Kingsbury, Doris (NCCAM)

From: jfredin [jfredin@email.msn.com]
Sent: Sunday, October 29, 2000 12:18 AM
To: Whccamp
Subject: Written Testimony for Oct 30

ATTENTION:

Staff Members of The White House Commission on CAM Policy

Attached is written testimony supplementing the oral testimony I will be presenting next Monday, October 30, at your Town Meeting in Seattle.

Sorry I have been late in getting this through to you. I tried unsuccessfully several times yesterday but each time my email was rejected.

I do hope that this reaches you in time.

Respectfully,

Jerri Spalding Fredin
Seattle, WA

WRITTEN TESTIMONY

for the

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

October 30, 2000
Seattle, WA

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

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

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

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

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

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

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

Jerri Spalding Fredin, testifying for Citizens for Alternative Health Care
2328 NE 104th Street
Seattle, WA 98125
206-526-8091
jfredin@msn.com

FINAL DRAFT: HEALTH CARE AMENDMENTS

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

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

RCW 18.71.015 is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

RCW 18.71.010 Definitions (Also for chapter 19.130 RCW)

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

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

(a) "Integrative" or "Complementary" health care, also known as "Complimentary" or "Complementary and Alternative Medicine" (CAM), shall mean those health care methods of diagnosis, treatment, or interventions that may depart from conventional health care and the conventional standard of care.

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

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

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

The disciplining authority has the following authority:

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

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

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

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

(5) To compel attendance of witnesses at hearings;

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

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

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

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

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

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

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

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

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

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

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

RCW 18.130.180 Unprofessional Conduct.

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

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

Whccamp (NCCAM)

From: mrhuson@mindspring.com
Sent: Wednesday, November 01, 2000 3:23 PM
To: Whccamp

BIG SPEECH2.doc

Dear WHCCAMP,
Attached is a copy of the speech I delivered to the Comission yesterday in Seattle. Thank you for allowing me the opportunity to contribute.
Please enter this document into the record.
Respectfully,
Christopher Huson, L.Ac.
President, Acupuncture Association of Washington

For the Consideration by the White House Commission on Complimentary and Alternative Medicine Policy, October 31, 2000

"GUIDANCE FOR APPROPRIATE ACCESS TO AND DELIVERY OF CAM: A FEW NOTES ON INTEGRATION FROM THE PROVIDER PERSPECTIVE."

Christopher Huson, L.Ac., President, Acupuncture Association of Washington

My name is Christopher Huson and I am the President of the Acupuncture Association of Washington. Thank you for letting me contribute my two cents.

Our experience in Washington State in the last four years within the framework of conventional medicine's access and delivery marketplace is that the primary function of the insurance or "payment" industry is making money off the patients, off the employers, and off us, the providers.

Integration is truly the buzzword of the times. Integration. Into what? A health care system that

1) Isn't a system, but a marketplace?
2) Isn't focused on health care but (reductionist) illness-based disease management?

Some health care system!

Our experience of "**integration** " is that it is a euphemism for **obedience training** by an entrenched industry seeking to enforce *our* compliance through competitive exploitation. Are we opposed to integration? Well, not really, no. Are we opposed to our own exploitation? Well, yes. Especially if we can see it coming... Consider this: *CAM* though undefined, has itself become a product to be marketed, as its various practitioners are organized into panels, bundled into contracts and sold as networks to the lowest bidder. Our experience tells us those merchants pass the expense of their savings onto us, the providers, in the form of discounted fee schedules, delay, and obstructionist gatekeeper policies.

How then, are we to puzzle out appropriate avenues of access and delivery for CAM when the models that Conventional medicine's marketplace provide are so clearly inappropriate to the practice of medicine? It is abhorrent to us that our participation or "integration" in CM's "medicine by actuarial decree" serves to perpetuate such a gross imbalance between commerce and spirit in the society we seek to serve.

Make no mistake; we want to get paid for what we do. We want to be respected for the quality of our craft and we want our craft to be valued on the basis of its merit. The days of western medical elitism and ethnocentric bias have got to come to an end. After 90 years it has finally become clear that the recommendations of 1910's Flexnor report were too restrictive and exclusionary and have deeply hurt the development of American medicine by the marginalization and demonization of its truly Traditional medical forms.

What steps do we recommend to address these great wrongs?

1) Get the moneychangers out of the temple: disentangle the insurance industry from its omnipotent role in medical access and delivery;

2) Continue the evolution of community-based CM/CAM collaborative models;

3) Dare to imagine how the work that we do today will affect access and delivery of American medicine 30 years from now.

For the sake of the health of our nation and its medicine, we *must* take the risk of dreaming the impossible.

Thank you.

Whccamp (NCCAM)

From: Sandra O'Neill [soneill@ncnm.edu]
Sent: Wednesday, November 01, 2000 5:20 PM
To: Whccamp
Subject: testimony attached

testimony_10-30-00.do

c Attached is the testimony given by Dr. Catherine Downey at the October 30 Town Hall Meeting which was held in Seattle. Dr. Downey was standing in for Dr. Clyde Jensen who was registered to speak at 11:35am on October 30.

Thank you,
Sandra O'Neill
Assistant to the President

Testimony to the White House Commission
on
Complementary and Alternative Medicine
October 30, 2000

My name is Catherine Downey. I am the Associate Dean for Clinical Affairs at the National College of Naturopathic Medicine in Portland, Oregon where we offer advanced degrees in naturopathic and classical Chinese medicine. I am here to present the testimony of our President, Dr Clyde B. Jensen who is the only person to have ever served as an executive in colleges of allopathic, osteopathic, naturopathic and oriental medicine. A death in his family has prevented Dr Jensen from delivering this testimony in person. The following are his comments.

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

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

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

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

Thank you for hearing my opinions.

Whccamp (NCCAM)

From: Kimber [kimber@olympus.net]
Sent: Saturday, November 04, 2000 5:10 PM
To: Whccamp (NCCAM)


Integration of CAM.doc


ATT80240.txt

Sir,

I was told that I could forward a written documents to you based on my presentation to the commission. I was speaker #107 at the Seattle Town Hall meeting. Will the commissioners be given copies of these documents or do I have to send them copies directly? I am attaching it as WORD document..OK? Also note that in the schedule I wasn't recognized as being a Medical Doctor with a Masters in Public Health. I felt bad that this was overlooked by organizers of the event.

Also some of us had to travel long distances with significant expenses to be there. I think it would have been helpful to have a schedule sent to the speakers at least the week before.

Sincerely,
James K. Rotchford, MD, MPH

James K. Rotchford MD, MPH President of MARF (Medical Acupuncture Research Foundation)

Comments to (WHCCAMP) Seattle Town Meeting: October 31st 2000

Integration Strategies/Issues for acupuncture (pertinent to other CAM modalities?):

1. I believe that all practitioners who are licensed to make a medical diagnosis need to have a common medical educational background and some basic demonstrated level of competency relevant to a capacity to make "appropriate" diagnoses. I'm not saying everyone needs to be competent to make a western medical diagnosis, I'm meaning a selective test.such as a general medical IQ test that assures the public that the person is able to make appropriate diagnoses based on whatever medical model that they eventually espouse. In Europe, this often works by requiring anyone who is licensed to practice medicine to be first an MD. I don't believe the European model would work here. Nonetheless this approach would be adequate to facilitate communication between providers of different medical models and lay the groundwork for future cooperation and less fragmentation in health care.

2. If one doesn't create reimbursement schemes that encourage physicians to familiarize themselves with complementary models and to utilize them when appropriate, I think physician involvement will unfortunately continue to be marginal. In some states non-physician acupuncturists have lobbied legislatures to disallow physicians from practicing acupuncture unless they go through the same training as they did. In other states physicians have kept acupuncturist out saying to practice acupuncture they need to have the same training as a physician. This political/legal posturing has significant roots in economic competition. The arguments about quality of care are genuine but generally unfounded based on current evidence.

3. What training is required to get the best outcomes with practitioners who utilize acupuncture needs to be formally studied? Currently, you have a number of practitioners pounding their breasts and saying my way is the best way. Or another strategy is to say that one's way is the true way based on history. These claims are inherently false given the historical diversity of approaches in traditional oriental medicine. What's more, most old texts are like scripture; they are clearly open to broad interpretation. It is very problematic based on current research to objectively recommend how to train practitioners who use acupuncture. From a practical standpoint if you pay a physician the same as a non-physician acupuncturist for caring for a patient you are going to limit physician involvement.

In allied services such as Physical Therapy, the physician is willing to make referrals because they utilize the same language and physicians generally maintain authority with regard to indications and necessity of care. Allied services that utilize models/beliefs/diagnoses for which the physician has little knowledge and hence little authority would be understandably less referred to by physicians.

I believe that for integration to occur and for there to be less in the way

of turf wars, physicians need to be educated about alternative and complementary modalities. More importantly, I believe the financial incentives for physician involvement need to be there. If we continue to pay practitioners simply based on CPT codes and do not take into account the value of training and experience I'm afraid physician involvement in CAM will continue to be marginal. This is especially true as third party payers start to cover CAM. When it comes to acupuncture I believe that policy should help assure that patients get the best of both worlds.

4. Integration must not require one to buy into the prevailing "belief" system that in order for something to be effective or worthwhile we have to understand why or how it works. We have methodology now that can demonstrate if practioners employing an alternative modality are effective (using reliable and valid outcome measures) from " a population" standpoint. Government, in so far as it takes some responsability to pay for a service, must only be interested if an intervention provides a predictable positive/cost effective outcome in patients with a medical condition/symptom. Goverrnment and science are hard pressed to predict outcomes on an individual basis so it should allow the individual to make choices based on their experiences or belief systems but when it comes to paying for services then I believe the data has to be there to support favorable cost effective outcomes. If the government is to be objective then it needs to provide for studies that as much as possible focus on outcomes rather than processes. Otherwise, it is contributing to belief systems that often come very close to being religious if not outright so. One last point, I think initially most studies federally supported to evaluate CAM should look at CAM techniques as adjunctive therapy. This is consistent with my belief that patients should be encouraged to benefit from the best of both worlds and through the process of clinicians from different backgrounds working together integration would be facilitated. Only if a CAM based on these preliminary studies showed significant potential then studies could be designed to evaluate them head on with conventionally proven/accepted interventions.