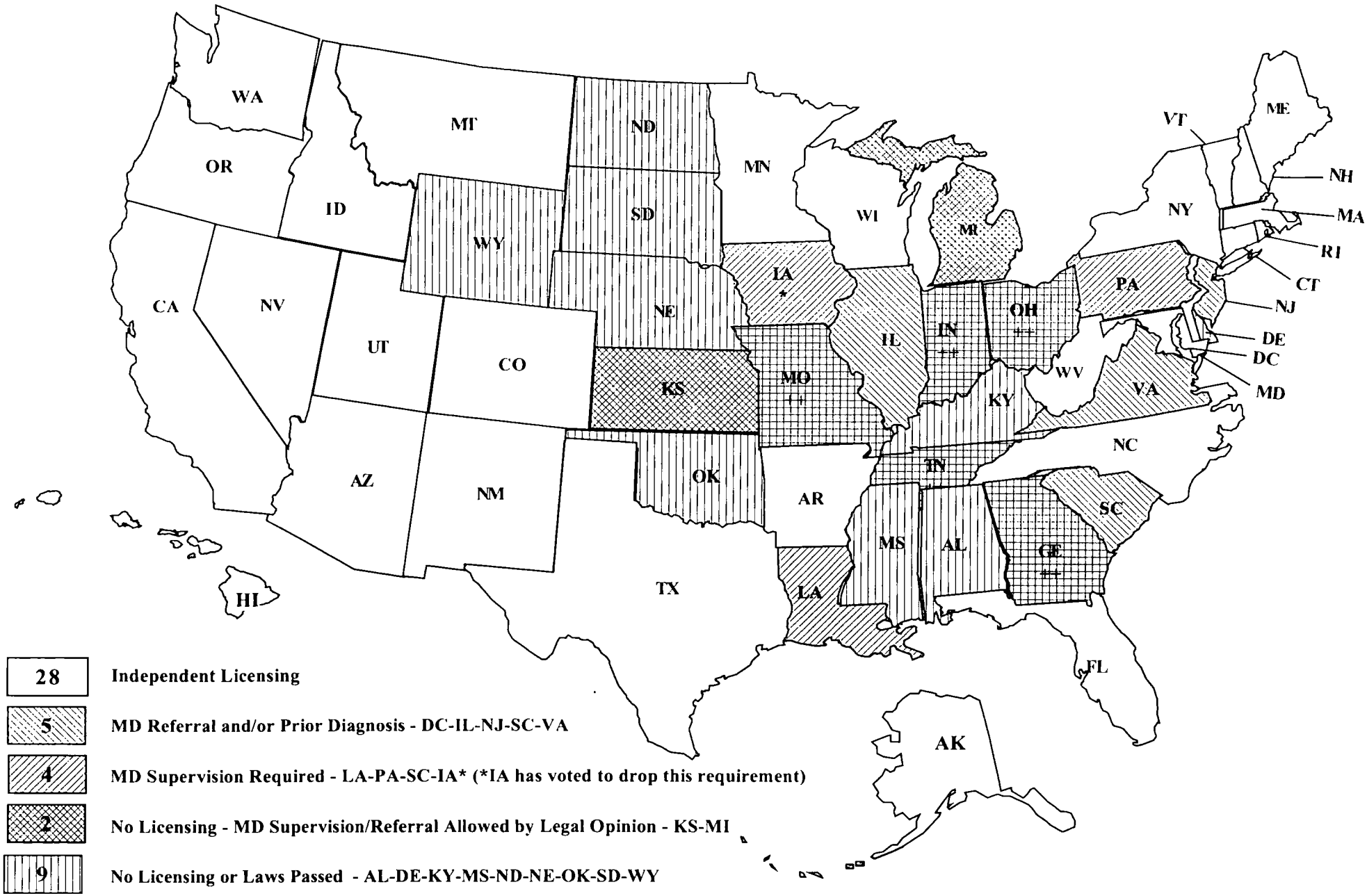
Protects the unlicensed practice of complementary and alternative health care practices from education, examination, and other standard licensing requirements.

Allows what is essentially regulatory authority to take enforcement action against unlicensed practitioners who violate professional standards.

Requires unlicensed practitioners to provide clients with a copy of the "alternative health care client bill of rights," and have all clients sign this form before providing treatment.

Defines "Complementary and alternative health care practices" to means the broad domain of complementary and alternative healing methods and treatments, including but not limited to:

- Acupressure
- Anthroposophy
- Aroma therapy
- Ayurveda
- Cranial sacral therapy
- Culturally traditional healing practices
- Detoxification practices and therapies
- Energetic healing
- Polarity therapy
- Folk practices
- Healing practices utilizing food, food supplements, nutrients, and the physical forces of heat, cold, water, touch, and light
- Gerson therapy and colostrum therapy
- Healing touch
- Herbology or herbalism
- Homeopathy
- Nondiagnostic iridology
- Body work, massage, and massage therapy
- Meditation
- Mind-body healing practices
- Naturopathy
- Noninvasive instrumentalities
- Traditional Oriental practices, such as Qi Gong energy healing.

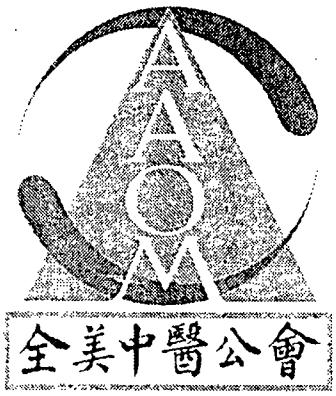


28	Independent Licensing
5	MD Referral and/or Prior Diagnosis - DC-IL-NJ-SC-VA
4	MD Supervision Required - LA-PA-SC-IA* (*IA has voted to drop this requirement)
2	No Licensing - MD Supervision/Referral Allowed by Legal Opinion - KS-MI
9	No Licensing or Laws Passed - AL-DE-KY-MS-ND-NE-OK-SD-WY
5	++Recent Licensing Laws Passed - No licenses issued - 1999 Statutes: IN-MO 2000 Statutes: GA-OH-TN

New Licensing Statutes usually take 18 months or more to implement. MO expects licenses by 1/1/2002.

Acupuncturist Licensing in the United States

AcuMap 2000 - revised 09/15/00 by Brian Fennen



AMERICAN ASSOCIATION OF
ORIENTAL MEDICINE
433 FRONT ST., CATASAUQUA, PA 18032
PHONE 610-266-1433 FAX 610-264-2768

AAOM Information:

1) Facts Sheet
2) AAOM Facts Sheet
3) Medical Board Listing
4) OM School Listing
5) State Acupuncture Association Listing
6) National Press Club Listing

FACTS

AMERICAN ASSOCIATION OF ORIENTAL MEDICINE

The Practice

Oriental medicine with acupuncture comprise a system of health care which originated in China more than 3,000 years ago and has been offered in the United States for more than 150 years. Oriental medicine is a comprehensive system for the diagnosis and effective treatment of acute and chronic disorders as well as preventative health care and maintenance.

The practice of Oriental medicine is based on a paradigm of the body unlike that used in Western medicine. This model centers on the concept of "Qi" (pronounced "chee"), loosely translated as "energy", and its effect on physiological function and health. Oriental medicine's basis is supported by the scientific understanding that human beings are complex bioelectric systems. Oriental medicine functions to promote the body's ability to heal itself.

Treatment with sterile disposable acupuncture needles is the most commonly used technique. Oriental medicine practitioners also utilize other forms of treatment such as moxibustion (a form of heat therapy), massage, manipulation and movement techniques. Dietary modifications, including herbal and vitamin supplements, specific therapeutic exercises and lifestyle management strategies may also be recommended.

Oriental medicine is a cost-effective treatment system. Back pain (a common reason for employee absence) and chronic pain (a common and costly condition) are both readily and effectively treatable by acupuncture at far less cost than current, conventional treatment modalities. The treatment of substance abuse by acupuncture has a record of excellent results and costs far less for a year of treatment than only a month's stay in an inpatient program.

Training and Certification of Acupuncturists

More than 50 schools of acupuncture exist in the United States, Mexico, and Canada. Acupuncture courses are also offered in medical schools.

There are currently over 9,000 licensed acupuncture practitioners in the United States with more than 1000 new practitioners being certified each year.

Thirty six states and the District of Columbia license, certify, register acupuncturists or officially recognize the practice of acupuncturists. Twenty-two of these states license, register or certify acupuncturists for independent practice.

Acceptance and Support

The World Health Organization, the medical branch of the United Nations, issued a provisional list of 41 diseases amenable to acupuncture treatment. These include respiratory ailments, pain and chronic pain conditions, PMS and other gynecological disorders, gastrointestinal disorders and many other health problems.

The U. S. government has funded more than $1 million in research monies for the study of acupuncture's effectiveness in the treatment of addictions. Programs in New York NY, Miami FL, and Minneapolis MN, have been funded to research the treatment of crack/cocaine addiction and alcoholism with acupuncture.

12 million Americans received acupuncture treatment in 1995, with the number of persons seeking acupuncture treatment in this country increasing substantially every year.

The American Osteopathic Association, the American Chiropractic Association and the American Veterinary Medical Association all endorse acupuncture. Former Surgeon General E. Koop MD, has recognized acupuncture treatment as a useful method of overcoming nicotine addiction.

Acupuncture is increasingly being used in the treatment of addictions. More than 20 hospitals around the country have incorporated acupuncture into their substance abuse treatment programs. In the correctional system, several programs use acupuncture in prisons to treat addiction.

Private and public insurance coverage for acupuncture is available in many states. Blue Cross/Blue Shield State Employee's Plans and Worker's compensation, Mass. Mutual, and other major insurers cover acupuncture treatment in several states. Medicaid covers acupuncture treatment for substance abuse in several states.

The American Association of Oriental Medicine (AAOM), formerly the AAAOM, founded in 1981, is the nation's largest professional association organized to further development of Oriental medicine with acupuncture as a complementary field of health care in America. AAOM has more than 1,000 individual members practicing in most states of the United States.

AAOM
433 Front Street, Catasauqua, PA 18032
1-888-500-7999 FAX 610-264-2768
AAOM1@aol.com www.aaom.org

AAOM
全美中醫公會

AMERICAN ASSOCIATION OF ORIENTAL MEDICINE

AMERICAN ASSOCIATION OF ORIENTAL MEDICINE

THE WORLD HEALTH ORGANIZATION VIEWPOINT ON ACUPUNCTURE

R.H. Bannerman, M.D.
World Health Organization, Avenue Appia, 1211 Geneva 27, Switzerland

Abstract: A World Health Organization interregional seminar on acupuncture, moxibustion and acupuncture anesthesia was held in Beijing (Peking) in June 1979, attended by participants from twelve countries. Its purpose was to discuss ways in which priorities and standards could be determined in the acupuncture areas of clinical work, research, training, and technology transfer. Scientific investigation must be closely correlated with demonstrations of acupuncture's clinical efficacy. Apart from acupuncture analgesia used in major surgical procedures, acupuncture also has been applied as a diagnostic aid and in conjunction with fluoroscopy in gastrointestinal diseases. Acupuncture is clearly not a panacea for all ills; but the sheer weight of evidence demands that acupuncture must be taken seriously as a clinical procedure of considerable value.

During the past decade, there has been a growing convergence between the most advanced research knowledge from physiology, biochemistry and pharmacology, and knowledge obtained by research in the field of acupuncture; that is to say, a convergence of modern international science with traditional Chinese medicine. For example, in more than 600 cases of coronary heart disease, the effectiveness of acupuncture in relieving the symptoms was over 80 percent. In 645 cases of acute bacillary dysentry, 90 percent of the patients were cured within ten days as judged by clinical symptoms and signs and the results of stool culture. The technique is also comparatively effective in controlling fever, inflammation and pain.

From the viewpoint of modern medicine, the principle action of acupuncture (and of moxibustion) is to regulate the function of the human body and to increase its resistance by enhancing the immune system and the antiphlogistic, analgesic, antispastic, antishock and antiparalytic abilities of the body.

Table 1.
The World Health Organization Interregional Seminar drew up the following provisional list of diseases that lend themselves to acupuncture treatment. The list is based on clinical experience, and not necessarily on controlled clinical research: furthermore, the inclusion of specific diseases are not meant to indicate the extent of acupuncture's efficacy in treating them.

Upper Respiratory Tract
Acute sinusitis
Acute rhinitis
Common Cold
Acute tonsillitis

Respiratory System
Acute bronchitis
Bronchial asthma (most effective in children and in patients without complicating diseases)

Disorders of the Eye
Acute conjunctivitis
Central retinitis
Myopia (in children)
Cataract (without complications)

Disorders of the Mouth
Toothache, post-extraction pain
Gingivitis
Acute and chronic pharyngitis

Gastro-intestinal Disorders
Spasms of esophagus and cardia
Hiccough
Gastroptosis
Acute and chronic gastritis
Gastric hyperacidity
Chronic duodenal ulcer (pain relief)
Acute duodenal ulcer (without complications)
Acute and chronic colitis
Acute bacillary dysentery
Constipation
Diarrhea
Paralytic ileus

Neurological and Musculo-skeletal Disorders
Headache and migraine
Trigeminal neuralgia
Facial palsy (early stage, i.e., within three to six months)
Pareses following a stroke
Peripheral neuropathies
Sequelae of poliomyelitis (early stage, i.e., within six months)
Meniere's disease
Neurogenic bladder dysfunction
Nocturnal enuresis
Intercostal neuralgia
Cervicobrachial syndrome
"Frozen shoulder," "tennis elbow"
Sciatica
Low back pain
Osteoarthritis

AAOM
433 Front Street, Catasauqua, PA. 18032
PHONE 610-266-1433 FAX 610-264-2768

AMERICAN ASSOCIATION OF ORIENTAL MEDICINE

WHAT IS THE AAOM?

The America Association of Oriental Medicine (AAOM) is the oldest organization representing Licensed Acupuncturists and students, along with Oriental Medical Schools and acupuncture-related businesses. It is registered with the District of Columbia as a nonprofit corporation. The American Association of Oriental Medicine (AAOM), was formed in 1981 to be the unifying force for American Acupuncturists to uphold ethical and well regulated standards of practice and to lobby for legislation to advance the profession.

PHILOSOPHY OF AAOM:

The AAOM acknowledges and respects ALL traditions of Acupuncture and Oriental Medicine, and believes that cooperation and strength among practitioners and supporters will ensure that this ancient medical art will retain its integrity and achieve the recognition and legal status to which it is entitled, thus enhancing the quality of health care for people in the United States.

MISSION STATEMENT

- As the oldest National Organization representing the individual practitioner of Oriental Medicine, we pledge to serve as the official representative and spokesperson for Acupuncturists in the United States.
- We will protect in every way, the philosophy, science and art of Acupuncture and Oriental Medicine
- We will establish where necessary, and maintain where existing, the practice of Acupuncture and Oriental Medicine as a separate and distinct primary care healing art and profession in the United States
- We will educate legislators, regulators and the general public regarding the nature and scope of practice of acupuncture and Oriental Medicine
- We will develop, where necessary, and maintain standards of education and professional competence. We will strive to develop health research programs and foster inter-professional relationships

WHAT ARE THE GOALS OF THE AAOM?

- TO UPHOLD the highest professional ethics and standards.
- TO MONITOR, initiate, and support (acupuncture/Oriental medicine) legislation regarding the profession as well as the safety of the public.
- TO ACHIEVE licensing procedures in all 50 states and US territories for Acupuncture and Oriental Medicine practitioners as independent health care providers.
- TO PROTECT the public by promoting competency by OM practitioners
- TO PROMOTE third-party insurance coverage and Medicare coverage for all Nationally Board Certified and licensed practitioners of Acupuncture and Oriental Medicine.
- TO SUPPORT clinical research verifying the effectiveness of Acupuncture and Oriental Medicine.
- TO DEVELOP public relations campaigns to educate the public, insurance companies, and state and federal legislators not only about the benefits of Acupuncture and Oriental Medicine but also the criteria for choosing a qualified practitioner.
- TO SEEK and promulgate the highest educational standards of Acupuncture and Oriental Medicine in the United States.
- TO PROMOTE and support continuing education of licensed acupuncturists by presenting conventions and seminars.
- TO WORK in conjunction with the World Health Organization to set educational criteria worldwide.
- TO PROVIDE a democratic forum for the profession.

AAOM
433 Front Street, Catasauqua, PA 18032
610-266-1433 FAX 610-264-2768
AAOM1@aol.com (email)

全美中醫公會

AMERICAN ASSOCIATION OF ORIENTAL MEDICINE

A CLARIFICATION OF OUR STANCE ON THE PERTINENT ISSUES

The AAOM stands for high educational standards.

What Does This Mean?

-The AAOM believes anyone may practice Oriental Medicine, provided they have passed the NCCAOM acupuncture examination or it's equivalent. We believe it is necessary to display a basic understanding of the core concepts of Oriental Medicine to provide safe and effective treatments..

-The AAOM supports the NCCAOM examination(s) as representation of the minimum standard for entry into the profession of acupuncture

-The AAOM supports the ACAOM accreditation process which protects our education standards and integrity.

The AAOM's Membership Criteria:

-The AAOM's voting membership is comprised solely of NCCAOM Diplomats in Acupuncture (or equivalent - California examination)

- Our membership represents the diversity of practice that is synonymous with Oriental Medicine. In order to develop high-quality practitioners, we feel it is most useful to teach core principles of the many DIVERSE forms of Oriental Medicine. Whatever form of Oriental Medicine one chooses to focus on or specialize in is a personal decision that each practitioner has the right to make. The AAOM encompasses and supports practitioners from all branches and styles of Oriental Medicine.

Our vision for the future of Oriental Medicine

-The AAOM supports the inclusion of Chinese Herbal Medicine as part of the basic curriculum for future students of Oriental Medicine. The vast majority of the ACAOM accredited schools already have herbal programs available. Chinese Herbal Medicine provides a crucial support in the treatment of many conditions, and is an important aspect in the full compliment of delivering our medical system. At present the majority of graduates of acupuncture-only training eventually return back to school to study herbs. Of course, just because one is educated in the use of herbal therapy, it does not mandate that herbal therapies must be prescribed. The same is true with acupuncture. One may choose to practice only herbs, even though acupuncture was learned. At the very least, the practitioner will have an awareness of what else is possible in maintaining the health of his/her patients.

-The AAOM supports the process begun by the five organizations to create the criteria for the academic DOM degree.

-The AAOM envisions the evolution of our profession with a continued upgrading of our educational standards so that the DOM degree eventually becomes the entry level into the profession in all 50 states. We realize this will take some time and believe a long-term vision of the future of the profession is necessary and required of a professional organization.

-The AAOM continues to give input into the independent psychometric company, Shroeder & Co. on the development of criteria for a credentialed title signifying advance education and experience in Oriental Medicine being practiced at the level of a Doctor of Oriental Medicine. The criteria is still being developed, but will include a minimum of five (5) years of clinical experience.

The AAOM wishes to see Oriental Medicine evolve with its core knowledge and integrity intact, while retaining its unique view of Nature and man's place within it.

The AAOM Board of Directors

State Medical Boards

American Association of Oriental Medicine
(610) 266-1433 / Fax: (610) 264-2768

Alabama Board of Medical Examiners
Trisch Shaner
PO Box 946
Montgomery, AL 36101
334-242-4116

Arkansas Board of Medical Examiners
115 East "C" Avenue
North Little Rock, AR 72116
501-812-4500

Arizona Board of Medical Examiners
Mark Speicher
1651 E. Morton Ave., Suite #210
Phoenix, AZ 85020-4160
602-255-3751

Acupuncture Examining Board
Marilyn Nielsen
1424 Howe Ave., Suite #37
Sacramento, CA 95825-3233
916-263-2680

Office of Acupuncture Registration
Linda Flemming
1560 Broadway, Suite #680
Denver, CO 80202-5140
303-894-2464

Dept. of Public Health
Div. of Medical Quality Assurance
Stephen Harriman
410 Capitol Ave., PO Box 340308
Hartford, CT 06134-0308
860-509-8000

D.C. Board of medicine
Division of Acupuncture
Ms. Crawford
614 "H" Street, NW, Room #108
Washington, DC 20001
202-727-5365

Board of Medical Practice
Carmen Nazario
1901 N. Du Pont Highway
New Castle, DE 19720
800-464-4307

Dept. of Business & Prof. Reg.
1940 N. Monroe St.
Tallahassee, FL 32399-0781
904-488-8860

Georgia Medical Board
Andrew Watry
166 Pryor St., SW
Atlanta, GA 30303
404-656-3913

Dept. of Comm.& Consumer Affairs
Board of Acupuncture
Ruth Gushiken
1010 Richards Street
Honolulu, HI 96813
808-586-2698

Iowa State Board of Medical Exam.
Ann Martino
1209 E. Court Ave.,
Executive Hills West
Des Moines, IA 50319-0180
515-281-5171

Idaho State Board of Medicine
Darleen Thorsted
280 N. 8th St., SUite #202
Boise, ID 83720
208-334-2822

Dept. of Professional Regluation
Nikki Zolar
320 W. Washington St., 3rd Floor
Springfield, IL 62786
217-785-0820

Helath Professions Bureau
Laura Langford
402 W. Washington St., #401
Indianapolis, IN 46204
317-232-2960

State Board of Healing Arts
Larry Buening
235 S. Topeka Blvd.
Topeka, KS 66603
913-296-7413

Kentucky Board of Med. Licensure
C. William Schmidt
310 Whittington Prkwy., #1-B
Louisville, KY 40222
502-429-8046

State Board of Medical Examiners
Delmar Rorison
630 Camp St.
New Orleans, LA 70130
504-524-6763

Board of Registration in Medicine
Acupuncture Unit
Alexander Flemming
10 West St., 3rd Floor
Boston, MA 02111
617-727-3086

State Board of Medical Examiners
Board of Acupuncture
Penny Heisler
4201 Patterson Ave.
Baltimore, MD 21215
410-764-4766

Dept. of Professional Reg.
Div. of Licensing/Enforcement
Jeri Betts
State House Station, #35
Augusta, ME 04333
207-624-8603

Dept. of Health Services
PO Box 30670
Lansing, MI 48909
517-335-0918

State Board of Medical Practice
2829 University Ave., SE #400
Minneapolis, MN 55414
612-617-2130

State Board of Regulations
Tina Steinman
PO Box 4
Jefferson City, MO 65102
573-751-0098

Mississippi State Board of Med.
Acupuncture
Thomas E. Stevens
2600 Insurance Center Drive,
Suite #200-B
Jackson, MS 39208
601-354-6645

Public Health & Human Services
Laurie Ekanger
PO Box 4210
Helena, MT 59604
406-444-5622

Health and Human Services
H. David Bruton, MD
101 Blair Drive
Raleigh, NC 27603
919-733-4534

Health Department
State Capitol-Judicial Wing
600 E. Boiulevard
Bismarck, ND 58505-0200
701-328-2373

Health and Human Servces System
Regulation and Licensure
Charles Andrews, MD
301 Centennial Mall South
PO Box 950261
Lincoln, NE 68509
402-471-2133

NH Board of Medicine
Karen Lamoureux
2 Industrial Park Dr., Suite #8
Concord, NH 03301
603-271-1203

State Board of Medical Examiners
Kevin Earle
140 E. Front St., 2nd Floor
Trenton, NJ 08608
609-826-7100

Medical Board of New Mexico
Acupuncture Division
Lynne Schmolke
PO Box 25101
Santa Fe, NM 87504
505-827-7554

Nevada State Board of
Oriental Medicine
Brant Hardy, Exec. Director
6586 Pecan Grove Court
Las Vegas, NV 89122-0957
702-643-7224 / Fax: 702-641-3322

State Medical Board of NY
Professional Licensing (Acup.)
Ronnie Huasheer
Cultural Education Center
Room #302
Albany, NY 12230
518-473-0221

State Medical Board of Ohio
Ray Bumgarner
77 S. High St., 17th Floor
Columbus, OH 43266
614-466-3934

OK Board of Medical Licensure
Lyle Kelsey
PO Box 18256
Oklahoma City, OK 73154
405-848-6841

Medical Examiners Board of Oregon
Kathleen Haley
1500 SW First Ave., Suite #620
Portland, OR 97201-5827
503-229-5770

Penn. State Board of Medicine
Acupuncture Licensing
Susan Smith
PO Box 2649
Harrisburg, PA 17105
717-783-1400

Dept. of Health, Rhode Island
Professional Regulation
3 Capitol Hill
Providence, RI 02908
401-222-2827

State Board of Medical Examiners
Acupuncture
Carole Schauvin
PO Box 11289
Columbia, SC 29211-1289
803-896-4500

State Board of Medical Examiners
Commerce & Regulations
Mitzi Turley
1323 S. Minnesota Ave.
Sioux Falls, SD 57105
605-336-1965

Tenn. Board of Health
Acupuncture Division
1st Fl., Cordell Hall Bldg.,
425 5th Avenue, North
Nashville, TN 37247-1010
615-532-3202

State Board of Medical Examiners
Acupuncture Division
Sandy Lyle
333 Guadaloupe, Tower #3, Ste. #610
Austin, TX 78701
512-305-7010 (extention: #5)

Medical Examiners Office of Utah
Todd Grey
48 Medical Dr., PO Box 8739
Salt Lake City, UT 84158-0739
801-538-6101

Virginia Board of Medicine
Acupuncture Division
Debbie Ordinay
6606 W. Broad St., 4th Floor
Richmond, VA 23230-1717
804-662-9908

Medical Board of Vermont
Gloria Herst
109 State Street
Montpelier, VT 05609-1106
802-828-2673

State Medical Board of WA
Dept. of Medical QAC
Bonnie King
1300 SE Quince St., #7866
Olympia, WA 98504-7866
360-753-2287

State of Wisconsin Board
Regulation & Licensing Division
PO Box 8935
Madison, WI 53708-8935
608-266-2112

Board of Medicine, West Virginia
Licensing Division
Crystal Lowe
101 Dee Drive
Charleston, WV 25311
304-558-2921

Board of Medicine
Health Department
Don Rolston
117 Hathaway Bldg.
2300 Capitol Ave.
Cheyenne, WY 82002
307-777-7656

Comprehensive Listing of Schools

American Association of Oriental Medicine
Toll-free: 888-500-7999
(610) 266-1433 / Fax: (610) 264-2768

Rainstar College **
Edward R. Richards
4120 N. Goldwater Blvd., #110
Scottsdale, AZ 85251
(480) 423-0375 / Fax: (480) 945-9824
www.rainstargroup.com

Phoenix Institute of Herbal Medicine & Acupuncture **
PO Box 2659
Scottsdale, AZ 85252 (602) 994-3648
Fax: (602) 423-0589
e-mail: pihma@aol.com

Samra University of Oriental Med. *
3000 S. Robertson Blvd., 4th Floor
Los Angeles, CA 90034
(310) 202-6444 / Fax: (310) 202-6007
www.samra.edu

Emperor's College of TOM *▲
1807-B Wilshire Blvd.
Santa Monica, CA 90403
(310) 453-8300 / (310) 829-3838
e-mail: outreach@emperors.edu
web site: www.emperors.edu

Five Branches Institute College & Clinic of TCM *
200 Seventh Avenue
Santa Cruz, CA 95062
(831) 476-9424 / Fax: (831) 476-8928
e-mail: tcm@fivebranches.edu
web-site: www.fivebranches.edu

Dongguk Royal University *
440 Shatto Place
Los Angeles, CA 90020
(213) 487-0110 / Fax: (213) 487-0527
Toll Free: 1-800-303-1800
info@dru.edu / www.dru.edu

Kyung San University *
8322 Garden Grove Blvd.
Garden Grove, CA 92844
(714) 636-0337 / Fax: (714) 636-8459

California Union University, ▲ School of OM
905 South Euclid St.
Fullerton, CA 92632
(714) 446-9133 / Fax: (714) 446-9106

South Baylo University *
1126 N. Brookhurst Street
Anaheim, CA 92801
(714) 533-1495 / Fax: (714) 533-6040
e-mail: admin@southbaylo.edu
web site: www.southbaylo.edu

Pacific College of Oriental Medicine *
7445 Mission Valley Road, #105
San Diego, CA 92108
(619) 574-6909 / Fax: (619) 574-6641
Toll Free: (800) 729-0941
e-mail: jmiller@ormed.edu o/r
cparrish@ormed.edu
web-site: www.ormed.edu

American College of TCM *
455 Arkansas Street
San Francisco, CA 94107
(415) 282-7600 / Fax: (415) 282-0856
lhuang@actcm.edu

Meiji College of Oriental Med. *
2550 Shattuck Avenue
Berkeley, CA 94704
(510) 666-8248 / Fax: (510) 666-0111
e-mail: meiji@pacbell.net
web-site: www.meijicollege.org

Santa Barbara College of OM *
1919 State St., Suite #207
Santa Barbara, CA 93101
(805) 898-1180 / Fax: (805) 682-1864
web site: www.sbcom.edu
e-mail: admission@sbcom.edu

Yo San University of TCM *
1314 2nd St., #202
Santa Monica, CA 90401
(310) 917-2202 / Fax: (310) 917-2203
e-mail: info@yosan.edu

Academy of Chinese Culture & Health Sciences *
1601 Clay Street
Oakland, CA 94612
(510) 763-7787 / Fax: (510) 834-8646
web-site: http://www.acchs.edu
e-mail: acchs@best.com

Colorado School of TCM
1441 York St., Suite #302
Denver, CO 80206
(303) 329-6355 / Fax: (303) 388-8165

University of Bridgeport
60 Lafayette Street
Bridgeport, CT 06601
(203) 576-4963 / Fax: (203)576-4962
e-mail: admit@ubcom.bridgeport.edu
web-site: www.bridgeport.edu/acupunct

Acupressure / Acupuncture Institute **
10506 N. Kendall Dr.
Miami, FL 33176
(305) 595-9500 / Fax: (305) 595-2622
e-mail: aai@acupuncture.pair.com
web site: www.acupuncture.pair.com

Acad. of Chinese Healing Arts, Inc.*
513 S. Orange Ave.
Sarasota, FL 34236
(941) 955-4456 / Fax: (941) 330-1951
e-mail: info@acha.net / web-site: www.acha.net

Atlantic Institute of OM *
1057 SE 17th Street
Fort Lauderdale, FL 33316-2116
(954) 463-3888 / Clinic: (954) 522-6405
Fax: (954) 463-3878
e-mail: atom@atom.edu / web: www.atom.edu

Tai Institute of Oriental Medicine
108 E. Broadway Street
Oviedo, FL 32765
(407) 366-8615 / Fax: (407) 366-8648
e-mail: hhci@holistichealthconcepts.com
web site: www.holistichealthconcepts.com

Florida Institute of TCM Inc. *
5335 66th St. North
St. Petersburg, FL 33709
(727) 546-6565 / Fax: (727) 547-0703
Toll Free: (800) 565-1246
e-mail: fitcm@gte.net

National College of Oriental Medicine *
7100 Lake Elanor Dr.
Orlando, FL 32809
(407) 888-8689 / Fax: (407) 888-8211
e-mail: info@acupunctureschool.com
web-site: www.acupunctureschool.com

Chinese Medical Institute
8386 SW 40th Street
Miami, FL 33155
(305) 228-0380 / Fax: (305) 221-7972

Florida School of Acupuncture & OM
1705 NW 6th Street
Gainseville, FL 32609
(352) 371-2833 / Fax: (352) 371-2876
dbole@aol.com

Florida College of Natural Health ▲
1751 Mound Street, #G-100
Sarasota, FL 34236
(941) 954-8999 / Toll Free: 800- 966-7117
Fax: (941) 954-8991
e-mail: fcnh@acun.com / web site:
www.fcnh.com

Han Yang School of Acup. & OM
3149 N. Cortenay Pkwy.
Merritt Island, FL 32953
(407) 454-9259 / Fax: (407) 454-9974

Florida Health Academy - Naples
261 9th St., South
Naples, FL 34102
(941) 495-8282 / Fax: (941) 263-8680
www.ceuonline.org

Suncoast School
4910 West Cypress Street
Tampa, FL 33607
(813) 287-1099/ Fax: (813) 287-1914
runanue@aol.com

Acad. for Five Element Acup. Inc. *
1170-A E. Hallandale Beach Blvd.
Halandale, FL 33009
(954) 456-6336 / Fax: (954) 456-3944
afea@compuserve.com

Hawaii College of Health Sciences
1750 Kalakaua Ave., #2503
Honolulu, HI 96826
(808) 941-8223 / Fax: (808)944-8343
hawaiicollege@hotmail.com

Oriental Medical Institute of Hawaii
181 S. Kukui Street, #206
Honolulu, HI 96813
(808) 536-3611 / Fax: (808) 537-5821

Tai Shuan Fndtn. College of Acupuncture & Herbal Medicine *
PO Box 11130
Honolulu, HI 96828
(808) 947-4788 / Fax: (808) 947-1152
e-mail: taishuancollege@cs.com

Trad. Chinese Medical College of HI **
PO Box 2288
Kamuela, HI 96743
(808) 885-9226 / Fax: (808) 885-7886
chinese@ilhawaii.net

Institute of Clinical Acup. & OM
1270 Queen Emma St., Suite #107
Honolulu, HI 96813
Phone & Fax: (808) 521-2288
icaom@aol.com / www.orientalmedschool.com

Kansas College of Chinese Medicine **
9235 E. Harry Bldg., 100, #1-A
Wichita, KS 67207
(316) 691-8822 / (316) 691-8868
e-mail: kccm@southwind.net

New England School of Acupuncture *
40 Belmont Street
Watertown, MA 02472
(617) 926-1788 / Fax: (617) 924-4167
e-mail: info@nesa.edu / web site:
www.nesa.edu

Maryland Institute of TCM. Inc. *
4641 Montgomery Ave., Suite #415
Bethesda, MD 20815
(301) 718-7373 / Fax: (301) 718-0735
e-mail: martindell@aol.com / web:
www.mitcm.org

Traditional Acupuncture Institute *
The American City Building
10227 Wincopin Circle, Suite #100
Columbia, MD 21044
(301) 596-6006 / Fax: (410) 964-3544
www.tai.edu

MN Institute of Acup. & Herbal Studies **
Northwestern Health Sciences University
2501 W. 84th Street
Minneapolis, MN 55431
(612) 885-5435 / Fax: (612) 887-1398
e-mail: miahs@muhealth.edu
web-site: www.mwhealth.edu

Rocky Mountain Herbal Institute
PO Box 579
Hot Springs, MT 59845
(406) 741-3811
web-site: www.rmhiherbal.org
e-mail: rmhi@rmniherbal.org

The Eastern School of Acupuncture & Traditional Medicine
37 N. Fullerton Avenue, Suite #205
Montclair, NJ 07042
(973) 746-8717 / Fax: (973) 746-8714

International Institute of Chinese Med. *
4884 La Junta Del Almo
Santa Fe, NM 87505
(505) 473-5233 / Toll Free: (800) 377-4561
Clinic: (505) 837-9778
Fax: (505) 473-9279
www.iicm.com

International Institute of Chinese Med. *
Albuquerque Branch
4600 Montgomery, #1-1
Albuquerque, NM 87109
(505) 883-5569 / Toll Free: 888-937-4426
Clinic: (505) 474-9330
Fax: (505) 880-1775
www.iicm.com

International Institute of Chinese Med.
Denver, CO Branch
1385 S. Colorado, #110-A
Denver, CO 80222
(303) 584-9050 / Toll Free: 877-577-1044
Fax: (303) 584-0285 / www.iicm.com

Southwest Acupuncture College *
2960 Rodeo Park Drive West
Santa Fe, NM 87505
(505) 438-8884 / Fax: (505) 438-8883

Southwest Acupuncture College *
Albuquerque Branch
4308 Carlisle N.E., #205
Albuquerque, NM 87107
(505) 888-8898 / Fax: (505) 888-1380

Southwest Acupuncture College *
Boulder, CO Branch
6658 Gunpark Drive
Boulder, CO 80301
(303) 581-9955 / Fax: (303) 581-9944

New York College for Wholistic Health Education & Research *
6801 Jericho Turnpike
Syosset, NY 11791
(800) 922-7337 / Fax: (516) 364-0989
e-mail: nycinfo@nycollege.edu
web site: www.nycollege.edu

Mercy College: Program in Acupuncture & Oriental Medicine ** ▲
555 Broadway
Dobbs Ferry, NY 10522
(914) 674-7401 / Fax: (914) 674-7374
e-mail: acu@mercynet.edu

Tri-State College of Acup. *
80 8th Ave., 4th Floor
New York, NY 10011
(212) 242-2255 / Fax: (212) 242-2920
TSITCA@aol.com

Pacific College of Oriental Medicine, NY *
(Branch of Pacific College, San Diego)
915 Broadway, 3rd Floor
New York, NY 10010
(212) 982-3456 / Fax: (212) 982-6514
e-mail: rdeming@ormed.edu
jpark@ormed.edu
web-site: www.ormed.edu

New York Institute of Chinese Medicine ** ▲
155 First Street
Mineola, NY 11501
(516) 739-1545 / Fax: (516) 739-2798

American International Acupuncture Inst. **▲
Stanley Chang, Ph.D., President
5223 Seventh Avenue
Brooklyn, NY 11220
(718) 854-3826 / Fax: (718) 946-2492
aiacup@aiacup.com

National College of Naturopathic Med. **
49 S.W. Porter
Portland, OR 97201
(503) 499-4343
Fax: (503) 499-0022
e-mail: admissions@ncnm.edu
web site: www.ncnm.edu

Oregon College of OM *
10525 SE Cherry Blossom Drive
Portland, OR 97216
(503) 253-3443 / Fax: (503) 253-2701
e-mail: Lpowell@teleport.com
web: www.infinite.org/oregon.acupuncture

American College of Acupuncture & OM *
9100 Park West Drive
Houston, TX 77063
(713) 780-9777 / Fax: (713) 781-5781
web site: www.acaom.edu

North American School of OM
3917 Booth Calloway Rd.
Richland Hills, TX 76118
(817) 284-3037 / Fax: (817) 284-1047
naoms@doctor.com

Academy of Oriental Medicine at Austin * ▲
Stuart Watts, President
2700 W. Anderson Lane, #204
Austin, TX 78757
(512) 454-1188 / Fax: (512) 454-7001
e-mail: academyom@aol.com
web site: www.aoma.edu

Texas College of TCM *
4005 Manchaca Road
Austin, TX 78704
(512) 444-8082 / Fax: (512) 444-6345
Toll Free: (800) 252-5088
www.texastcm.edu

Bastyr University *
14500 Juanita Dr., NE
Kenmore, WA 98208
(425) 602-3330 / Fax: (425) 823-6222
e-mail: admiss@bastyr.edu / web site:
www.bastyr.edu

Northwest Institute of Acupuncture & Oriental Medicine * ▲
701 N. 34th Street, Suite #300
Seattle, WA 98103
(206) 633-2419 / Fax: (206) 633-5578
www.niaom.edu

Seattle Inst. of Oriental Medicine *
916 NE 65th Street, Suite B
Seattle, WA 98115
(206) 517-4541 / Fax: (206) 526-1932
web site: www.siom.com

Midwest College of Oriental Medicine *
6226 Bankers Road, Suite #8
Racine, WI 53403
(262) 554-2010 / Fax: (262) 554-7475
www.acupuncture.edu

Midwest College of Oriental Medicine *
Chicago Campus
4334 N. Hazel, #206
Chicago, IL 60613
(773) 975-1295 / Fax: (773) 975-6511

Canadian College of Acupuncture & OM *
(accredited through Canadian authority)
855 Cormorant St.,
Victoria, BC, Canada, V8W 1R2
(250) 384-2942 / Fax: (250) 360-2871
Toll Free: (888) 436-5111
ocaom@islandnet.com
www.ccaom.com

* = Accredited Programs
** = Candidate Programs
▲ = AAOM School Member

State Acupuncture Associations (In Order by State)

American Association of Oriental Medicine
(610) 266-1433 / Fax: (610) 264-2768

Arizona Acupuncture Society
Leslie McGee
PO Box 64452
Tuscon, AZ 85728
Toll Free: (800) 955-7985

Arkansas Assn. of Oriental Medicine
Dan Martin
7117 E. Broad St.
Texarkana, AR 71854
(870) 772-8622 / Fax: (870) 774-2008
northfield@aol.com

California Acupuncture Medical Assn.
Charles Tsai
1042 S. San Gabriel Blvd.
San Gabriel, CA 91776
(626) 287-0938 / Fax: (626) 287-8312

California Assn. of Acupuncture & OM
Benjamin Dierauf
2710 X Street, #2-A
Sacramento, CA 95818
(800) 477-4564 / Fax: (916) 455-0356
office@csoma.org

California Certified Acupuncturists Assn.
Shen Xiang
777 Stockton St., Suite #106
San Francisco, CA 94108
(415) 981-8384 / Fax: (510) 530-7018

Center for Chinese Medicine
(Public Information Center)
Pedro Chan
5266 E. Pomona Blvd., #106
Los Angeles, CA 90022
(323) 721-0774 / Fax: (323) 721-0960

Japanese Acupuncture Assn. of California
Doann T. Kaneko
2309 Main Street
Santa Monica, CA 90405
(310) 396-4877

Acupuncture Association of Colorado
Elissa Blesch
2050 S. Oneida St., #118
Denver, CO 80224
(303) 572-8744
aac@ntw.net

US Korean Assn. of Acupuncture & OM
Hong To Na
1244 5th Street, NE
Washington, DC 20002
(202) 544-1091 / Fax: (202) 544-2929

Florida State Oriental Medical Assn.
Carol Bates
335 Beard Street
Tallahassee, FL 32303
(850) 222-6000 / Fax: (850) 222-6002
melinda@hmgnet.com

Big Island Acupuncture Assn.
Chieko Maekawa
72-3996 Hawaii-Belt Rd.
Kai Lua-Kona, HI 96740
(808) 325-7778 / Fax: (808) 325-7748
Maekawa!@gate.net

Hawaii Acupuncture Assn.
Leon Le Toto
PO Box 11202
Honolulu, HI 96828
(808) 538-MOXA / Fax: (808)735-2961
needle@pixi.com

Idaho Acupuncture Assn.
Emi Miller
750 Warm Springs Ave., Suite G
Boise, ID 83712
(208) 343-0800

Illinois State Acupuncture Association
Connie Aburano
1525 E. 53rd St., #705
Chicago, IL 60615
(773) 363-0370 / Fax: (773) 955-9953
mjrogel@earthlink.com

Acupuncture Association of Kansas
Qizhi Gao
9235 E. Harry Bldg. 100, #1-A
Wichita, KS 67207
(316) 691-8822 / Fax: (316) 691-8868
kccm@southwind.net

Acupuncture Society of Massachusetts
Elaine Eliopoulos
PO Box 400998
Cambridge, MA 02140
Elaine direct: (781) 894-2083
(617) 926-7192 / Toll Free: 800-444-1565
Fax: (617) 926-7192
email: ReachASM@aol.com

Mass. Association of Acupuncture & OM
Kathy Tamilio
465 Park Avenue
Worcester, MA 01610
(508) 798-0638 / Fax: (508) 795-7363
acumom@bigplanet.com

Maryland Oriental Medicine Association
Steven Kaufman, President
3681 Offutt Rd., PMB 289
Randallstown, MD 21133
(410) 466-7033
email: drtcm@bigplanet.com

Maryland Acupuncture Society
David Blaiwas
1615 York Rd., Suite #205
Lutherville, MD 21093
(301) 854-9950 / Fax: (301) 854-9950
dblaiwas@aol.com

Maine Assn. of Acupuncture & OM
Elizabeth Garrett
PO Box 2131
S. Portland, ME 04106
(207) 871-5966 / Fax: (207) 871-5966
ekgarnett@aol.com

Michigan Association of Acupuncture & OM
Deborah Lincoln
4655 Dobie Rd., #270
Okemos, MI 48864
(517) 347-2293 / Fax: (517) 349-2733
koalablue@prodigy.net

Acupuncture Assn. of Minnesota
Emily Hoecherl
PO Box 50213
Minneapolis, MN 55405
(651) 641-0467

Acupuncture Association of Missouri
Kathleen Coleton
7216 Wormall Rd.
Kansas City, MO 64114
(816) 822-0500 / Fax: (816) 525-2322
coleton@solve.net

Montana AAOM
Jean Logan
1200 S. Reserve St., Suite H
Missoula, MT 59801
(406) 728-1600 / Fax: (406) 327-6702
acuclinic@montana.com

Acupuncture Assn. of North Carolina
John McGimsey
1500 Scott Avenue
Charlotte, NC 28203
(704) 737-4412

New Hampshire Acupuncture Assn.
Joseph Dudley
39 Grove Street, #8
Peterborough, NH 03458
(603) 924-1380 / Fax: (603) 924-1380
jpdudley@monaa.net

New Jersey Acupuncture Assn.
James Golding
373 E. Main Street
Somerville, NJ 08876-3187
(908) 526-5868 / Fax: (908) 253-9826
golding4@aol.com

OM Association of New Mexico
Alix Bjorklund
PO Box 67381
Albuquerque, NM 87193-7381
(505) 982-5156 / Fax: (505) 982-2344
omaam@hotmail.com

Nevada Oriental Medical Association.
Damon Yang
2404 Santa CLara
Las Vegas, NV 89104
(702) 369-3688 / Fax: (702) 369-7366
drbyang@cs.com

Acupuncture Society of New York
Fred Cramer
1858 Pleasantville Rd., Suite #112
Briarcliff, NY 10510-1038
(914) 923-0632 / Fax: (914) 923-0632
asnymail@compuserve.com

Acupuncture & OM Society of Oregon
Evelyn-Brust-Thille
1245 NW Galveston Ave.
Bend, OR 97701
(541) 383-3424 / Fax: (541) 383-2227

Acupuncture Society of Pennsylvania
Beverly Shapiro
PO Box 7676
Philadelphia, PA 19101
(215) 992-6991

Rhode Island Society of Acupuncture & OM
Tierney Tully
PO Box 6681
Providence, RI 02940-6681
(401) 247-0221 / Fax: (401) 247-0221
ebacupuncture@earthlink.com

Southeast Acupuncture Assn.
William Skelton 620 Sims Avenue
Charleston, SC 29205
(803) 256-1000 / Fax: (803) 782-6234
wdskelton@cs.com

Texas Acupuncture Assn.
Leslie Myers
PO Box 3902
Austin, TX 78764-3902
(512) 463-1463 ext. #2045
Fax: (512) 463-1418
lmyers @texasbar.com

Korean American Acupuncture Assn.
Dong Rae Park
3068 Forest Lane, #120
Dallas, TX 75234
(972) 243-4567 / Fax: (972) 247-2449
doctor@ohte.com

Utah Acupucnture Association
Kris Justesen
545-E 4500 South, #E-230
Salt Lake, UT 84107
(801) 263-9380 / Fax: (801) 263-9925
kjustesen@uswest.net

Acupuncture Society of Virginia (ASVA)
Floyd M. Herdrich
6174 Pohic Station Drive
Fairfax Station, VA 22039
(703) 978-4956 / Fax: (703) 978-9864
76415.621@compuserve.com

Vermont Assn. of Acupuncture & OM
28 E. State Street
Montpelier, VT 05602
(802) 229-1800 / Fax: (802) 229-1800
mela@together.net

Acupuncture Assn. of Washington
Christopher Houston
PO Box 31385
Seattle, WA 98103
(206) 329-9094 / Fax: (206) 851-6883

West Virginia Board of Acupuncture
C.P. Negri
Po Box 252
Huntington, WV 25707-0252
(304) 529-9355 / Fax: (304) 529-3710
Voice Mail: (304) 529-4558

State Status Regarding Oriental Medicine

Timeline of Adoption of Statutes

- 1973 - Nevada, Oregon, Maryland
- 1974 - Hawaii, Montana, South Carolina
- 1975 - Louisiana
- 1976 - California
- 1978 - Rhode Island
- 1981 - Florida, New Mexico
- 1983 - New Jersey, Utah
- 1985 - Vermont (registration), Washington
- 1986 - Massachusetts, Pennsylvania
- 1987 - Maine
- 1989 - Colorado, D.C., Wisconsin
- 1990 - Alaska
- 1991 - New York
- 1993 - Iowa, North Carolina, Texas, Virginia
- 1994 - Vermont (certification)
- 1995 - Connecticut, Minnesota
- 1996 - W. Virginia
- 1997 - Illinois, Arkansas, New Hampshire
- 1998 - Arizona, Missouri
- 1999 - Idaho, Indiana
- 2000 - Georgia, Ohio, Tennessee

Practice Requirements

State	Medical Referral, Prior Diagnosis or Supervision
Alaska	Independent
Arizona	Independent
Arkansas	Independent
California	Independent
Colorado	Independent
Connecticut	Independent
D.C.	Written Authorization
Florida	Independent
Georgia	Independent
Hawaii	Organic Disorders
Idaho	Independent
Iowa	Evaluation & Referral
Illinois	Written Authorization
Louisiana	Supervision
Maine	Independent
Maryland	Independent
Massachusetts	Independent
Minnesota	Independent
Missouri	Independent
Montana	Independent
Nevada	Independent
New Hampshire	Independent
New Jersey	Referral or Diagnosis
New Mexico	Independent
New York	Independent
North Carolina	Independent
Ohio	Supervision
Oregon	Independent
Pennsylvania	Supervision
Rhode Island	Independent
South Carolina	Supervision & Referral
Texas	Evaluation or Referral
Utah	Independent
Vermont	Independent
Virginia	Independent
Washington	Independent
West Virginia	Independent
Wisconsin	Independent

Summary of individual laws by state

Licensure

Alaska
Arizona
Arkansas
California
Connecticut
D.C.
Florida
Georgia
Hawaii
Idaho
Illinois
Louisiana
Maine
Maryland
Massachusetts
Minnesota
Missouri
Montana
Nevada
New Hampshire
New Jersey
New Mexico (DOM)
New York
North Carolina
Oregon
Rhode Island (Dr. / Acu.)
Texas
Virginia
Washington
Wisconsin
West Virginia

TOTAL: 31

State Boards of Acupuncture

Arizona
Arkansas
California
Connecticut
Florida
Georgia
Hawaii
Illinois
Idaho
Maine
Maryland
Minnesota
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
Texas
Utah
West Virginia
Wisconsin

TOTAL: 22

States with no Boards or Committees

Alaska
Kansas
Michigan
Missouri
Ohio
Rhode Island
S. Carolina

TOTAL: 6

Registration

Colorado - R.A.
Iowa - R.A.
Ohio - R.A.
Pennsylvania - R.A.
S. Carolina - Permission
Utah - C.A.
Vermont - C.A.

TOTAL: 7

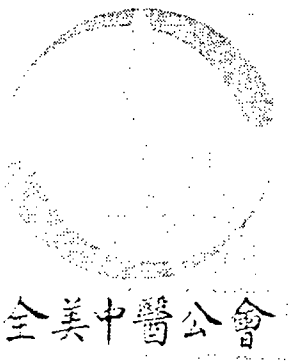
State Committees of Acupuncture

D.C. - Acu. Com./Med. Board
Iowa - Med. Board
Louisiana - Med. Board
Mass. - Acu. Com./Med. Board
Oregon - Acu. Com./Med. Board
Pennsylvania - Med. Board
Virginia - Adv. Com.
Washington - Dept. Health
Missouri - Adv. Com.

TOTAL: 9

NATIONAL PRESS CLUB

ACUPUNCTURE



AMERICAN ASSOCIATION OF ORIENTAL MEDICINE

AAOM, a professional association of practitioners, has worked to preserve the integrity of acupuncture and Oriental medicine since 1981. AAOM remains the nation's largest and strongest advocate for the national recognition of the profession of Oriental medicine.

AAOM acts as an advocate to protect the consumer's right to freedom of choice in health care providers while at the same time being vigilant to insure that the public is offered acupuncture and Oriental medicine that is performed with a high standard of competency.

The source for acupuncture information

AMERICAN ASSOCIATION OF ORIENTAL MEDICINE
433 Front Street, Catasauqua, PA 18032 610-266-1433 or 1-888-500-7999
fax: 610-264-2768 e-mail: aaom1@aol.com web site: www.aaom.org

ADDICTION MEDICINE

AMERICAN SOCIETY OF ADDICTION MEDICINE
Arcade Suite 101
4601 No. Park Avenue
Chevy Chase, MD 20815

JAMES F. CALLAHAN, D.P.A.
Executive Vice President/CEO
(301) 656-3920
(301) 656-3815 FAX
E-Mail: email@asam.org
Home Page: www.asam.org

ASAM is a professional medical society whose 3,200 physician members are involved in treatment, research, education, and prevention of alcohol, nicotine and other drug dependencies. ASAM promotes public policies to increase availability and effectiveness of treatment, and publishes criteria for treatment of addictions. The Society publishes a textbook, *Principles of Addiction Medicine: Second Edition*; the *Patient Placement Criteria for Treatment of Substance-Related Disorders: Second Edition Revised (ASAM PPC-2R, 2000)*; and a quarterly *Journal of Addictive Diseases*. ASAM administers a certification examination in addiction medicine, conducts courses for primary care physicians and practitioners of addiction medicine, and holds conferences, including the Annual Medical-Scientific Conference and the Conference on Nicotine Dependence.

Brian C. Fennen, L.Ac., QME, CMT

2436 Foothill Blvd., Suite D, Calistoga, CA 94515
tel: 707-942-9380 fax: 707-942-8242 email: brianf@sonic.net

LICENSES & CERTIFICATIONS

Oriental Medicine

Licensed Acupuncturist
Acupuncture Board, State of California 1989
Diplomate in Acupuncture
National Commission for the Certification of Acupuncturists, Acupuncture 1988

Workers Compensation

Qualified Medical Evaluator
State of California, Industrial Medical Council 1996

Massage Therapy

Oriental Bodywork Therapy
National Certification Commission for Acupuncture and Oriental Medicine 1998
Certified Massage Therapist
National Certification Board for Therapeutic Massage and Bodywork 1993
Certified Massage Technician
Okazaki Restorative Massage Certification Program 1983

Teaching

Certified Dan Zan Ryu Jujitsu Instructor
American Judo & Jujitsu Federation 1993
Certified Massage Instructor
American Oriental Bodywork Therapy Association 1992
Registered Massage Instructor
California Superintendent of Public Instruction 1991
Certified Massage Instructor
Okazaki Restorative Massage Certification Program 1987

DIRECTORSHIPS

Council of Acupuncture & Oriental Medicine Associations
President ..... 1998 - 2000
California State Oriental Medical Association (CSOMA)
President ..... 1997 - 1999
Mayacamas Healing Arts Network
Director ..... 1998 - 2000

COMMITTEES & TASK FORCES

Curriculum Task Force, California State Acupuncture Board
Member ..... 1999 -2000
Legislative Committee, CSOMA
Chair 1997-2000
Examination Task Force, California State Acupuncture Board
Member 1999
Massage Advisory Committee, American Specialty Health Plans
Member ..... 1999 -2000
Herbal Medicine Advisory Committee, American Association of Oriental Medicine
Member ..... 1998 -2000
Oriental Medicine Doctorate Task Force
Accreditation Commission for Acupuncture & Oriental Medicine ..... 1998 -1999
Acupuncture Quality Improvement Committee, American Specialty Health Plans
Member ..... 1997 -2000
Editorial Board, California Journal of Oriental Medicine
Member ..... 1996 -2000
CSOMA Peer Review Committee
Member 1994
Massage Instructor Review Committee, American Oriental Bodywork Therapy Association
Member 1993-1995

PANELS & PRESENTATIONS

Chinese Herbal Medicine Panel
Moderator, Acupuncture Expo2000 Conference 4/30/00
Practice Essentials for New Practitioners Seminar
Speaker, Acupuncture Expo2000 Conference 4/30/00
Oriental Medicine in Primary Care Panel
Panelist, Acupuncture Expo2000 Conference 4/29/00
Current Status of Oriental Medicine Panel
Panelist, Acupuncture Expo2000 Conference 4/28/00
Chinese Herbal Medicine Panel
Moderator & Panelist, Acupuncture Expo'99 Conference 3/99
The Future of Oriental Medicine Panel
Panelist, Acupuncture Expo'99 Conference 3/99
The Status of Oriental Medicine Panel
Panelist, Acupuncture Expo'99 Conference 3/99
Acupuncture in Managed Care Seminar
USC-sponsored Managed Care Conference 8/98
Chinese Herbal Medicine Panel
Moderator, Acupuncture Expo'98 Conference 5/98
Acupuncture & Managed Care Panel
Moderator, Acupuncture Expo'98 Conference 5/98
Herbal Medicine Round-Table
Panelist, California Herb Consortium 7/96

Brian C. Fennen, L.Ac., QME, CMT

PROFESSIONAL ASSOCIATIONS

California State Oriental Medical Association (CSOMA)
Member 1990-
Associated Massage & Bodywork Professionals
Member 1996-
American Association of Oriental Medicine
Member 1989-
National Sports Acupuncture Association
Founding Member 1993-
American Oriental Bodywork Therapy Association
Member 1993-
American Judo & Jujitsu Federation
Member 1983-

EDUCATION & TRAINING

Acupuncture Orthopedics
250-hour post-graduate course - Lerner Education, Oakland. 1995
Jujitsu
American Judo & Jujitsu Federation - Dan Zan Ryu Jujitsu 1983-
Acupuncture & Oriental Medicine
San Francisco College of Acupuncture & Oriental Medicine 1988
Massage
AJJF National Massage Certification Program - Japanese Restorative Massage 1983
Conservation of Natural Resources
Bachelor of Science, University of California, Berkeley 1978

PROFESSIONAL EXPERIENCE

Consultant
Oriental Medicine, Acupuncture, Herbal Medicine, Massage 1997-2000
Acupuncturist & Herbalist
Self-employed 1989-2000
Instructor
Various Massage Certification Programs 1986-2000
Manager
Le Spa Francais Resort & Spa 1986-1988
Administrator
Okazaki National Massage Certification Program 1985-1997
Massage Therapist
Self-employed 1984-2000

#117

CITIZENS COMMISSION ON HUMAN RIGHTS OF SEATTLE

300 Lenora Street, #B252, Seattle, WA 98121 (206) 283-1099

TESTIMONY

October 31, 2000

My name is Richard Warner. I am the President of the Seattle Chapter of the Citizens Commission on Human Rights, which was established in 1969 by the Church of Scientology to investigate and expose psychiatric violations of human rights and to clean up the field of mental healing. At present we have 130 chapters in 31 countries worldwide.

I'd like to address the subject of mental health treatment. We believe this is a field in which standard medical practice and alternative medicine could effectively complement each other.

A large percentage of the people who get labeled "mentally ill" actually have a physical condition which has not been properly diagnosed. There are well over one hundred physical conditions which can produce symptoms such as anxiety, depression, hallucinations, and other mental and emotional disturbances. Unfortunately, due to decades of mental illness marketing, these symptoms are immediately identified as symptoms of a "sick" mind instead of symptoms of diabetes, brain tumors, thyroid disorders, and mild epilepsy or as symptoms of nutritional deficiencies, hormonal imbalances, or toxic and allergic reactions.

Accompanying my written testimony you will find information on several studies of psychiatric misdiagnosis. There is a growing body of evidence which indicates that 40 to 75% of mental patients are suffering from undiagnosed physical illness. Let me mention just one study cited by Dr. Sydney Walker in his book, "A Dose of Sanity." In 1990, Lorrin Koran and his colleagues examined 529 randomly selected patients in eight treatment programs in a state mental health system. They found nearly 38% of those patients had significant, detectable physical disease - but less than half of them had been diagnosed.

This problem of misdiagnosis is really one of non-diagnosis. Individuals with mental or emotional symptoms are quite likely to simply be stamped with a psychiatric label with no attempt made to determine what is actually producing their symptoms. They are told they have an incurable illness and that they need to take psychiatric drugs for the rest of their lives. These drugs, far from correcting alleged chemical imbalances, produce them. They also, in many instances, produce permanent, irreversible brain damage.

In his recent book, "Blaming the Brain, Elliot Valenstein, Professor Emeritus of Psychology and Neuroscience at the University of Michigan, writes, "...the evidence and arguments supporting all these claims about the relationship of brain chemistry to psychological problems and personality and behavioral traits are far from compelling and are most likely wrong."

If what are known as mental illnesses are chronic, it is only because their actual cause is never searched for, never found, and never treated. Individuals with mental and emotional disturbances should be given thorough and searching physical examinations to determine what is actually wrong with them. This would include an investigation of nutritional deficiencies. Treatment would be targeted at whatever condition was uncovered by the exam and might well include treatments with vitamins, minerals, amino acids, essential fatty acids and other nutrients.

The marketing of mental illness continues to this day and often government institutions work hand in hand with psychiatry and the psychiatric drug industry to insure that the first thoughts of anyone with a mental or emotional difficulty are, in order, 1) "mental illness;" 2) "biochemical imbalance," and 3) the name of a well-advertised psychiatric drug. Turning this around will not be easy, but if governments can spend billions on programs to convince us we're all mentally ill, then, with your help, we can get the government to send a different message - that wellness is achievable with proper medical attention.

Recommendations:

1. We currently spend billions of state and federal money promoting a theory of mental illness which even the experts admit is just a theory. These same experts also admit they do not know what causes mental illness and they do not have any cures. If we can spend billions promoting one theory which has led to no causes and cures then we surely spend an equal amount educating the public and primary care physicians on the mental and emotional symptoms of a wide range of physical illnesses and infirmities and on workable approaches to mental healing.

2. Promote research into workable treatments for mental illness. What are the outcomes - both long and short term - for someone who receives allopathic or CAM treatment for the actual physical condition which is causing their symptoms versus standard psychiatric labeling, drugs and electroshock? What are the costs of a lifetime of psychiatric treatment versus treatment that can produce wellness? If the National Institute of Mental Health can spend $600 million a year studying such things as the sexual behavior of hamsters, prairie voles, lizards and horses, or how rats react to LSD then surely, with your help, we can find money to research medical treatments which actually work.

3. Set up CAM treatment centers around the country where individuals who are experiencing mental and emotional difficulty can receive thorough medical exams and expert medical attention in a safe, restful environment with ample food, excellent nutrition and access to CAM treatments.

Respectfully submitted,

Richard Warner, President
Citizens Commission on Human Rights of Seattle

PSYCHIATRY THE ULTIMATE BETRAYAL

BY BRUCE WISEMAN

FREEDOM PUBLISHING
LOS ANGELES

betrays common-sense virtues.

As much as the psychiatrist likes to rail against morals as being too stressful and as much as he promotes the notion that "people can't help themselves," the truth is that all of us have managed to rise above our more base impulses when necessity has dictated.

It is not only possible, but, contrary to the psychiatrist's teachings, it is *necessary* to sanity.

Many an individual has undergone miraculous change of mental state by ending immoral behavior and deciding to live a "clean" life.

For some people, however, this may not be enough to resolve their troubles. They may need to talk their difficulties over with a friend, a family member, a religious counselor, or simply someone they trust.

Some may need to separate themselves from people or situations that make chronic trouble for them.

However, there are certain individuals who are simply so overwhelmed or disturbed that no amount of talk or moralizing will assist them.

They need help. And help is possible.

WHEN PHYSICAL ILLNESS OVERWHELMS THE MIND

In a 1967 article in the *American Journal of Psychiatry*, researchers Richard Hall and Michel Popkin wrote the following: "The most common medically induced psychiatric symptoms are apathy, anxiety, visual hallucinations, mood and personality changes, dementia, depression, delusional thinking, sleep disorders (frequent or early morning awakening), poor concentration, changed speech patterns, tachycardia [rapid heartbeat], nocturia [excessive urination at night], tremulousness, and confusion.

"In particular, the presence of visual hallucinations, illusions, or distortions indicated a medical etiology [cause] until proven otherwise. Our experience suggests this to be the most reliable discriminator [between medical and mental problems]. We were able to define a specific medical cause in 97 of 100 patients with pronounced visual hallucinations."[21]

This report is telling us that 97 percent of the cases of visual hallucinations they saw were *medical* in origin.

Visual hallucinations have always been a classic characteristic of the lunatic or *schizophrenic*. Given that millions of people have been lobotomized, shocked, extensively drugged, or relegated to the back wards of

state hospitals for the rest of their lives because they were "seeing things," this 97 percent figure takes on a rather monolithic—and sobering—significance.

In and of itself this single psychiatric error may constitute the equivalent of a Medical Holocaust.

In this and other reports we are told studies have shown time and again that in a high number of patients, what appear to be "mental" problems are actually caused by physical ailments.

And these are generally ordinary medical problems that have nothing to do with psychiatry.

Hall and Popkin claim these mental symptoms are often the first or only signs of an underlying physical disorder.

This is not even new news.

In 1936, B.I. Comroe reported in the *Journal of Nervous Mental Disorders* that 24 out of 100 patients labeled *neurotic* developed organic disease within eight months of their initial diagnosis.[22]

A 1949 survey found that 44 percent of psychiatric patients were physically ill.[23]

A report published in 1965 cited a 42 percent incidence of "physical disease causative of initial psychiatric symptoms." The same researcher found 58 percent of the patients attending his psychiatric clinic suffered from some physical illness.[24]

A 1967 study in the *American Journal of Psychiatry* investigated 46 patients who had carcinoma (a type of cancer) of the pancreas, an illness which is very difficult to diagnose in its early stages. The result was that 76 percent had psychiatric symptoms which appeared to be closely related to the initial presence of the carcinoma growth. Symptoms of depression, anxiety, and premonition of serious illness were characteristic. The "psychiatric symptoms" appeared before any others in nearly half of the patients.[25]

Researcher Erwin Koranyi's 1972 study published in the *Canadian Psychiatric Association Journal* and presented to the Sixth World Congress of Psychiatry in 1977, showed that half of the people seeking psychiatric help in a clinic population had readily diagnosable physical problems which were often the sole cause for their mental symptoms.

In a 1977 study of the deaths of psychiatric patients, Koranyi found that 80 percent were physically ill at time of death. People had died from

undiagnosed or misdiagnosed physical maladies such as cancer of the pancreas, water on the brain, bronchial cancer, syphilis, diabetes, and hardening of the arteries.

In 1979, Koranyi reported that out of 2,090 psychiatric patients referred to a Canadian outpatient clinic, 43 percent were suffering from one or more major, previously undetected physical illnesses, including hepatitis, syphilis, malaria, cancer, hypoglycemia, vitamin deficiencies, anemia, epilepsy, heart disease, asthma, and ulcers.

He stated: "Conditions believed to be primarily psychiatric or 'psychosomatic' in nature, but in fact concealing a physical illness, may don the apparel of a depression, an anxiety state, apathy,...aggression, a variety of sexual problems, delusions, hallucinations, confusional states, or changes in the customary features of the personality. No single psychiatric symptom exists that cannot at times be caused or aggravated by various physical illnesses.[26]

A major report confirming these findings was presented at the 1980 convention of the American Psychiatric Association. It was found that out of 100 patients:

- 76 percent were found to be psychotic at the time of admission.
- 46 percent of the 100 patients were found to have a previously unrecognized or undiagnosed medical illness underlying or exacerbating their mental problems.
- 28 of these 46 patients (61 percent) showed a dramatic and rapid clearing of their mental problems following treatment for their medical condition.
- 18 more patients experienced a significant improvement of their mental condition following medical treatment.
- 80 percent of the patients studied were found to have a previously undetected physical disorder requiring treatment.

Illustrative of this phenomena is the case of Jeanette Wright of Bear Creek, Wisconsin. For thirty-five years she was labeled by psychiatrists as variously schizophrenic, manic depressive, and acutely psychotic. She was treated with large quantities of psychiatric drugs as well as electroshocks. After enduring this nightmare for most of her life, she was finally correctly diagnosed by a physician as having hypothyroidism.

She was cured in 11 days.

According to Dr. Douglas Hunt, author of a 1988 self-help book on anxiety disorders, "Many of the symptoms seen in patients with an overactive thyroid gland are also found in those with high levels of anxiety. Naturally, any highly anxious patients should be screened for thyroid disease to avoid misdiagnosis.[27]

Psychiatrists have access to this vast body of data; many know it. Why, then, do they not apply it?

In spite of the obvious role medical illness plays, Drs. E. Cheraskin and W. M. Ringsdorf, Jr. of the University of Alabama, wrote in 1974, "In an informal survey of psychiatrists in the Washington, D.C., area a highly placed American Psychiatric Association official found that not one had ever requested medical information of any sort when accepting a new patient for treatment. Only rarely did they ask a patient if he was taking any drugs before prescribing their own favorite medication, despite the possibility that their prescription could be fatally incompatible with something already in the patient's medicine chest."[28]

Nutrition also plays a factor.

In 1975, Carlton Fredericks, a world-renowned nutritionist, detailed cases of patients who responded immediately to vitamin and mineral therapy after having shown no improvement through conventional psychiatry.

Dr. H. L. Newbold taught traditional psychiatry at Northwestern University Medical School until he found the connection between nutritional disorder and mental unrest. In his 1975 *Mega-Nutrients for Your Nerves*, Newbold describes hundreds of case histories, including his own, where mild anxiety and depression were eliminated by implementing the latest scientific knowledge about nutrition.[29]

George Watson, former professor of philosophy of science at the University of Southern California, became aware that many mental and emotional disorders stem from the physical malfunction of the body's metabolism. In his 1972 book *Nutrition and Your Mind: The Psychochemical Response*, he describes research in which more than 300 subjects yielded significant improvement rates:

"The rate of improvement we have found among those suffering from virtually every kind of mental illness is very high—about 80 percent—and we have seen dramatic case histories of complete clinical remissions in what heretofore have been considered almost intractable illness."[30]

Eric Braverman, director of research at the Atkins Center in New York City and Carl Pfeiffer, director of the Brain Bio Center in Rocky Hill, New Jersey, documented the therapeutic effect of amino acids (the constituents of protein) on mental and physical health. In their 1987 *The Healing Nutrients Within: Facts, Findings, and New Research on Amino Acids*, these doctors presented hundreds of clinical studies on the medical application of these nutritional substances. Amino acids, they asserted, can be used to treat depression and are an alternative to psychiatric drugs.[31]

Anorexia nervosa, a condition marked by loss of appetite and self-starvation to the point of death, has also been shown to diminish with doses of zinc or amino acids.[32]

Former psychiatrist William H. Philpott, now a specialist in nutritional brain allergies, reports, "Mental illness and an assortment of physical diseases can result from a low concentration in the brain of any one of the following vitamins:

"Thiamine (B-1), niacin (B-3), pyridoxine (B-6), hydroxocobalamin (B-12), pantothenic acid (B-5), folic acid and ascorbic acid (C).

"Volunteers fed a diet which was low in pantothenic acid very quickly became emotionally upset, irritable, quarrelsome, sullen, depressed, and dizzy.

Symptoms resulting from B-12 deficiencies range from poor concentration to stuporous depression, severe agitation and hallucinations.

Evidence showed that certain nutrients could stop neurotic and psychotic reactions and that the results could be immediate."[33]

Academic or behavioral problems, often called Attention Deficit Disorder by the psychiatric world, can also respond to nutritional measures. A study published in 1986 correlates a modification of diet in 803 New York City public schools with significantly improved test scores. For four years, amounts of sugar and food additives were lowered in the children's diets, after which these children's academic performance improved 16 percent against the national average.[34]

There may also be a direct correlation between diet and some criminal behavior. Studies at juvenile facilities in Virginia, Alabama, and California reveal that restricting foods with high allergy potentials dramatically reduced antisocial behavior.[35]

Nonpsychiatric methods have also been shown to cure phobias. In 1986,

Dr. Harold Levinson, associate professor of psychiatry at New York University Medical Center, proposed that most "phobias" are due to an easily diagnosable inner-ear dysfunction and not to emotional illness. In his book *Phobia Free* Levinson points out that 90 percent of all phobias are due to a hidden physical problem and respond to motion sickness medications and rest.[36]

Dr. Douglas Hunt, one of America's foremost experts on phobias, cured his own with a nutritional program of vitamins, minerals, and amino acids. In *No More Fears* Hunt writes that anxieties can originate from nutritional deficiencies and explains how such deficiencies come about and how nutritional supplementation can bring about positive results.[37]

Dr. Alan Goldstein, professor of psychiatry at Temple University in Philadelphia, agrees that vitamin deficiencies can worsen phobias. In his 1987 book, *Overcoming Agoraphobia: Conquering Fear of the Outside World*, he outlines his highly effective, drug-free program that has helped hundreds of people conquer their fears. Goldstein discovered that even the most severe phobias can be overcome by breathing from the diaphragm, putting one's attention on the present, and looking at things around one's immediate environment. He points out that tranquilizers are addictive and create psychological dependency, destroying the patient's ability to regain control over his own responses to his problems. "I have never seen anyone who was able to change his or her self-perception of 'sick' to 'well' while on drugs," Goldstein says.[38]

According to 1989 findings by the Board on Environmental Studies and Toxicology of the National Academy of Sciences, one in seven Americans is sensitive to household chemicals.[39] This sensitivity can bring about manifestations of mental problems. The same is true of high levels of heavy metals, like lead or cadmium, in the body.

Pediatrician Doris Rapp explains in *The Impossible Child* how children's allergies to common household items can cause trouble for youngsters, yet can be detected and effectively treated.[40]

Dr. John Nash Ott (originator of time-lapse photography) discovered that long periods under fluorescent lights cause some people to become tense and irritable. He found that emotional behavior improves dramatically when full-spectrum lights, designed to approximate natural daylight, are used instead.[41]

Even periods of withdrawal from being bombarded by sensory stimulation produces radical improvements in a variety of mental disorders.

In his 1990 book *Rickie*, psychiatrist Frederic Flach tells the harrowing story of what happened to his own daughter when he turned her over to the mental health system. After an emotional outburst at the age of thirteen, Rickie was institutionalized and diagnosed as schizophrenic. For ten years she suffered the ordeal of private and state mental hospitalizations, including restraints, drugs, and electric shocks.

When a prominent psychiatrist recommended lobotomizing Rickie, Flach finally rebelled against the practices of his profession and sought alternatives. Dr. Melvin Kaplan discovered Rickie had a visual perception problem; Dr. Carl Pfeiffer of the Brain Bio Center found Rickie also had a metabolic imbalance. Extensive vitamin treatment and special glasses containing prisms freed Rickie from her former "psychiatric" symptoms and restored her to a productive life.

All of the "respected" psychiatrists Flach consulted during the ten years of Rickie's ordeal had shunned such alternative treatment. Flach related that, because of his own psychiatric training, the idea that diet could overcome mental problems "struck me as preposterous." Yet Dr. Pfeiffer confided to Flach that other physicians had also turned to the nutritional program at the Bio Center, when it was their child or loved one who needed help.

In the 1974 book, *Psychodietetics*, authors Cheraskin, Ringsdorf, and Brecher remark, "All our research, everything in our clinical experience over the past twenty-five years, has convinced us that you can improve your emotional state by improving your nutrition: by making sure that every body cell receives optimal amounts of every essential nutrient."

In short, there is a great deal of nonpsychiatric help available to those who seek it.

These are *not* created realities.

These are actual physical solutions to real medical problems.

They are the real answers to what is actually wrong with the mentally troubled—a far cry from the pat, unsolvable response, "mental illness."

TRULY HELPING THE MENTALLY DISTURBED

The first action one can take to help those in mental distress is to *not* tell them they are mentally ill. Do not tell them they have a psychiatric disorder.

They are having enough trouble as it is. They do not need a barrage of advice on how mentally sick they are or how wrong they are.

More than anything they need rest and security.

Secondly, do not put them in a mental institution with conditions the way they are today in these facilities; this only adds to the environmental disturbance they must deal with and overloads an already overwhelmed mind.

In rare instances, a judicious use of drugs may initially be necessary to deal with violence or extreme situations such as life-threatening sleeplessness, starvation, etc.

As soon as possible, the person should receive a full, searching examination by a medical doctor.

This should be done to *find* what is wrong, not to see if anything is there. Nutritional deficiencies should be investigated as well.

A great many things could be the cause.

Hall and Popkin list:

- 21 medical conditions that can cause anxiety
- 12 conditions that can cause depression
- 56 conditions that can cause mental disturbance in general
- 40 types of drugs that can create "psychiatric symptoms"

The 1986 book, *Ill Not Insane,* lists over 140 medical problems which can cause mental troubles.[41]

Treat what is found in the medical exam. Get further tests if nothing is showing.

The insane individual is commonly in pain and may not even know it. His "switchboard" may be so overloaded by such stimuli that he can no longer function and behaves strangely.

In addition to any medical treatment required, *let the individual rest in a safe environment with no harassment and with ample food.*

He may have to rest a short time or long, depending on his condition and on him. Tolerance and patience are the jewel virtues in helping such an individual.

Note: people with extensive histories of past psychiatric treatment may have a hard time. Drugs and electroshock take their toll on the mind and nervous system and the natural healing mechanisms can be altered or, in extreme circumstances, destroyed in such people. Whatever the circumstances, any effort is well worth trying.

When treated as above he has a chance to come out of it.

Unlike those treated with shock and drugs, he will truly understand what occurred and will not spend the rest of his life wondering what is "wrong" with him.

And he will probably not relapse as the medical condition has been found.

However, if the psychosis recurs, do the program again. The medical condition could have returned or he may have something new or something that was missed the first time.

A LOOK TOWARD TOMORROW

Standard medical (nonpsychiatric) treatments can cure many—perhaps most—cases of "mental illness."

Rest and food in an unharassed environment can help a great many more.

And these are nonviolent means. No intrusive drugs, cutting, or shock.

It gives the mentally disturbed a truly humane chance to live again.

In 1978, psychiatrist E. Fuller Torrey, then director of St. Elizabeth's Hospital, a mental institution in Washington, D.C., predicted that psychiatrists will have no more patients when physical illnesses are referred to appropriate and more competent specialists, and when people with simple "problems of living" are referred to nonpsychiatric professionals who use educational approaches.

"With nobody left to call a patient," he wrote, "psychiatry will wither and die."[42]

Also by the Author

Help for the Hyperactive Child
Psychiatric Signs and Symptoms Due to Medical Problems

A DOSE OF SANITY

MIND, MEDICINE, AND MISDIAGNOSIS

Sydney Walker III, M.D.

John Wiley & Sons, Inc.
New York • Chichester • Brisbane • Toronto • Singapore

Jane, another of my patients, was a svelte, 66-year-old widow who looked twenty years younger than her real age—a definite advantage in her career as a flamboyant cabaret singer. But Jane's career hit the rocks when she abruptly developed anxiety, stomachaches, sweating, ringing in her ears, and dizziness. She also began sleeping badly, and she awoke exhausted every morning. Formerly an active and vivacious woman fond of parties and late nights on the town, Jane had spent the past year at home taking powerful antianxiety drugs. She'd stopped dating, canceled all of her performances, and shut herself off from family and friends. "I used to feel like I was sixty going on twenty," she told me. "Now I feel like sixty going on ninety."

Jane had been admitted to a psychiatric hospital and had even contemplated committing suicide. Her DSM label: classic panic disorder. The recommended treatments: Xanax and psychotherapy. But the drug, the psychotherapy, and the hospitalization didn't help Jane a bit. That's because Jane didn't have "panic disorder"; she had a serious medical problem that wasn't being treated.

A careful examination and history revealed that Jane's symptoms began shortly after she reduced her dose of thyroid medication, which she'd taken for many years for a condition known as hypothyroidism (underactivity of the thyroid gland). Hypothyroidism causes the heart, intestines, and other organs to "slow down," leading to symptoms such as cold feet, weight gain, dry and lifeless hair, dry skin, a deep voice, hearing loss, and heavy menstrual periods. Hypothyroidism also can cause drastic changes in personality and behavior. The patient often feels "achy," and even simple tasks like preparing a meal become overwhelming. Many patients lose all interest in sex. Some, like Jane, become suicidally despondent or anxious.

I put Jane back on her thyroid medication, and her symptoms began to disappear almost immediately. In the meantime, I'd also discovered that Jane had inner-ear problems that were causing her dizziness. I prescribed a medication to handle her inner-ear

disorder (which was also alleviated by treatment of her thyroid disorder), and told her to replace her waterbed with a regular mattress because waterbeds often contribute to sleep disturbance in individuals with inner-ear problems. Jane was back to normal—and back to singing—in a matter of weeks.

The moral is that ***very little is undiagnosable, but much is not being diagnosed.*** Psychiatrists who fail to find the real causes of mental disorders (or, more correctly, brain dysfunctions) cannot possibly treat them effectively. Indeed, the drug "treatments" commonly prescribed after tagging a patient with a DSM label often don't treat at all; they merely mask symptoms. And although drugs often provide temporary relief, they always do so at a price. The patient on Halcion who commits suicide, the child on Ritalin who feels like a zombie, and the anxious patient who becomes addicted to Valium, all have suffered unnecessarily, if their symptoms were caused by treatable physical disorders. Patients who spend years undergoing psychoanalysis based on DSM labels are victims too, if they have physical problems that could have been accurately diagnosed and cured.

Cases like these are not, as psychiatrists would like to think, isolated incidents. In 1982, Robert Hoffman reported that, of 215 patients admitted to a medical-psychiatric hospital unit, 41 percent were initially misdiagnosed; in addition, he found that 63 percent of patients labeled as having "untreatable dementia" actually had treatable disorders. M. M. Herring, in a 1985 study of 131 randomly selected patients at the Manhattan Psychiatric Center, found that "approximately 75 percent of the patients reevaluated may have been wrongly diagnosed when admitted to the center," and that "frequent misdiagnosis of schizophrenia caused severe harm to many patients who were inappropriately given powerful drugs, such as neuroleptics [drugs affecting the nervous system], that mask symptoms and may cause irreversible side effects." Erwin Koranyi's studies in the 1980s found that psychiatrists misdiagnosed about half of patients with detectable physical illnesses; commenting that "psychiatrists often lose their skills of performing competent

physical examination," Koranyi cited a survey in which *none* of 100 psychiatrists questioned said that they performed routine physical examinations on their patients.

More recent research reveals that, even with modern laboratory and brain imaging technologies available to them, psychiatrists often fail to diagnose obvious physical problems in their patients. In 1990, Lorrin Koran and colleagues, who examined 529 randomly selected patients in eight treatment programs in a state mental health system, found that nearly 38 percent of those patients had a significant, detectable physical disease—but less than half of them had been diagnosed. The harm done by such misdiagnosis and nondiagnosis can last forever. As Koran points out, "A physical disease incorrectly diagnosed as a mental disease can lead to a lifetime on psychotropic drugs, loss of productivity, physical and social deterioration and shattered dreams."

"People with real or alleged psychiatric or behavioral disorders are being misdiagnosed—and harmed—to an astonishing degree," Charles B. Inlander, president of The People's Medical Society, and his colleagues say in *Medicine on Trial*. "Many of them do not have psychiatric problems but exhibit physical symptoms that may mimic mental conditions, and so they are misdiagnosed, put on drugs, put in institutions, and sent into a limbo from which they may never return. . . . On the other hand, the physical illnesses of psychiatric patients go underdiagnosed or undiagnosed." Famed neurologist Sir Francis Walshe has charged that mental hospitals "are living museums of undiscovered bodily disease . . . undiagnosed but not undiagnosable."

An accurate diagnosis doesn't always mean a cure. Diagnosing a psychiatric patient as having a brain tumor, or multiple sclerosis, or lupus, doesn't mean I can always help the patient. (Any patient is better off with an accurate diagnosis, however, because there's always a chance, given the rapid rate of medical discoveries, that a treatment or cure will become available.) And there are occasions when it's impossible—even with state-of-the-art technology and careful differential diagnosis—to determine the cause of a patient's symptoms. In such a case, however, I'm able to *rule out* hundreds of possible causes and to establish a baseline that may later help me detect the emergence of telltale signs of a diagnosable disorder. I'm also able to avoid potentially dangerous treatments for disorders the patient doesn't have. (This is much more important than it sounds. A remarkable number of patients today suffer from "iatrogenic"—literally, "doctor-caused"—disorders traceable to unnecessary and harmful medications or surgeries.)

But in a surprisingly large percentage of cases labeled as "mental" disorders, there *is* a diagnosable physical problem, and that problem *does* have a treatment or even a cure.

Why Patients Buy Into the DSM Myth

DSM labels don't cure. Neither do psychotropic drugs and psychotherapy, the two treatments that almost always follow a DSM "diagnosis." Powerful drugs such as Thorazine, Valium, and Xanax often cause as many symptoms as they alleviate. And psychotherapy may help a patient cope with disturbing symptoms, but it won't cure an underlying brain dysfunction. In short, simply naming a patient's symptoms doesn't help a psychiatrist understand or correct these symptoms.

Bear in mind that a label is simply a name—much like the names of your friends. And, to quote Mr. Shakespeare, "What's in a name?" Everything—and nothing. Calling your friends "Sam" and "Bertha" and "Susan" helps you to get their attention, or to describe them to others, but it doesn't tell you anything about what makes them tick. Similarly, labeling patients as "depressed" or "anxious" may allow a psychiatrist to group them conveniently, but it won't reveal anything about the causes of their problems. A psychiatrist who believes that all "depressed" patients are alike is as misguided as a person who believes that all people named "Jim" are alike. Both labels are handy, but neither is very informative.

In other words, a patient with syphilis, or a brain tumor, or a thyroid disorder, isn't any better off after being labeled as "depressed" or "anxious" than before receiving the label from the

#12

White House Commission on Complementary and Alternative Medicine Policy

Town Hall Meeting
October 30-31, 2000

Statement of

Merrily Manthey, MS

My name is Merrily Manthey.

A special thank you to Chair Gordon for allowing me to speak before this Commission today.

Special greetings to Commission Members and congratulations on being selected for this all-important role.

I guess by now you realize you've been exposed to the GROUND ZERO for 21st Century medicine.

I am the initiator (some refer to me as the "Godmother") of the landmark King County Natural Medicine Clinic in Kent, Washington. It is true, I developed the idea for the highly-publicized and successful clinic and I assembled the initial team of experts who, through their compelling testimony, convinced the policy makers to unanimously endorse the creation of the first clinic of its kind in the US. The policymakers, through their leadership, created the circumstances for providing access to effective, natural treatments for the underserved population in King County ... and by so doing, created a model for publicly-funded integrative clinics that is the equivalent of breaking the four-minute mile ... and being duplicated throughout the country.

As you have discovered throughout this Town Hall Meeting, many brilliant leaders have helped bring this outstanding model of the best of both worlds to reality. Without them, my idea would have remained simply an idea.

With that said,

As one who has worked for the recent passage by the King County Council of the mental health accountability and measurement ordinance sponsored by Dr. Kent Pullen,

As one who created and produced the award-winning film, "A Message of Hope," featuring natural treatments for the treatment of mental conditions,

As one who has known nearly 30 years and has worked with Dr. Abram Hoffer, MD, Ph.D., pioneer of orthomolecular treatment for bi-polar and schizophrenia,

As one who brought actor Margot Kidder to Seattle in support of the recent mental health ordinance to tell of her model recovery using natural treatments after 30 years of failed conventional approaches,

As one who is the only person in the US is on a nationally-respected teaching hospital and medical center board, Harborview, and was on the board of Bastyr University at the same time,

As one who is presently starting my 9th year as a member of Harborview Board of Trustees and has urged such research as our exciting antioxidant study for trauma patients in the ER,

As a clinician working 30 years in my private clinic,

PO Box 873 Kent WA 98035 206 718 3334 merrily@msn.com

As a pioneer in teaching Stress Management concepts and application, who, nearly 30 years ago, initiated and taught the first course on managing stress in the State of Washington college system ... trained as a psychotherapist using principles of psychology, biofeedback, meditation, optimum lifestyle;

As an educator, producer of videos, handbooks, and general all-round busy body,

I see great opportunity for a revolution in mental health through the advocacy of this commission.

When the experts tell us that mental health issues have a basis in the individual's biochemistry, it's easy to see how natural medicine is so logical for the mental health world. Yet, when you ask mental health professionals what tests they ran for each client to determine the individual biochemical situation that could be causative and/or contributory, they stare blankly. Candace Pert reminds us it's "Body/Mind" and not the other way around. We once thought neurons were only in the brain. Now we know, neurons are everywhere in the body. The Error of Descartes led early healers off track by splitting the Mind from the Body. A nifty little plea-bargain with the religious leaders of the time. Now we need to plea bargain with the doctors to get back to science and the reality of "molecules of emotion."

Mental health professionals should want to know such things as:

Is the person too high in lead?
Too low in copper?
What is the functioning of their thyroid?
What about their histamine levels?
Do they have too much or too little niacin?
What about food allergies?
Could there be amino acid imbalances?
and more .....

We have created untold misery and suffering by conventional approaches to mental health treatments. I was shocked to learn, as I compiled research for the film, "A Message of Hope," 90% of acute schizophrenic episodes quickly respond to low-cost, effective natural treatments ... over 50% of chronic cases get well .... Getting people well, by my definition here means: having a good relationship with one's family, one's community, holding a job, and paying taxes.

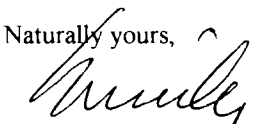
Conventional treatment for people who are simply deficient in niacin or who have amino acid imbalances is wrong.

CONCLUSION.

When you review the tapes and notes from this Town Hall meeting, I urge you to put major focus on natural medicine MENTAL HEALTH policy, research on treatments that help people get well, and protocol to include such in national guidelines.

I stand ready to assist you as you prepare the Manifesto for Effective Health Care ... I hope you will be bold, synergistic, inclusive, and creative beyond all your previous action.

Naturally yours,



Merrily Manthey
www.merrily.com
www.kentwa.org
www.stressmgmt.com
206 718 3334

116


WASHINGTON STATE PHARMACISTS ASSOCIATION
1890

White House Commission on Complementary and Alternative Medicine Policy

Testimony by:

Donald F. Downing R.Ph.
Washington State Pharmacists Association
1501 Taylor Ave SW
Renton, WA 98055

October 31, 2000

Good afternoon, my name is Don Downing and I represent the Washington State Pharmacists Association today. I want to thank Director Groft and the White House Commission for this opportunity to speak to the issues related to Complementary and Alternative Medicine. I have spent most of my professional career as a pharmacist providing care for the urban underserved at the Seattle Indian Health Board clinic and for the Puyallup Indian Tribe.

I am concerned that the most accessible, most often visited health care professional in the United States –the pharmacist – is not being acknowledged as a CAM provider, nor recognized by the Federal Government, as an allopathic health care provider. Our health care interventions result in the savings of billions of health care dollars and the improvement of the quality of life for millions of Americans.

The quality and cost-effectiveness of pharmacist monitoring and co-management of chronic medical conditions such as asthma, diabetes, dyslipidemias, hypertension, pain and depression, among other maladies are well documented in the medical literature. Pharmacists also provide needed preventative services such as influenza, pneumococcal and hepatitis immunizations. We use behavioral modification techniques and education to help people end their tobacco usage and to help manage their nutrition, weight and improve their level of physical activity and ultimately their quality of life.

Even in Washington State where we are fortunate enough to have the "Every Category of Provider Law," it has been an uphill struggle to have pharmacists invited to the table. Up until now, the efforts by the Washington State Office of the Insurance Commissioner have not included pharmacists – even though this law speaks to access to "any category of provider licensed by the state of Washington." Yesterday's testimony by the Insurance Commissioner's office, failed to mention pharmacists even though we are licensed health care providers in the State of Washington and have worked for months to be recognized as such under this law. How ironic that a state that is so progressive has

repeatedly positioned the pharmacy profession in a state of purgatory between CAM and allopathic practice.

The perception is that pharmacists count and pour pills. The reality is that they are university-trained for a minimum of 6 years in the treatment and management of the whole patient. We are well positioned to assist in the co-management of patients taking herbal as well as other treatments and to refer patients to other providers for comprehensive care.

A health system that compensates such a highly skilled and accessible provider of health care only when they sell another prescription is missing an opportunity to provide accessible, cost-effective care. We have the training, the research, the licensure and accountability, but not the recognition and compensation incentive to provide care to the underserved and poorly served.

Patients deserve to have access to our country's medication experts. I would ask three things of this commission:

1. Include pharmacists in all your discussions and decisions related to complementary and alternative medicine.
2. Assist the profession of pharmacy in being recognized by the Federal Government as a health care provider
3. Take the message home that pharmacists are complementary providers, well positioned to help integrate the best of CAM and allopathic care.

Thank you,

Don Downing
Clinical Associate Professor
University of Washington School of Pharmacy
dondown@u.washington.edu

Disease Management – Studies on the benefits of disease management services for the treatment of asthma

Effects of an Asthma Management Program on the Asthmatic Member: Patient-Centered Results of a 2 year Study in a Managed Care Organization.

Buchner DA, Butt LT, De Stafano A, Edgren B, Suarez A, Evans RM
American Journal of Managed Care, 1998;4(9): 1288-1297.

Key Results: Knowledge about asthma and health-related quality of life improved; percentage of patients with claims for an inhaled corticosteroid increased; rate of inpatient hospitalizations declined; ER visits were unchanged.

Economic evaluation of pharmacist involvement in disease management in a community pharmacy setting.

Munroe WP, Kunz K, Dalmady-Israel C, Potter L, Schonfeld WH.
Clinical Therapeutics. 1997;19:113-123

Key Results: Decrease in monthly medical costs by $293 per person despite an increase in prescription costs.

Pharmacist-managed, physician-directed asthma management program reduces emergency department visits.

Pauley TR, Magee MJ, Cury JD.
Annals of Pharmacotherapy. 1995;29:5-9

Key Results: Reduced ER visits from 47 to 6. The time period studied was 6 months after start of intervention compared with same 6-month period for previous year and also 6-month period before intervention.

Developing and marketing a community pharmacy-based asthma management program.

Rupp MT, McCallian DJ, Sheth KK.
Journal of the American Pharmaceutical Association. 1997;NS37:694-699

Key Results: Decrease in hospitalization (77%), ER visits (78%), urgent care visits (25%); the HMO renewed its contract for the program, which was expanded to include 40 patients.

The economics of an intensive education programme for asthmatic patients.

Sondergaard B, Davidsen F, Kirkeby B, Rassmussen M, Hey H.
PharmacoEconomics. 1992;1:207-212

Key Results: No difference between the patient education groups and the control group in number of admissions and readmissions to the hospital; cost of drugs, appropriateness of drug therapy, adherence, quality of life, and health status higher in the education group; number of days lost lower in the education group; unclear cost-benefit analysis.

Disease Management – Studies on the benefits of disease management services for the treatment of diabetes

Management of patients with type 2 diabetes by pharmacists in primary care clinics.

Coast-Senior EA, Kroner BA, Kelley CL, Trilli LE
Ann Pharmacother: 1998;32:636-41

Key Results: Pharmacists' efforts as part of a multidisciplinary team improved glycemic control significantly in patients with type 2 diabetes who require insulin.

Evaluation of a clinical pharmacist in caring for hypertensive and diabetic patients.

Hawkins DW, Fiedler FP, Douglas HL, Eschback RC
Am J Hosp Pharm. 1979;36:1321-1325

Key Results: Care provided by the clinical pharmacist and care provided by the physician were equivalent in controlling blood glucose and diastolic blood pressure. The kept-clinic-appointment rate was higher and the clinic dropout rate was lower in the experimental group (pharmacist managed care) compared with the control group (pharmacist managed care) compared with the control group (physician-managed care), suggested greater patient satisfaction with care provided by the clinical pharmacist.

Pharmacist-managed diabetes education service.

Huff PS, Ives TJ, Almond SN, Griffin NW
Am J Hosp Pharm. 1983;40:991-4

Key Results: Pharmacists were able to provide more instructional time than typically is provided by physicians, thereby improving patient understanding. Patients were grateful to have ready access to pharmacists for information or help solving problems. Physicians had more time available to spend with other patients once pharmacists assumed the patient education responsibility. Communication between pharmacists and physicians improved.

Evaluation of pharmaceutical care model on diabetes management.

Jaber LA, Halapy H, Fernet M, Tummalapalli S, Diwakaran H.
Ann Pharmacother: 1996;30:238-43

Key Results: A comprehensive model of pharmaceutical care effectively improved glycemic control, but not blood pressure, lipid levels, body weight, or measured quality-of-life parameters, in a clinic-based population of urban African American patients with type 2 diabetes. Changes in glycemic control were attributed to improved patient understanding of diabetes and optimization of oral hypoglycemic regimens.

Pharmacists' interventions using an electronic medication-event monitoring device's adherence data versus pill counts.

Matsuyama JR, Mason FJ, Jue SG.
Ann Pharmacother: 1993;27:851-855

Key Results: The MEMS data allowed pharmacists to individualize recommendations to a greater extent than the pill count method.

Asheville Diabetes Project

See References listed on attached document

Patient Satisfaction of Asheville Diabetes Project
Key Results:

- Overall patient satisfaction with the pharmacist, pharmacists' explanation of drug therapy, technical competence and courteousness of staff improved over baseline.
- Quality of life showed a significant improvement in general health perception, energy, emotional status, pain and physical function over baseline.
- Asheville Diabetes Project has grown from 38 patients to 60 patients with about 1 additional patient per month.

Clinical and Economic Outcomes
At 14 months, 85% of patients showed at least some improvement of hemoglobin A1c values. The mean improvement was 1.4%. This improvement of hemoglobin A1c results in a decreased risk of up to 63% for retinopathy, 60% for neuropathy, and 54% for albuminuria.

- Patient-provider interactions increased (ie. Less in-patient acute care needs)
- Shift of services from inpatient to outpatient
- Sick leave decreased by 47.6%
- Payer incurred total one-time start-up costs of $262 per diabetic patient for blood glucose monitors and diabetes education by diabetes education center.
- Average pharmacist reimbursement of $30-$38 per follow-up visit (about $1 per minute)

Washington State Pharmacists Lead the Nation

Since mid-1996, Washington has led the nation with innovative programs designed to benefit patients. These programs have been cooperatively designed and implemented by numerous professional, educational, and government organizations. These services become more accessible and augment the services already provided by other health care practitioners, and are done in cooperation with the patient's primary physician or health professional. Areas of healthcare services include:

Smoking Cessation: The Washington State Pharmacists Association, in cooperation with the WSU College of Pharmacy, SmithKline Beecham, Glaxo Wellcome, and McNeil Consumer Products, began training and certifying pharmacists to provide comprehensive smoking cessation services based on the Agency for Health Care Policy and Research (AHCPR) recommendations for helping patients quit smoking. Washington has trained **over 100 pharmacists** thus far in providing management of medications and behavioral management of patients. Pharmacists are trained to ask patients about quitting and to assist them in determining what steps to take for the best chance of success for that patient's personal situation. A one-year, pilot project has just been completed in our state with the Department of Social and Health Services (DSHS) Medical Assistance Administration (MAA). Pharmacists at 18 pharmacies encouraged and educated Medicaid patients to quit smoking and to assist them in doing so. Preliminary results demonstrate the high degree of smoking cessation effectiveness of pharmacists and suggest long-term savings to Medicaid in reduced health care costs.

Immunizations: The Washington State Pharmacists Association, in cooperation with the Centers for Disease Control (CDC), developed a comprehensive program designed to train and certify pharmacists to provide these services based on the CDC's methods and recommendations for immunizations. Pharmacists recognized the urgent need to immunize more people by making these services more accessible and providing immunizations to those that might not be reached elsewhere. **Over 400 pharmacists** in our state are currently trained and certified to provide immunizations and are practicing in diverse settings from the community pharmacy to hospitals to community clinics in providing these services. ***Pharmacists have administered more immunizations in Washington State, than in all other states combined.***

Emergency Contraception: In order to lower the number of unintended pregnancies in Washington State, the Washington State Pharmacists Association, in cooperation with the Program for Appropriate Technology in Health (PATH), Wash. State Dept. of Health's Board of Pharmacy, and U.W. School of Pharmacy, developed a "first in the nation" program. Pharmacists prescribe emergency contraception pills, counsel patients on contraceptive methods and refer patients to other providers for follow-up care. Using prescriptive protocols in cooperation with physicians in their communities this allows patients unprecedented access to Washington pharmacists to receive treatment in what is often a very difficult and time-sensitive situation. **Over 1200 pharmacists** in more than 145 pharmacies in our state are currently trained and certified to provide emergency contraception services. Using the 1-800-NOT-2-LATE toll-free number, patients may locate pharmacists to help them. ***Over 50 percent*** *of women surveyed said they obtained these services on a weekend or after 6 p.m. on a weeknight, when locations and services other than the pharmacist would have been difficult to obtain.* **Over 20,000 emergency contraception patient visits with a pharmacist have occurred since the project began in 1998.**

Hyperlipidemia Study: The Washington State Pharmacists Association, in cooperation with Bristol-Myers Squibb and KOS Pharmaceutical, initiated a project providing equipment and lipid management certification training to over 100 pharmacists at over 50 pharmacies in our state. This efforts allows pharmacists to screen patients for high cholesterol levels, monitor physician-prescribed drug treatments and educate patients about the need for appropriate diet and physical activity, and to refer patients for appropriate follow-up. This study will provide information to demonstrate the role pharmacists can play in community health care and disease management.

These pharmacist-provided health care services have now become models for other states that are beginning to have similar success with providing patients with pharmacist health care services.

See the back of this page for a list of Washington pharmacy organizations.

Pharmacy Organizations in Washington

Washington State Pharmacists Association

Donald Hobbs, R.Ph., President
c/o Kurbitz Medical Center Pharmacy
3910 W. Nixon
Pasco, WA 99301
Phone: 509-547-1739
Fax: 509-547-2762
Email: hobbsrph@televar.com

University of Washington School of Pharmacy

Dr. Sid Nelson, Dean
UW School of Pharmacy
Box 357631
Seattle, WA 98195
Phone: 206-543-2030
Fax: 206-685-9297
Email: sidnels@u.washington.edu

HealthWise: A Pharmacists' Health Services Network

Mimi L. Fields, M.D., Medical Director
6035 Woodard Bay Road N.E.
Olympia, WA 98506
Phone: 360-481-1242
Fax: 360-754-3956
Email: mfields@mail.tss.net

Don Downing, R.Ph., Pharmaceutical Care Coordinator
1501 Taylor Ave SW
Renton, WA 98055
Phone: 425-228-7171
Fax: 425-277-3897
Email: dondown@u.washington.edu

Wash. State Society of Health-System Pharmacists

David J. Tomich, Pharm.D., President
3541 Crystal Ridge Drive
Puyallup, WA 98372-5233
Phone: 253-968-2536
Fax: 253-968-3349
Email: dtomich@aol.com

Washington State University College of Pharmacy

Dr. William Fassett, Dean
WSU College of Pharmacy
P.O. Box 646510
Pullman, WA 99164-6510
Phone: 509-335-5637
Fax: 509-335-0162
Email: fassett@mail.wsu.edu

Northwest Pharmaceutical Services

Norman G. Reitz, R.Ph, C.E.O. & Pres.
107 N. Meridian, Suite 100
Puyallup, WA 98371
Phone: 253-840-5604
Fax: 253-840-5013
Email: nwpscorp.com@worldnet.att.net

Issues in Medication Use in the United States

Issue:

The costs to our health care system from drug-related problems easily surpass costs related to diabetes and obesity, and are rapidly approaching those related to cardiovascular disease (see graph). Studies show that billions of dollars would be saved each year, and quality of care would be improved, if pharmacists and pharmaceutical care were utilized properly to reduce incorrect medication use and medication errors.

Discussion:

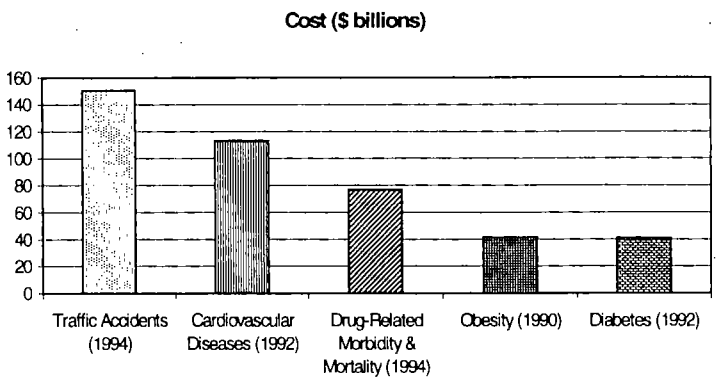
As health care costs spiral out of control and public tolerance dwindles, policy makers must make tough decisions about how to manage health care costs. Many of these decisions, however, are hugely unpopular with the American public when they perceive that their quality of care is being compromised. The dilemma, then, is to manage health care costs in ways that will improve quality of care while gaining public acceptance.

Recent in-depth studies in the field of pharmacy have unearthed startling statistics that clearly indicate that the above criteria can be met. In a landmark initiative called The Fleetwood Project, a comprehensive approach to examine patient outcomes and the cost of drug-related problems, the following conclusions were reached:

- Americans pay more for drug-related problems than they do for the drugs themselves. For every $1.00 spent on drugs in nursing facilities, $1.33 in healthcare resources are consumed in the treatment of drug-related problems;
- Patients who receive enhanced pharmaceutical care in nursing facilities have increased optimal outcomes of more than 40%: and
- With current federally mandated drug regimen review, it is estimated consultant pharmacists help to reduce healthcare resources due to drug-related problems in nursing facilities by $3.6 billion.

In addition, a study published in 1995 in the **Archives of Internal Medicine** states that:

- Drug-related morbidity and mortality in the ambulatory setting costs $76.6 billion. If consistent drug therapy management is provided. ***$45.6 billion could be saved - a cost reduction of 59.6%.*** If lost productivity costs are factored in with the health care costs, the $76.6 billion figure would increase to $138 to $182 billion;
- Greater than 16% of all hospital admissions in the U.S. result from drug-related problems, with those admissions related to medication noncompliance having direct costs of $8.5 billion; and
- In terms of resources consumed, these drug-related morbidity and mortality costs are in the same cost range as many of the major public health issues or diseases, leading many to suggest that drug-related problems should be considered a major category of disease.



– OVER –

Americans want to believe that there are medications to cure all ills. With so many strides being made in the pharmaceutical industry today, it is easy to understand why consumers feel this way. Over the past 30 years, the number of prescription medications available has increased from around 650 to nearly 10,000. Advances in pharmaceutical therapy often allow this form of treatment to replace more invasive and costly procedures and technologies such as surgery.

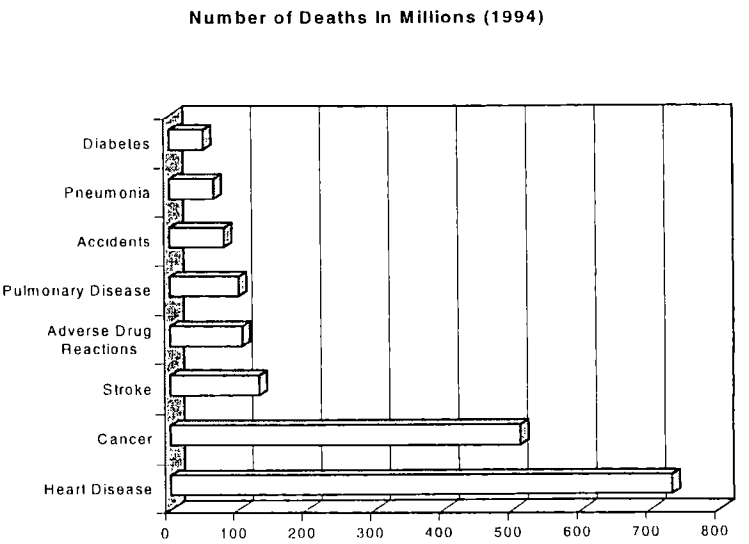
However, it is a little-known fact that drug-related problems frequently occur, often with costly or devastating effects. Drug-related problems include:

- failing to obtain a necessary prescription for a medical condition
- taking the wrong medication
- taking too little or too much of a medication
- failing to take a prescribed medication
- experiencing adverse effects as a result of a prescribed drug
- experiencing adverse effects as a result of a drug/drug, drug/food or drug/laboratory interaction
- taking a medication for no medically valid reason

A study published in the April 1998 Journal of the American Medical Association (JAMA) identifies adverse drug reactions (ADRs) as an important clinical issue, even when drugs are properly prescribed and administered. Estimates reveal that 106,000 hospital patients died in 1994, ranking ADRs as the fourth leading cause of death. Furthermore, the study suggests that ADRs could be responsible for an additional $1.56 billion to $4 billion in direct hospital costs per year, costs that are related to both fatal ADRs and nonfatal ADRs, of which 2.2 million were estimated in 1994. The study excluded errors related to administration, more commonly known as medication errors. As an increasingly reported problem, medication errors can also have costly consequences, and should be viewed as a significant public health issue.

Solution:

Pharmacists are highly educated, yet currently underutilized, in monitoring patients for the many factors that can lead to drug-related problems. As such, they should be fully integrated participants on the patient's healthcare team in all practice settings for the purpose of achieving optimal outcomes and cost savings. Policy makers can have a direct and dramatic impact by recognizing the value of enhanced pharmaceutical services and working to make them more widely available. Studies show that increased use of pharmaceutical services will lead to significant cost savings in our health-care system.



Pharmacists' Services Can Save Medicaid $7.5 Billion Annually Nationwide

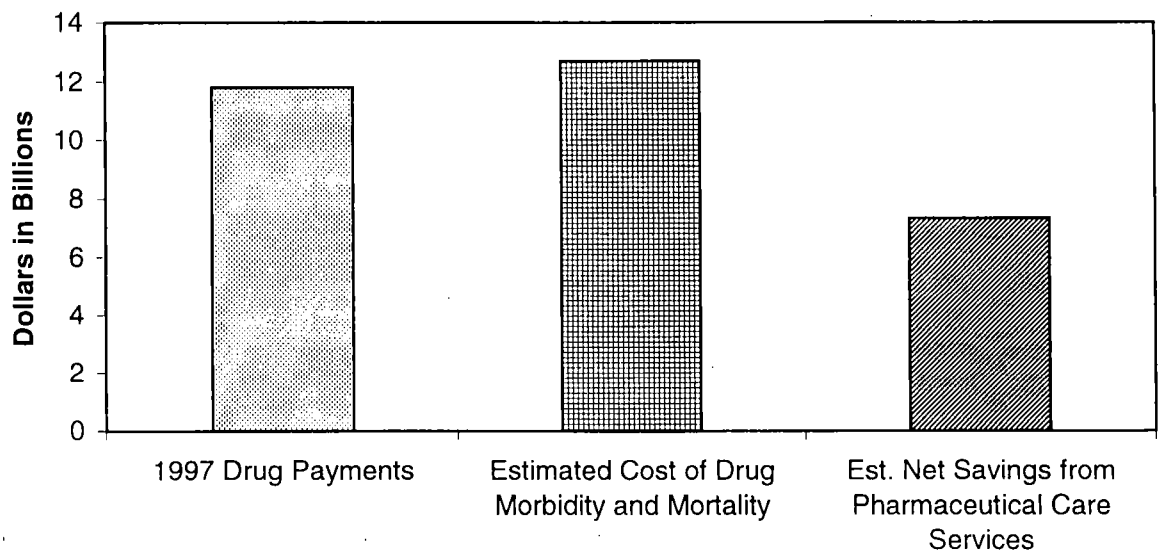
A frequently cited, cost-of-illness analysis conducted in 1995 estimated that drug-related morbidity and morality among ambulatory patients costs the U.S. economy $76.6 billion annually in direct costs alone (Arch Intern Med 1995; 155:1949-1956). Current estimates that include both long-term care and hospital care put these costs at $100 billion. These costs resulted from incremental utilization of health care services for physician, urgent care, or emergency department visits; hospital or long-term care admissions; or additional medications when patients received less-than-optimal outcomes from their prescription medicines. A follow-up analysis suggested that $45.6 billion could be saved annually if pharmacists are more fully enabled to provide comprehensive pharmaceutical care for these ambulatory patients. (Am J Health Syst Pharm 1997;54:554-558; Arch Intern Med 1997; 157:2089-2096; JAMA 1997; 277 no. 4: 307-311.)

Of special interest is the cost that drug-related morbidity and mortality represents to the nation's-and individual state's Medicaid programs. In 1997, prescription drug payments for Medicaid beneficiaries in the U.S. totaled nearly $12 billion. Extrapolating from the $76.6 billion spent nationwide on drug-related morbidity and mortality, an estimated $12.7 billion was incurred on such expenses by Medicaid that year. The current analysis suggests over 30 states may very well spend more each year on managing drug-related morbidity and mortality than they do on prescription medications themselves. ***Washington is one of these states.***

This analysis also suggests that pharmacists could save approximately $7.3 billion annually within Medicaid programs alone through activities like drug therapy and disease-state management. Cost savings are achievable within all 50 states. Within individual states, these estimated savings range from $4.3 million in Rhode Island to $904 million in California. ***Washington State's estimated net savings is $97,473,611***

- OVER -

Potential Savings to State Medicaid Programs if Comprehensive Pharmacy Services are Universally Available



Potential Savings to State Medicaid Programs if Comprehensive Pharmacy Services Were Universally Available

State	1997 Drug Payments	Estimated Cost of Drug Morbidity and Mortality	Estimated Net Savings from Pharmaceutical Care Services
Alabama	$226,105,163	$210,156,779	$120,312,526
Alaska	$28,376,842	$77,822,429	$41,970,591
Arizona	$1,855,572	$49,188,187	$25,017,110
Arkansas	$135,767,334	$207,619,708	$118,810,590
California	$1,335,066,753	$1,533,777,170	$903,895,798
Colorado	$96,964,173	$97,035,892	$53,344,901
Connecticut	$166,667,301	$110,897,624	$65,551,107
Delaware	$34,713,581	$20,206,002	$7,861,668
Dist. of Columbia	$37,512,355	$28,798,513	$12,948,483
Florida	$772,760,639	$932,039,487	$547,687,089
Georgia	$339,257,021	$769,045,795	$451,174,824
Hawaii	$26,854,246	$44,711,513	$22,368,928
Idaho	$45,042,165	$65,570,094	$34,717,209
Illinois	$523,581,885	$456,943,729	$266,410,401
Indiana	$293,318,000	$268,183,961	$154,664,618
Iowa	$123,861,339	$111,962,751	$62,181,661
Kansas	$104,628,978	$75,276,545	$40,403,428
Kentucky	$316,464,180	$319,957,934	$185,314,810
Louisiana	$315,440,010	$374,363,783	$217,523,072
Maine	$102,537,198	$31,364,680	$14,467,603
Maryland	$172,701,280	$159,287,968	$90,198,190
Massachusetts	$398,076,067	$309,452,721	$179,095,724
Michigan	$365,282,227	$341,904,444	$198,307,144
Minnesota	$158,830,088	$207,772,618	$115,901,100
Mississippi	$208,577,199	$311,855,757	$180,518,321
Missouri	$320,680,206	$108,667,950	$60,231,139
Montana	$35,170,912	$55,037,443	$28,481,879
Nebraska	$79,727,194	$85,562,367	$46,552,035
Nevada	$26,852,299	$76,445,963	$41,155,723
New Hampshire	$45,361,700	$32,884,637	$15,367,418
New Jersey	$369,839,049	$158,461,478	$89,708,908
New Mexico	$83,345,890	$146,680,516	$82,734,579
New York	$1,090,917,486	$641,918,670	$375,915,566
North Carolina	$403,811,339	$563,228,692	$329,331,099
North Dakota	$25,226,544	$22,864,520	$9,435,508
Ohio	$580,582,988	$504,863,491	$294,778,800
Oklahoma	$110,880,182	$113,285,371	$62,964,652
Oregon	$73,216,763	$50,757,702	$25,048,272
Pennsylvania	$552,266,949	$357,841,582	$207,741,930
Rhode Island	$52,186,739	$14,219,697	$4,317,774
South Carolina	$159,000,414	$230,564,759	$132,394,050
South Dakota	$27,591,466	$35,881,211	$17,141,390
Tennessee	$1,118	$247,340,968	$142,325,566
Texas	$750,056,208	$1,280,729,942	$701,091,038
Utah	$50,825,675	$46,074,438	$23,175,780
Vermont	$44,291,004	$26,038,683	$11,314,613
Virginia	$249,620,903	$328,359,632	$190,288,734
Washington	**$204,980,309**	**$171,577,531**	**$97,473,611**
West Virginia	$133,044,883	$208,989,303	$119,621,380
Wisconsin	$205,503,614	$68,236,316	$36,285,612
Wyoming	$14,264,016	$32,065,939	$14,882,749
Total	$11,972,331,192	$12,736,352,820	$7,324,906,494

Pharmaceutical Benefits Under State Medical Assistance Programs 1998, National Pharmaceutical Council, pgs. 4-19. Drug-related morbidity and mortality in ambulatory patients in the US has been estimated to cost 576.6 billion annually, or approximately $114 per physician visit (Arch Intern Med 1995;155:1949-1956). Based on the number of outpatient physician visits, the direct cost for drug-related morbidity and mortality in ambulatory Medicaid beneficiaries is estimated for each state. Provision of comprehensive pharmacy services as described in the accompanying materials, could reduce the total U.S. cost of drug-related morbidity and mortality in ambulatory patients by $45.6 billion annually, or approximately $68 per physician visit (Am J Health Syst Pharm 1997;54:554-558). Based on the number of outpatient physician visits, the direct cost savings is estimated for each state.

Innovative Pharmacists Can Improve Care and Reduce Health Care Costs

Value of the Pharmacist

The pharmacist has a responsibility to prevent, identify, and resolve potential and actual drug-related problems. A pharmacist also has a role in recommending effective medications, educating other providers about appropriate drug therapy, and counseling patients so they understand proper medication requirements. A drug regimen review is the process where a pharmacist analyzes each prescription to optimize drug therapy and minimize drug-related problems. In a nursing home setting, federal law requires that each resident receive the services of a consultant pharmacist, including drug regimen review, at least monthly. A recent study published in the Archives of Internal Medicine found that consultant pharmacist-conducted drug regimen review improves optimal therapeutic outcomes by 43% and saves as much at $3.6 billion annually in costs associated with drug-related problems.

Collaborative Drug Therapy: Pharmacists Working with Health Care Team

Enhancing the way health care is delivered ultimately results in improved quality for the patient and increased savings for the health care system. One way this is achieved is through collaborative drug therapy management, where a physician and a pharmacist enter into a written agreement to manage the drug therapy of a particular patient.

Currently, 21 states **including Washington,** recognize that pharmacists may work with physicians to initiate, modify or discontinue drug therapy, perform physical assessments, order laboratory tests, and provide other services to manage the drug therapy of patients. An additional 22 states are currently developing or reviewing proposals to provide for pharmacist and physician collaborative practice agreements.

Many other states have realized that collaborative drug therapy management improves overall patient care by allowing pharmacists to assist other health professionals by offering their assessment of a patient's drug use and drug therapy.

Pharmacists in Washington are also involved as part of the health care team in several retail, hospital, hospice, and home health care settings. These services include:

Anticoagulation Therapy: Expanding in Washington and the nation due to the fact that only 40% of patients who need this therapy are currently receiving it. So, in an effort to control clotting and bleeding problems that often result in hospitalization, pharmacists are work with other health care practitioners in providing this care. It is estimated that as much as $1,400 per year per patient can be saved by this collaborative care.

Pain Management: Patients, pharmacists, nurses, and doctors are partnering to provide safe and effective pain control to patients. This management ensures better quality of treatment, during periods where patients are receiving care for underlying causes or during chronic or life-threatening illness. Pharmacists believe this collaborative care will prevent worsening illness and costly emergency room visits and other acute care.

Pharmaceutical Care

Pharmacists are uniquely trained to provide the component of the health care system known as pharmaceutical care. Pharmaceutical care activities involve the collaboration of the pharmacist with physicians, nurses, and other health care professionals to ensure medications are used appropriately to improve patient health, improve a patient's quality of life, and contain health care costs.

Pharmacists in Washington launched "Cognitive Activities and Reimbursement Effectiveness" (CARE) in 1996. This project was initiated to test a payment system for pharmaceutical care services provided by pharmacist to Medicaid patients in addition to the standard dispensing fee. Targeting principally the most vulnerable patients, the elderly with chronic diseases, the pharmacist-provided services focused on:

1. identification and resolution of drug-related problems
2. provision of compliance-enhancing packaging of medications for high-risk patients
3. administration of vaccines such as flu and pneumonia

A state study conducted in 1997 showed that payment for those pharmaceutical care services, which led to drug therapy changes, resulted in a savings of over $78,000 over a period of 18 months after the pharmacist fees were already deducted.

Kingsbury, Doris (NCCAM)

From: Byron Katsuyama & Sue Seegers [byronka@ix.netcom.com]
Sent: Tuesday, November 14, 2000 7:34 PM
To: Whccamp (NCCAM)
Subject: Seattle Town Hall Meeting Comments

CAMcomments.doc

I gave testimony at the Commission's Seattle Town Hall Meeting on Tuesday, October 31, 2000 and am submitting (file attached) a copy of my remarks at that meeting.

Thank you for the opportunity to speak on this important issue. I look forward to the commission's final report.

Katherine Schmidt
Co-Director
Bellevue Massage School

16301 NE 8th
Suite 106
Bellevue, WA 98008

Phone: 425-641-3409

Intention. Intention for the best outcome when acting as a facilitator for someone's healing process. I emphasis in my classes that this is probably the most important aspect of working with someone, even before technique, or deciding on what kind of treatment to offer them. If you have the right intention that is 98% of the healing process!

Referrals. Knowing when it is not within your scope of practice to be able to refer to another provider. We need Tahoe a common algorithm that will provide a bridge for CAM and allopathic health care providers to communicate with each other. Also a system where all providers can access information on what treatments are available, and to have the patient be active in choosing that treatment.

Preventative Care. Teaching people to work on their health maintenance from a preventative approach and not wait until they are suffering from a particular condition to contact a health provider. Classes that provide the general public a different way to view their health-care, will give them tools they can use on a daily basis to keep themsleves healthy before a disorder occurs.

Self-Empowerment. This is a very important aspect of someone's healing process. When you can take part in your own treatment or preventative health it changes the paradigm of how you look at yourself, and can be very empowering and make a difference in long term effects.

Here are three people that stand out in my mind that were deeply affected by complimentary alternative medicine: A woman in her mid-seventies wanting to learn how to use reflexology to work on her husband who had recently undergone a quadruple bypass surgery and had been diagnosed with congestive heart failure. He is currently recovering from an abscess located around his pace-maker and is sensitive to his many prescribed medications. She knows she cant reverse his condition but it gives her something she can do for him that will make him feel cared for and have a positive out-come. A mother wanting to learn how to perform reflexology on her thirty year old son who has been diagnosed with MS. She had been caring for him all his life, and it gave her some tools that she felt would be helpful in his healing process. My own mother was diagnosed with breast cancer that had metastasized to her lungs and brain and had lost her eyesight during radiation treatments. She had something other than her pain medication to look forward to when she received her daily reflexology sessions from me. All three of these peoples live were touched by CAM.

Thank-you.

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

SeattleTown Hall Meeting
October 31, 2000

Mr. Chairman, Commissioners, I wanted to start off by thanking you for being here in this capacity for us. This is a very exciting time of expansion and growth in the natural health field and I am excited, as others here are, to be a part of that process. I appreciate your interest and the opportunity to share our views on this very important issue.

My name is Kathy Schmidt. I am co-director, along with my husband Jim, of the Bellevue Massage School, and am currently a certified reflexologist and a Touch for Health Kinesiology instructor at our school, as well as four local community colleges. I am a strong advocate for Complementary Alternative Medicine (CAM).

In particular, I feel strongly that CAM practices and interventions should be accessible to everyone including people of low income. Current insurance industry practices and policies effectively deny such access.

A system whereby people seeking health care can choose from a wide range of options, including both CAM and conventional medicine, should be the ultimate goal. When a person seeks services from their health care provider they should have the option of choosing the best course of action, by being provided with the latest research and data on the most effective and least invasive treatments. For this to be possible more education on CAM as well as the most current allopathic treatments should be available to Health Care Professionals and setting up a common language from which everyone can communicate.

When I was 20 years old and suffering from a chronic condition I was told by a doctor I would probably have this for the rest of my life and that I would probably be on medication for the rest of my life. I rejected that diagnosis and started looking into other options. Thus started my journey toward an alternative healing process, that included chiropractic, homeopathy, kinesiology and reflexology.

I am glad to be living in the state of Washington where most of these services are covered by insurance. Had they not been, I would not have been able to afford these options.

Many people giving testimony yesterday have addressed some important issues such as collaboration, bridging the gap between conventional medicine and CAM, quality of life and cross-training. I would like to bring up four other important points: (1) intention; (2) referrals; (3) preventative care; and (4) self-empowerment.

Kingsbury, Doris (NCCAM)

From: Tommy Lewis [tlewis@nwic.edu]
Sent: Tuesday, November 14, 2000 6:14 PM
To: Whccamp (NCCAM)
Subject: Testimony

Testimony-WWCommission on CAM....

Here is the testimony I presented at the meeting held at Seattle on October 31. I am speaker #92 on your list. Tommy Lewis
<<Testimony-WWCommission on CAM.doc>>

Fourth: family members (both immediate and extended) are part of the healing process and have roles to play throughout the duration of the healing time. We do not call it illness – we consider these times as an imbalance of the harmonies. The healers will restore the balance. There are many other things to consider in healing. We can teach you.

We will prepare our students to understand all ways of the healing practices. It is our intent to have them view healing in as many ways as possible - becoming familiar with the very old methods from other cultures, the ancient folk medicines of Europe, the modern technologies of western medicine, and their own tribal methods. This is what we call medical knowledge.

Thank you for this opportunity to illustrate how the best of our medical worlds are important to share. We will teach each other.

Through centuries, our People, have learned from Mother earth, about the plants and minerals which are her gifts to us to use. We have carefully guarded these things so that they will always be here. We have people who understand these things as that is their responsibility. They have been taught from an early age by the wise people to carry the knowledge. Not all people can do this. The medicine way is a sacred way. There are some things, however, that we can share. We can teach you.

The Sharing Way:

You have asked us to tell how the Native American student can be prepared to learn about your medicine ways. It is important to know that :

First : there are many practices that are similar, but many more that are different and sacred between our systems. It is important for your faculty to understand that each Native community is different, that the medicines used are different, that many procedures and ceremonies are very private. Neither our Native students nor our healers can be pressured to explain these.

Second: medicines are prepared for special cases and are not uniform in mixtures or strengths. Medicines are gathered, stored and prepared in a sacred way known only to our healers. The medicine bag is important for it contains the material and spiritual elements for curing.

Third: other methods are used for healing such as singing sacred songs and dancing. Sacred songs are used as apart of the healing process. The Native American Church using the peyote sacrament is a very powerful ceremony to heal the mind, body, sole and spirit. It is the fast growing Indian religion throughout the country among many Tribes.

monthly changes, and the completion of the annual circle fulfilling sacred events on the continuum of Time. This is what we teach our children.

The indigenous Peoples have their stories of how and where they began. Their places of origin are where they must spend their lives. If they go away for awhile, they must return. They must take care of their Space – their part of Mother Earth. We are taught that there is sufficient Space for everyone – and that every one is responsible for their Space. Our spaces are our hogans, log cabins, teepees , and other structures that are adapted to our lands. We have around our living spaces, fragrant soil for gardens, pure water for growth, cleansing wind and air, and seeds of life. We balance all of these in our Time on earth.

We teach our children to honor the Directions, for they each guide our lifeways. From the East (morning) we receive and praise the early light; from the South (noon) we receive and praise the warmth; from the West (twilight) we receive and honor the closure of the day; and from the North (night) we receive wisdom. From Above we receive gifts from and honor the Great Spirit, and from Down Below we are reminded that we are mortals. Every day we have ceremonies that honor the Directions, and everyday we teach our children these things.

The Medicine Way:

The People sustain their lifeways by growing, tending and harvesting the seeds necessary for food, for shelter, for warmth, for feeding the four-legged animals, the birds and the creatures of the sea, and for medicines and for ceremonies. Our indigenous People throughout the earth continue their harvests from the earth, the sea and the sky maintaining the balance needed in sustaining all of life. Please - look to us for understanding the old ways in doing these things. We can teach you.

We Can Teach You

Yahatee', it means hello in my Navajo language.

Introduction:

Thank you for this opportunity to share with you, today, how the Native American Educational System approach to teaching and learning blends the best of the new ways with the old ways of my Indian people.

Each Place has its own culture, language, food, medicines, lifestyle and ways of transferring the knowledge from the elders to the newest members of the tribe. Whether it is in the United States, South America, Australia, Lapland, Russia, or Africa, where there are indigenous peoples, each Place is different and adds to the magnificent diversity of the worlds' peoples.

The Indian Way:

In each of our different ways, the basic principles of achieving harmony and peace within ourselves and others, with the forces of the earth and all living things are what guide our daily lives. Our teachings include knowing about the four elements of earth, fire, air and water. As we learn about each, we learn how they relate to each other and how they are balanced.

The Education Way:

Throughout the circle of life, we are influenced by Time, Space, and Direction. These are the basic elements of our learning. This planet maintains its relationship with the greater universe through forces that are governed by Time – the gifts of this earth, both living and inanimate, are inter-related – none changing in mass, but always changing their form with Time. The People have special ceremonies throughout the Time cycle – honoring the daily blessings, the

Kingsbury, Doris (NCCAM)

From: David Matteson [matteson@matteson.seanet.com]
Sent: Monday, November 13, 2000 2:23 PM
To: Whccamp (NCCAM)
Cc: Sheila Quinn; Pamela Snider; judy colchin
Subject: here's testimony for submittal

DCM WH testmny 10-31-00.doc

greetings --
thank you for the opportunity to present testimony at the recent town hall
meeting in seattle. attached is the expanded and written version of my testimony.

thanks for all the good work, and the pleasure of getting to meet you.
i
hope we'll see each other again soon.

sincerely,
david

David C. Matteson, President
PACIFIC SOLUTIONS
830 Northstream Lane
Edmonds, WA 98020
Ph: 425/670-2254
Fx: 425/969-8977
matteson@seanet.com

Suggestion 4.
Consider soliciting input from Dr. Ron Heifitz, head of the recently created Center for Public Leadership at Harvard. His work is very insightful on creating public leadership and building process structures that engage stakeholders in productive ways around what he terms 'adaptive questions' (in contrast to technical questions).

Suggestion 5.
Think outside the box. Consider the "chaordic" organizational model developed by Dee Houk, CEO-Emeritus of VISA corporation. It is the organizational model upon which the VISA corporation is built, and requires all its participants to be both strong competitors and motivated collaborators. Isn't this what is really required by health care professionals delivering services in an economic market place?

In summary:
Include in your queries and your recommendations provisions regarding the processes by which these very complex questions can best be addressed, and the framework within which the future will hold them. There are many deep thinkers in addition to those I've mentioned here. My dominant suggestion is that you seek them out with the same sense of curiosity that you are seeking people and ideas on CAM-specific issues.

Thank you for your leadership and courage in serving on this commission, and for your commitment to moving us one step further along the journey.

people interested in advancing health in the region. It has the potential to provide a place where relationships and leadership will continue to evolve.

Observation 5.
The process of this commission appears to be one typically used by many commissions, i.e., gather information and have a group of experts make recommendations for how to fix something. I believe this approach is ill fitted to the issue of health and health care. Health care is more a social movement than a technical question.

Observation 6.
The mere title of this commission suggests a bias of thinking, which could lead to sub-optimal conclusions. By focusing on 'complementary and alternative medicine' it is implicit that the focus is on medicine, not health, and that the unquestionable and assumed starting point is the conventional, western, allopathic medical perspective and model.

So, a few strong suggestions:

Suggestion 1.
Do not perpetuate the use of the terms 'Complementary and Alternative Medicine, aka CAM'. Their use is divisive and entrenches turf-protecting attitudes that are already so much of the problem in health care today. At best these are transitional terms. I don't have a solid suggestion for alternative terms. But, I propose that the commission should make this a focus of their investigation and consideration and nurture the discussion towards an answer.

Suggestion 2.
Ask the right question. Part of my background is in the area of public policy mediation and dispute resolution. One truism that I've learned is that durable, fair, and effective solutions emerge more easily when people first agree on the question. I believe that much of the tensions around CAM issues stem from disagreement over what is the correct question to address. I believe a correct macro-level question before this commission is along the lines of, "What federal policy and resource choices are most appropriate to ensure an effectively integrated health care delivery system, that incorporates the best of so-called complementary and alternative health care as well as conventional medicine." What I hear by contrast is a question that asks, "What can be incorporated from CAM therapies and modalities and grafted into the delivery of conventional medicine."

Suggestion 3.
While it may be impractical to alter the scope of work of this commission at this point, the commission should give careful investigation and thought to what would be the most appropriate process to effectively engage the right question in the future. One possible resource is someone like Parker Palmer at the Fetzer Institute in Kalamazoo, MI. His work on the process requirements for social movements would be insightful.

trustworthy relationships amongst stakeholders (or at least a structure for interaction that allows provisional trust), progress can not be made on any subject, let alone something as individual as health.

Observation 3.
Some structures and processes are better matched to certain questions. Too often a mismatch of substance and process can spark controversy rather than consensus, obfuscate rather than clarify, and protract rather than inspire a decision.

Observation 4.
Progress is generally only made when there is effective leadership.

Historical note:
The past ten years in WA are a great case study in these first four observations.

In the early 1990's Washington state had the dubious honor of being the guinea pig state for Hilary Rodam Clinton-style health care reform. We had a governor who was close to Ms. Clinton, had above average legislative leadership acumen, and enjoyed a friendly legislature. The result was passage of a sweeping health care reform bill. In addition to a laundry list of statue and regulatory changes, the bill mandated an extremely involved two-year process of investigation, discussion, and recommendation development. The Health Care Commission was created, which had half-a-dozen major committees that hosted dozens and dozens of public forums, committees, and work-groups. Over the two years of the Commission's work many of the people testifying here today first got to know each other.

In the beginning...it wasn't pretty. All of the predictable issues of legitimacy, credibility, data holes, differing world views, conflicting terminology, egos, turf wars, etc. dominated much of the energy expended. But the strong structure of the process held everyone in the discussion long enough to begin moving in a positive direction.

Two years later the tide of legislative power shifted, and an equally strong effort was mounted to gut the health care reform legislation. Suddenly, we found ourselves once again gathering together in hearing rooms...and more importantly, afterwards in hall ways, coffee shops and taverns. New alliances were made between previously oil-and-water organizations, in the interest of a common legislative focus. Relationships and friendships continued to emerge...provisional trust and an appreciation of interdependency began to grow.

Several things remained after the legislative pruning. The so-called 'Every Category of Provider' law that you've heard so much about survived, and later successfully ran the legal gauntlet all the way to the Supreme Court. Perhaps more importantly, many of the stakeholders sustained their relationships through work groups like the Insurance Commissioner's Clinicians' Workgroup on Integrative Care, Building Bridges, various roundtables and conferences, and other ad hoc gatherings. Today, the King County Integrative Medicine 2010 project is an effort to build a new common structure amongst

October 31, 2000

David C. Matteson, President
Pacific Solutions
830 Northstream Lane
Edmonds, WA 98020

Testimony before the
White House Commission on Complementary and Alternative Medicine Policy
October 31, 2000
Town Hall Meeting
Seattle, WA

Good afternoon, and thank you for hosting these proceedings.

I am David Matteson, President of Pacific Solutions. I have an extensive background in public affairs and public policy, with a heavy involvement in health care. An emphasis of my vocation is around the methods and processes by which diverse groups of people make complex socio-economic decisions. A focus of my professional work has been with the visionaries and leadership of many of the provider professions, from the MDs to the massage therapists. I also work with some of the CAM schools and colleges, including Bastyr University.

As many here before me have spoken extensively to the technical and clinical aspects of the question of CAM integration, I will take the advantage of being near the end of the agenda and speak to a perspective that has not received much attention.

Dr. Gordon, you asked the question yesterday, "How has so much been accomplished in the Seattle region?" Having been an intimate, 11-year participant in the answer to that question I will offer some observations, a short historical note, and a few strong suggestions.

Observation 1.
It's about people. We engage in most of our discussions as if health was a technical question with a definitive answer. Health is not a question like, 'How do we build a bridge over that river?' Health is more about a state of being...which is individually defined by one's own personal experience. People make up the rules by which we will know and achieve health. It is by definition, therefore, a people process, not a bureaucratic one. This leads to observation number 2.

Observation 2.
It's about relationships. In other words, it's about groups of people and how they are together. . . over time. It is the quality of these relationships that in large part determines the quality of the collective decisions people make. Relationships are fragile and powerful things. Without them, nothing can be accomplished. Without effective and

Kingsbury, Doris (NCCAM)

From: Stuart Cohn [stuartc@ffls.org]
Sent: Thursday, November 09, 2000 5:50 PM
To: Whccamp (NCCAM)
Subject: Testimonial

CAM testimonial.doc

November 9, 2000

Dear CAM Commission Members:

Thank you for the opportunity to write to you about my experience of complementary and alternative medicines.

Two times in my life I was diagnosed with terminal or life-threatening illnesses. The first time when I was 25 I was diagnosed with HIV and I was told I had about 2 years to live. Six years later, in January 1993, I was diagnosed with non-Hodgkin's lymphoma and given 6 - 18 months to live. The fear, anguish and panic that went through my mind each time I was diagnosed were a shock to the psyche.

My allopathic medical doctors treated me as an illness rather than an individual. They had little compassion and few possibilities or suggestions. I prepared to die.

Once I decided not to follow conventional/allopathic medicine regarding HIV, I became as informed and educated as I could about the immune system. It seemed to me that if my immune system was failing, I needed to do whatever I could to boost it. I began practicing meditation techniques to quiet my system, altering my diet by eating whole and natural foods, eliminating caffeine, cigarettes, alcohol and sugar. In addition, I began exercising, and appreciating nature and my relationships more. I researched herbs and vitamin supplements and began to implement them into my daily routine.

When I was diagnosed with non-Hodgkin's lymphoma, my life turned upside down. I thought I had done everything "right". How was it possible for me to get sick with a cancer that was going to take my life? I received 25 sessions of radiation treatment and refused chemotherapy treatment because my doctor told me that the outcome would be grim. I traveled and, at some point, remembered the number of accounts of individuals who had been told by their physician that they were going to die, but did not. I thought, "what did they do? What do I need to do to stay alive?"

I returned from my travels and plunged into alternative approaches to healing. I became a regular patient of Bastyr Natural Health Clinic. I received body treatment therapy including massage, acupuncture and

oriental
medicine, physical medicine, and vitamin & herbal supplementation. I continued to eat well, exercise, meditate and strengthen my relationships
with my family, friends and community.

In 1997, I decided to finally begin the standard allopathic medicine regimen
for people with HIV/AIDS. The drugs have increased my t-cell count and reduced my viral load to undetectable levels, but I have not stopped any of
my other healing methods. I found them to be necessary to stave off the ill
effects of my allopathic drugs.

I would not have survived HIV, cancer, PCP pneumonia & osteoporosis for the
past 20 years had I gone the route of conventional medicine alone without
the overwhelming support of the complementary and alternative medicine community.

Please do whatever it takes to ensure that all Americans can have access to
holistic medical approaches for whatever life-challenging illness they face.
Freedom to choose.

Respectfully,

Stuart Cohn

Kingsbury, Doris (NCCAM)

From: Ralph Forquera [ralphf@sihb.org]
Sent: Wednesday, November 08, 2000 11:21 AM
To: Whccamp (NCCAM)
Subject: Testimony


WHMTG.DOC

Attached is my testimony requested at the October 30-31 town hall meeting in Seattle Washington. If you have questions, please feel free to contact me.

individuals, particularly those with strong ties to culturally-sanctioned healing practices, providers must understand how to ask about such practices and even how to interact with non-western providers. Therefore, I would recommend that a course introducing non-western approaches to health be incorporated into the training curriculum of all levels of health care providers: physicians, nurses, dentists, etc.

Standards for Traditional Indian Medicine (TIM) among American Indians and Alaskan Natives must be established locally by community recognized traditional healers and not imposed by outside sources. Therefore, I would recommend that the Commission resist the idea of creating national standards for Traditional Indian Medicine or other forms of traditional healing that are cultural in nature.

In regions were the use of traditional medicine is an accepted practice, that Medicare and Medicaid, and other health insurers consider payment for such care as a specialty consultation or other form of complementary treatment. Therefore, I would recommend that the Commission encourage the Health Care Financing Administration to consider payment for recognized complementary treatments under Medicare and Medicaid, and that health insurers also be encouraged to study payment under health care insurance plans.

Ralph Forquera
October 31, 2000
Seattle, WA

The integration of western and traditional healing is not an option for those of us working to improve the health of urban American Indians and Alaskan Natives. Regardless of whether mainstream America accept these practices or not, for Indian people, the use of traditional Indian medicine will always be a vital part of their search for better health.

While we have made great strides at my agency to try and incorporate traditional practices into our community health setting, I can tell you we have far to go. Health care training serves to instill biases in health care professionals that often interfere with recognition and understanding of personal choices people make about their health. We chose to create the family practice residency program as a way of setting up opportunities for new doctors to understand and learn to respect traditional practices so they will be more effective in caring for Indian people. This experiment remains in its earliest stage..

As a multi-cultural society, it is important that we recognize and respect the vast array of cultural approaches to healing one may encounter. Both modern medicine and traditional Indian medicine, we have found, can play an important role in addressing health problems that affect Indian people. The more we understand and respect these practices, the easier we make it for patients to receive access to both types of treatments, the greater the likelihood that we will find acceptable ways to improve the health of all Americans including urban American Indians.

RECOMMENDATIONS

It is important that health care practitioners be introduced to non-western approaches to healing at an early stage in their training before professional biases solidify. It is clear that a vast majority of Americans do not restrict their health care seeking behavior to just western practitioners. Therefore, to effectively treat

the welcoming of a new life, or dealing with the trauma of death, this partnership has been shown to enhance our efforts to balance the traditional and contemporary approaches. It is this partnership and our agency's commitment to mutual respect for western and traditional approaches to health care that appears to benefit the patient. We have found that using the best of both approaches improves the prognosis of our patients and accelerates their recovery. It improves cooperation and establishes a sense of trust lacking in many health care systems today.

Like other Americans, American Indians seek help for their health problems from a variety of sources. Therefore, we are exploring non-Indian traditional practices that show promise for our patients. For example, we are currently exploring the use of acupuncture for our residential clients at our Thunderbird Treatment Center to help with drug and alcohol withdrawal symptoms and as a relapse prevention strategy. We know that some of our clients already use acupuncture for a variety of their ills.

Several on our staff have backgrounds and training with herbal remedies. Our providers routinely ask patients about their use of herbs and other remedies both to complement their western approach to care as well as to assess potential problems that might arise from mixing traditional and contemporary therapies.

The Seattle Indian Health Board does not view non-western healing practices as alternative or complementary. Indeed, these practices are more a part of most Indian people's lives than contemporary, western medicine. The failure to recognize and respect this simple truth only widens the gap between the benefits these two forms of healing can bring to the health of our community. It is therefore in the best interest of our patients that we understand their traditional beliefs and healing practices, and do whatever we can to incorporate these cultural dimensions into our work.

privilege this individual as we would any other provider. In doing so, the Traditional Health Liaison has become a credible specialty provider who now has the ability to perform traditional ceremonies and other healing methods in collaboration with medical providers in several area hospitals. His services are now requested by providers who are not directly affiliated with our agency; a demonstration of the acceptance of traditional healing by the local health care community.

In 1994, in response to a shortage of physicians trained to work with Indian people, we established the first and only family practice physician residency training program which focuses on Indian health in the nation. An important part of our curriculum includes our residents learning about traditional healing, learning how to discuss such matters with patients, and in some instances, participating in traditional activities when appropriate.

It is important to note that we do not train Traditional Indian Healers. In most native societies, the role of the traditional healer is one recognized at birth, and the responsibility is mentored by recognized Indian healers over a lifetime. Therefore, it is not our intent to train these cultural healers. Instead, our intent is to recognize that this form of medicine is widely used by Indian people and to demonstrate to new physicians interested in Indian health, the importance of understanding and respecting traditional healing as an integral part of their patient's lives. By incorporating these practices into our services, we have strengthened the healing options for our patients as well as enhanced the cultural understanding essential to addressing the health disparities that effect Indian people today. Thus far, this approach has been enormously successful.

Another key role played by our Traditional Health Liaison is one of cultural interpreter between our Indian patients and the western medical practitioner. Our medical staff and Traditional Health Liaison are learning to work in tandem in caring for our clients and their families. Whether it is preparing an individual for surgery or

TESTIMONY
WHITE HOUSE COMMISSION
ON COMPLEMENTARY AND ALTERNATIVE MEDICINE

My name is Ralph Forquera. I am a member of the Juaneno Band of Mission Indians, Acjachamen Nation. I am the Executive Director for the Seattle Indian Health Board, a community health center that serves a predominantly urban American Indians and Alaskan Natives population living in the greater Seattle/King County region of Washington state.

For many urban American Indians, western medicine might be considered "alternative" or "complementary". The majority of the Indian people we serve use some form of traditional Indian medicine on a fairly routine basis. Thus, in recognition of this fact, my agency established a position in our agency we call our "Traditional Health Liaison".

The Seattle/King County urban Indian community is very heterogeneous having more than 250 different Indian tribes from throughout the United States represented, each with unique histories and traditional health practices. The person we hired to fill the Traditional Health Liaison role is a locally recognized traditional healer who for many years prior to being hired into this position, conducted traditional health healing services throughout the region. Recognizing that one individual could not fulfill the desires of such a diverse community, a primary role of the position is to help guide those desiring traditional Indian medicine to regional practitioners who can perform tribally-specific interventions.

As a JCAHO accredited agency, we chose to treat the Traditional Health Liaison position as just another type of health care provider. Therefore, using other locally recognized traditional healers, criteria was established so that we could credential and

Ralph Forquera
October 31, 2000
Seattle, WA

6 4 99
4338

PhoneTools

BVRP software

2328 NE 104th Street
Seattle, WA 98125

Phone: 206-526-8091
Fax: 206-526-8091

Message :

ATTENTION:

Staff Members of The White House Commission on Complementary & Alternative Medicine Policy -

Written Testimony for the Town Meeting in Seattle, Monday, October 30, 2000

From: Jerri Spalding Fredin	**To:** Staff Members White House Commission on CAM
Date: 10/28/2000	**Page(s):** 6

White House Commission on Complementary Alternative Medicine Polite, 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*

The "checks and balances" amendment, referred to in my oral testimony (October 30t.) 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

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

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

"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

Jerri Spaldinz Fredin, testifying for
Citizens for Alternative Health Care
2328 NE 104th Street
Seattle, WA 98125
206-526-8091

FINAL DRAFT: HEALTH CARE AMENDMENTS

AN ACT Relating to Health Care; amending RCW 1 8.71.01 5, 1 8.1 30.1 80, 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 Integrativetreatments. 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 ounce 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 ammmative 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, The 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 Physicians license. In order to revolve a physician's license, a majority of the regular commission members must concur wig 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 ounce, 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 temm 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, When 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 ParticiDate 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 temms shall have the following meanings, unless the context clearly indicates otherwise.

(a) UIntearative" or"Complementarv" health care. also known as ~Complimentarv" 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) UConventionalr 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 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 disciDlinary decision by the commission shall have the right of appeal to the state judicial system, and a decision by such court shall affimm 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 Perfomm 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 aovernor 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 temminated 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. Infommation so gained shall not be subject to discovery or introduction into evidence in any civil action pursuant to RCW 70.41.200(3).

RCW 1 8.1 30.180 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 hammed. The use of ((a nontraditional treatment)) an Intearative 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 Prevailino 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 auiltv of unprofessional conduct solely because of that person's use of an Intearative therapy as defined in RCW 18.71.011 or because that person's

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 Intearative treatment that the patient requests. Health care providers have the duty to provide written infommation to the Patient as to the Proposed course of treatment, including substances to be used and known side effects.

Testimony by Kent Pullen, King County Councilman Oct. 30, 2000

Since I will be talking about the role of King County in promoting natural medicine, I should begin by defining natural medicine.

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

In 1994 I was curious to see if the county could promote better health care. I began by getting advice from a number of local leaders: Merrily Manthey, Dr. Joe Pizzorno, Dr. Jeffrey Bland, and Dr. Jonathan Wright. I think you will be hearing from most of this talented group, although at the present time Dr. Wright is in Asia, but he did leave a videotape for your viewing. I then consulted with my fellow elected officials and found that 11 of the 13 members of the County Council were already using natural medicine and were quite happy with the results.

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

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

Managed Healthcare Resources Northwest, LLC MHRN

7900 S.E. 28th Street, #200
Mercer Island, WA 98040

Phone: (206) 232-6300
Fax: (206) 236-8110

October 30, 2000

White House Commission on Complementary and Alternative Medicine Policy

Testimony: Lawrence M. Jacobson, MPH
Managed Healthcare Resources Northwest, LLC

Thank you very much for coming to Seattle and taking the time to consider our comments.

I have been in the business of health care consulting for the past five years. Much of my business involves representing health care providers, both conventional and CAM in their working with managed health care plans, primarily in Washington State. My business is very broad in that I have clients who are health plans, CAM providers, and specialty medical providers. Additionally I get many calls from consumers asking for help in navigating the health care system. I served for three years as the co-facilitator for the Clinician Workgroup on the Integration of Complementary and Alternative Medicine - CWIC. This effort was motivated by WA State Insurance Commissioner Deborah Senn whose goal it was to get health plans to work more cooperatively with CAM providers. We brought together a group of six health plan Medical Directors with the heads of the State Naturopathic, Chiropractic, Acupuncture, Massage Therapy, and Midwifery Associations, as well as a small group of primary care physicians. Lastly, I have been a consumer of CAM services and an interested party for many years.

The Washington State "Every Category Law" has provided an impetus for the previously underground CAM system to meet the conventional medical system. Though our CWIC was a very productive first step in bridging the many gaps in knowledge and understanding, there remains a long way to go. There were marked successes in building relationships across disciplines, but there remain many differences in experience, particularly from the payor - provider interaction. Much further work in research is needed both in clinical efficacy and in policy development. There are many issues before we can even get to the bottom line of "Are CAM services and add-on or replacement to conventional treatment costs?"

In my work with many highly skilled CAM professionals I have found many who support the concepts of integration with conventional providers, but a significant number who are concerned with being co-opted by the conventional system. As David Eisenberg has reported many consumers reflect the tension between the two systems by their reluctance to discuss their concerns with both their CAM and their conventional medical providers. Even with the new access law, and approval of my PCP I have experienced health plans which have prevented access to CAM services. Consumers remain confused by the law and still see CAM services as a step-child of the conventional system when it comes to payment.

I certainly applaud the many CAM professionals who have worked had to provide innovative and effective health services. They have worked in the shadows of conventional medical practice for far too long. Yet there still is a reasonable concern that there remain unqualified and potentially dangerous providers and herbal remedies which must be assessed. With further research and communication the balance can be more accurately struck. Yet where do the needed resources come from to make these studies, which may be very complex, happen?

There continue to be conflicting incentives to diverse groups which we would ideally like to work cooperatively together. CAM providers often are untrained in how health insurance works and why it can only generally reimburse acute treatments. They are afraid that their methods will be watered down by the conventional peers. Conventional medical providers may be interested in CAM disciplines since their patients often ask for more information which they may be unable to offer. Yet traditional physician organizations sometimes see CAM providers as a threat, given the consumer's dissatisfaction with the attention they currently receive in a ten minute physician visit. More discussion of this resistance is required. Health plans also recognize the need to learn more about CAM services, but when unable to quantify the results of CAM care, often opt to limit the benefit and cost of CAM services for fear of opening Pandora's Box. Consumers of course want access, but are reluctant to pay out of pocket, particularly if these services are now covered in Washington State.

Most of us who have worked in this arena recognize that there is both a danger and an opportunity in expanding access to these services. Significant manpower and resources are needed to ask the right questions and get the right answers. Government and other purchasers must have a serious discussion of how these decisions can be made without the quantification of experience. Washington State can be a real life laboratory, but we need your help to make it happen. We have many of the right questions, but we need resources to study the answers. I strongly urge you to support the growth of integrated service training opportunities in both conventional and CAM educational settings. We have to work together with consumers to foster a value of more individual responsibility and focus on health and wellness and only lastly treat disease.

The pattern of payment restriction is following a similar path to that of behavioral health ten years ago. When no one is paying attention, purchasers and payors set it aside to control their costs and developed "carve-outs". The "1-800 Just-Say-No" companies detract from the ability to integrate by taking CAM outside of the medical benefit. This is now a trend in CAM management. Though some of these companies employ CAM providers and sincerely work to establish CAM guidelines, many are simply trying to make a profit by limiting care. This is a dangerous trend that has already marginalized the industry and cut out many quality CAM providers. Since conventional providers are unsure of how to handle these services and neither they nor plan personnel have the time to look into it further, these services get treated like another cost center.

Recommendations:

1. Solicit opportunities for real long term integration in the conventional medical community
2. Compile up-to-date information to be disseminated effectively to consumers - what works?, what does not work?, what is dangerous? What communication channels?
3. Create a national multidisciplinary process similar to CWIC including payor reps, purchasers, and consumers to support mutual incentives
4. Study clinical efficacy and effectiveness, but also access and costs of care in different insurance models
5. Train CAM professionals in the use of CQI techniques so they can set up standards for themselves
6. Integrate consumer responsibility with health and wellness incentives wherever feasible

Lawrence M. Jacobson, MPH
MHRN, LLC
3230 73rd Ave SE
Mercer Island, WA 98040
206-232-6300 MHRNLLC1@aol.com

LAWRENCE M. JACOBSON HEALTH CARE CONSULTANT
MANAGED HEALTHCARE RESOURCES NORTHWEST, LLC
3230 73rd Avenue SE
Mercer Island, WA 98040 (206)232-6300 MHRNLLC1@aol.com

WORKING WITH HEALTH CARE PROVIDERS AND PAYORS FOR OPTIMAL QUALITY CARE AND COST EFFECTIVE SERVICE DELIVERY

SUMMARY OF EXPERIENCE

- Twenty five years of health care provision and management experience including Health Plan, Medical Group and Hospital positions
- Health Plan, Provider, and Hospital Contracting; Facility and Practitioner Evaluation; Contract Negotiation; Network Development, Provider Education
- Provider Consultation in IPA development and integrated managed care systems
- National Committee for Quality Assurance (NCQA) Administrative Surveyor, Health Plan Consultation
- Specialty Network Development in Complementary/Alternative Health, Behavioral Health, and Medical Specialties
- Ten Years Behavioral Health Program Management and Provider

CONSULTING

- HMO/PPO Network contracting with a wide range of health care providers
- Creation of a statewide independent long term care network
- Integrated Delivery Systems development (PHOs, IPAs, etc.), provider support, health plan contracting, provider education, utilization and quality management
- Provider based managed care system development, surgery centers, skilled nursing facilities, transitional care, complementary/alternative health providers
- Facilitation of a clinical workgroup on integration of complementary and alternative medicine incl. health plan medical directors, primary care and CAM providers
- Interim Marketing Manager for a nationally known preventive health service for Washington's largest HMO

EMPLOYMENT EXPERIENCE

- Director of Managed Care for a not-for-profit organization. consulting with physician groups, hospitals, and health plans
- Medical Services Contracting Manager for a 120 physician Seattle medical group
- Senior Contract Administrator for a large HMO working with primary care medical groups and acute care hospitals in Southern California
- Director of Provider Relations for a national provider of managed behavioral health services including customer service and case management
- 5 years management of mental health and chemical dependency recovery services for hospital based programs in Southern California

EDUCATION

- MASTER OF PUBLIC HEALTH, Program in Health Services Management, University of California at Los Angeles
- MASTER OF SOCIAL WORK, Barry University, Miami, FL
- BACHELOR OF ARTS, Syracuse University, Syracuse, NY
- Quality Improvement in Health Care Certificate, Seattle Central Community College

Kingsbury, Doris (NCCAM)

From: John Daley [JDALEY@bastyr.edu]
Sent: Monday, November 06, 2000 12:16 PM
To: Whccamp (NCCAM)
Subject: Electronic Testimony for Dr. John C. Daley, Bastyr University

White House Commission Town Ha...

To Whom It May Concern:

Here is a copy of my Testimony, which was delivered to the White House Commission Town Hall on CAM on October 31, 2000.

Thank you,

John C. Daley, PhD
Bastyr University
14500 Juanita Drive NE
Kenmore, WA 98028
Telephone: 425-602-3002
E-Mail: jdaley@bastyr.edu

White House Commission Town Hall on CAM: October 30-31, 2000
by John C. Daley, Ph.D., Bastyr University

My Topic: What Sources of Funds Exist for the Education and training of CAM Practitioners?

Personal: For the past seven years I have been the Executive Vice President of Bastyr University. This means I am the chief operating officer, and therefore familiar with the enormous fiscal challenges facing CAM education, research, and clinical services.

Background:

CAM education is now heavily dependent on tuition revenue and private giving to educate it's students. Traditional medicine, however, also relies heavily on federal money to enable them to provide educational opportunities to their students and graduates not available in CAM.

The sources of federal funds which exist to educate and train CAM practitioners is far more limited than those available to those in traditional medicine. We seek the elimination of the barriers to access federal funds for accredited CAM educational institutions.

The public is demanding access to quality CAM. The quality of that care is directly related to the quality of the provider and therefore, the education they receive. The best applicants to CAM institutions are not going to ultimately enroll if they cannot afford to. At this time, they do not have access to the same loan packages available to traditional medical students.

For example, the Association of American Medical Colleges announced to their members that the Department of Education recently increased the money they could borrow under the Stafford Loan program to pursue a medical education. Eleven professions were noted as eligible fields for this expanded Stafford program, but naturopathic medicine and AOM were not included. The only CAM provider included was chiropractic.

The quality of a CAM professional is also related to their access to

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

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

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

Specific Recommendations:

1. Under the Stafford Loan Program, include accredited schools of naturopathic medicine and acupuncture and oriental medicine to those authorized to provide increased unsubsidized loan amounts to students in health professional schools.

2. Require that accredited CAM academic institutions be eligible for inclusion in funding provided by the Health Resources Services Administration, the Health Care Financing Association, and the Bureau of Primary Health Care, to fund residency and continuing education programs for their graduates.

3. Seek amendments to current Medicare and Medicaide legislation to include naturopathic physicians, and any other appropriate CAM providers, as reimbursable providers.

4. Extend the federal loan forgiveness program to those willing to serve in rural areas to appropriate CAM graduates.

Kingsbury, Doris (NCCAM)

From: Karen Sherman [ksherman@niaom.edu]
Sent: Tuesday, October 31, 2000 5:51 PM
To: Whccamp
Subject: Written testimony in support of oral testimony

I am unable to submit my written testimony to your web server because I receive an error message. Therefore, I submit it my name and affiliations. Please pass this on to the relevant person.

Thank you,

Karen J. Sherman, Ph.D.
Research Director
Northwest Institute of Acupuncture and Oriental Medicine
701 N 34th St, Suite 300
Seattle WA 98103
Tel (206) 633 - 2419
FAX (206) 633-5578

Affiliate Assistant Professor
Dept. of Epidemiology
University of Washington

e-mail:

ksherman@u.washington.edu

Written Comments to Expand Testimony Given at the Town Hall Meeting, Seattle WA on October 30-1,2000 to the White House Commission on Complementary and Alternative Medicine Policy

Submitted by:

Karen J. Sherman, Ph.D., MPH

Research Director

Northwest Institute of Acupuncture and Oriental Medicine

Seattle WA 98103

Background and credentials:

I am trained as an epidemiologist and worked for nine years at the Fred Hutchinson Cancer Center in Seattle on women's health issues. During that time, my research involved collaboration with molecular virologists in assessment of exposure to human papillomaviruses. The virologists had no concept of sampling and reproducibility of test results from person to person in the way that epidemiologists did. Therefore, I gained valuable experience in how to speak their language and to help them understand our research needs. That experience in learning to understand and appreciate

different world views has proved crucial in the current research I am doing with a variety of complementary and alternative medicine (CAM) providers.

I have been the Research Director at the Northwest Institute of Acupuncture and Oriental Medicine (NIAOM), the oldest acupuncture school in the Pacific Northwest, since 1996. I am probably the first full time research director at a US acupuncture school. I am currently a Co-Principal Investigator on one NCCAM (National Center for Complementary and Alternative Medicine)/AHRQ (Agency for Healthcare Research and Quality) grant and a Co-Investigator on three other NCCAM funded grants. These three grants are all large pilot and developmental studies designed to collect data necessary for designing Phase III Clinical Trials. I have been involved in three other CAM related projects, including an "effectiveness trial" of massage and acupuncture for back pain and a study of what CAM practitioners actually do in their practices, modeled after the design of the National Ambulatory Medical Care Survey. I am also an Affiliate Assistant Professor in the Department of Epidemiology at the University of Washington and a Board Member of the nationally based Society for Acupuncture Research.

As part of my research, I have recruited and worked with over 45 acupuncturists who either performed treatments as part of the studies or collaborated with various phases of the development of protocols (including survey construction, and development of a non-needle control). I have trained acupuncturists to perform treatment according to strict protocols in three separate studies. I am beginning work in protocol design with massage therapists, chiropractors, and tai chi instructors in the next few months.

For five years, I have taught Research Design to acupuncture students (and have instructed over 150 of them) at NIAOM. I led a journal club on CAM methodology at the University of Washington. I have lectured on acupuncture research to medical students and residents at the University of Washington and lectured at local CME courses as well. I have served as a grant reviewer on CAM grants for NCCAM and the Centers for Disease Control and Prevention and have served as a consultant for several non-acupuncture CAM projects.

Recommendations and Supportive Documentation:

My oral testimony to the Commissioned focused on two important issues for the Commission: 1) How can we use our limited resources to stimulate research on CAM practices and 2) how can we encourage CAM and conventional researchers to work together for mutual benefit?

1) How can we use our limited resources to stimulate research on CAM practices?

The five year strategic plan outlined by the National Center for Complementary and Alternative Medicine presents an excellent argument for emphasizing clinical studies of the CAM therapies that are most commonly used by American. Data from a 1997 performed by Eisenberg et al. (Trends in Alternative Medicine Use in the United States, 1990-1997, JAMA 1998; 280: 1569-1575) shows that four in ten Americans used at least one CAM therapy that year. Numbers are even higher for Americans aged 25 to 49 and women. The therapies most commonly used in 1997 were relaxation therapies (16% used), herbs (12%), massage (11%), and chiropractic (11%). With the exception of herbal therapy, (specifically use of manufactured herb preparations), these therapies do not lend themselves to double – blind placebo controlled trials. Given this and the fact that these therapies are already being used by substantial numbers of the public, I think we should place *relatively more emphasis* on pragmatic clinical studies that examine CAM therapies as actually practiced, rather than

the efficacy studies that are typically done of medications. Pragmatic or "effectiveness" trials, which are often done in health services research, allow for a broader protocol than might be found in an efficacy study. They also make comparisons with usual care or other viable therapeutic options. They tend to focus on practical measures of outcome that matter to patients, such as functional status, rather than physiological measures, although this need not be the case. For example, in studies of carpal tunnel syndrome, a pragmatic trial might collect data on symptoms and functional status, while an efficacy study might measure median nerve conduction.

If the effectiveness studies show that a CAM therapy yields good patient outcomes, then further studies can be done to find out which components of the intervention were responsible for its success. In addition, in the context of pilot projects in integrated care, we can collect data on safety of CAM therapies and on some patient outcomes for common medical complaints.

The most common herbs that American's tend to use as "over the counter" herbs should be tested in double-blind, placebo controlled trials to see whether they are indeed effective. Information should also be obtained about the most common combination herbs used. Safety data should be collected for all professions with the cooperation of office-based practitioners.

The biomedical research community, as well as some conventional physicians, will require some efficacy research in order to accept CAM therapies. Such research should be done, but only when treatment protocols tend to warrant it. For example, the National Acupuncture Detoxification Association certifies acupuncturists to perform their "five needle protocol" for patients to help reduce cravings, increase retention in treatment, and reduce usage of alcohol and drugs. Such a protocol could appropriately be tested in an efficacy design. Such studies have been conducted (e.g., Bullock M et al. Controlled trial of acupuncture for severe recidivist alcoholism. Lancet 1989 Jun 24: 1435 – 9.; Avants AK et al. A randomized controlled trial of auricular acupuncture for cocaine dependence. Arch Intern Med 2000; 160: 2305 – 2312.). Another example is the work on acupuncture as an antiemetic, using a single acupoint (P6), for treatment of nausea and vomiting associated with chemotherapy, pregnancy, or surgery (see summary in Vickers A. Can acupuncture have specific effects on health? A systematic review of acupuncture antiemesis trials. J Royal Soc Medicine 1996; 89: 303 – 311). It is also important to note that some interventions simply can't be double blinded or even blinded at all. Examples would include studies of massage and exercise. Yet, numerous randomized controlled trials exist examining the impact of exercise on patients with heart disease, even though they don't use placebo controls.

It is important to retain some credibility with the biomedical community in order to facilitate appropriate integration. If weak research designs are legislated, that will that will lend credence to some who are convinced that CAM is a non-scientific movement. Nonetheless, there are some aspects of CAM therapies will require unique approaches for adequate testing, including the testing of whole systems of medicine. For example, Bensoussan et al. (Treatment of irritable bowel syndrome with Chinese herbal medicine: a randomized controlled trial. JAMA 1998; 280: 1585 – 9) performed a double blind placebo controlled study of Chinese herbal medicine as a treatment for irritable bowel syndrome. The Australian study had two treatment groups, one where all patients received the same multi-herb formula (which was created specifically for the trial) and one where patients received customized multi-herb formulas as typically happens in practice. Such a design satisfies the need for traditional scientists to see a single medicine tested and honors the reality that Chinese herbal medicine is NOT practiced in that manner.

Many traditional systems of medicine, including naturopathy, Traditional Chinese Medicine, Tibetan

Medicine, and Ayurveda use multiple herbs in individualized combinations for specific patients. They may use additional therapeutic modalities as well. Such studies present challenges at the moment because of the need for demonstrating safety of the herbs for the FDA. Especially in situations where herbal formulas are adjusted for individual patients, it's not clear what information should even be presented to the FDA.

Another crucial issue in conducting un-biased CAM research is the issue of patient choice, because of its effects on outcomes. This is especially prominent in CAM research where patients can not be blinded and where they have a clear preference for one therapy over another. This can also be an issue for biomedical research, but since most medical treatments are studied before they are widely introduced to the general population, it is less of a bias.

2) How can we encourage CAM and conventional researchers to work together for mutual benefit?

Performing rigorous research on CAM therapies is actually quite an intellectual challenge, even when collaborating with CAM practitioners as I do. CAM practitioners need training in research, as they are not well versed in research methodology. They need to understand why some kind of comparison group is essential to make meaningful statements about quality of life or functional status. While CAM practitioners prefer "outcomes research", this type of research is NOT actually a study design. Rather, it is an approach that focuses on a broad range of outcomes that are important to patients (and the health care system) and tends to look at the results of treatment under actual practice conditions. There are a number of designs that lend themselves to outcomes studies, including cohort studies, studies of analysis of variation of practice, and "effectiveness" clinical trials. While many CAM researchers prefer cohort studies, and these can give useful information about the changes in health status that may result in patients who receive a therapy, without comparison groups and adequate information on other factors that may influence outcomes of treatment, we can not make clear recommendations about the benefit of a therapy. CAM practitioners also need to develop openness to how research can help them improve their practice of medicine. There are multiple styles of many CAM therapies – including acupuncture, chiropractic, massage, meditation, tai chi, yoga. It is not known whether some of these styles are more effective than others (or more effective for certain people).

Often, CAM practitioners lack basic information that is necessary for construct protocols, such as how long interventions should last and how often they should be given. I recommend that funding be available to help develop a research culture among CAM providers that would include monies for development of rigorous courses on research methods in CAM institutions. Funding for Continuing Education on this topic is essential as well. Since many CAM schools are quite small (nearly all acupuncture and massage schools and some of the others), the development of research consortia – as with the NCCAM funded Consortial Center for Chiropractic Research – may be an important mechanism for stimulating research. In order to ensure high quality research, there is a need for a critical mass of researchers and none of the schools really has that. In addition, linkages with universities should be encouraged.

In addition, conventional researchers need a better appreciation of how CAM is actually practiced, so that they can think creatively and appropriately about designing studies. The development of

researchers who specialize in CAM methodology - people who would be familiar with the unique issues in conducting this research - is also important. I believe it is one area that is neglected in the otherwise superb 5-year plan just issued by the National Center for Complementary and Alternative Medicine. Federally sponsored conferences on CAM methods would also be important.

CAM research should be based on what practitioners actually do. If we do not know, we need to ask practitioners or perform surveys to find out. Most funded CAM grants, with the possible exception of studies of single herbs, have CAM practitioners listed as co-investigators or practitioners. However, very few of the grants truly looks at the interventions as they are practiced in the world. It can take a year or two to do the developmental studies to figure that out. It's important to make sure that there is funding for them. I think that greater emphasis needs to be placed on demonstrating real practitioner input into a project before a grant is funded.

Commissioner Chow asked about the use of CAM therapies for health promotion or optimum health, as opposed to for treatment of disease. The fact that the World Health Organization has embraced a very broad definition of health, as "not merely the absence of disease, but complete physical, psychological, and social well-being" (WHO The first 10 years of the World Health Organization. Geneva: WHO, 1958). Nevertheless, commonly used questionnaires designed to measure general health-related quality of life (HRQL) are designed from questionnaires developed for use with sick persons or the general population and they have substantial ceiling effects once good levels of function are achieved. Therefore, they are not designed to measure "optimal" health. At present, there is no clear way to measure optimal health. Funding priorities at NIH are disease or disease prevention based. Nonetheless, in several NIH funded CAM developmental grants, investigators have proposed to examine how various CAM professions view the success of their therapy, which they may be express more globally in terms of "health promotion" than do most disciplines in conventional medicine. If necessary, new questionnaires will be developed to measure those domains.

To summarize my recommendations:

1. I recommend we place greater emphasis in CAM research toward performing pragmatic clinical trials from the realm of health services research,
2. I think we should perform efficacy studies under carefully selected circumstances,
3. I recommend we ensure that suitable rigor is maintained in researching CAM to ensure that appropriate integration is unimpeded,
4. I recommend greater attention to cross educating CAM providers and conventional researchers about each other's disciplines so that they are capable of collaborating with each other, and in requiring clear evidence of real collaboration in preparation of grant applications