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PEER REVIEW MANUAL
for
LICENSED ACUPUNCTURISTS

Developed By

The California State Oriental Medical Association

#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.

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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.

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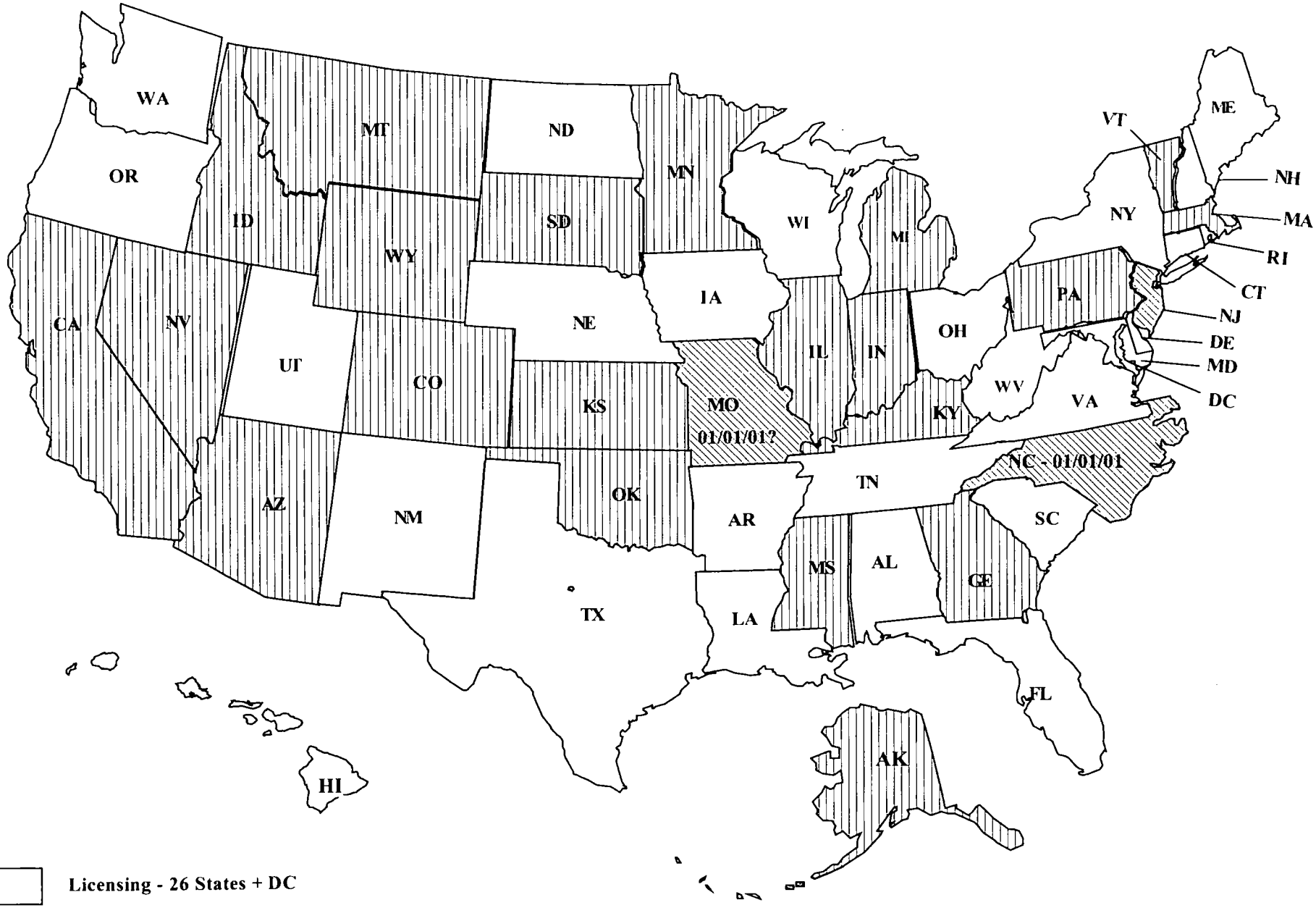
CAM Therapist - Licensing by State

State	Acupuncturist				Chiropractic	Massage Therapist		Naturopath		Osteopath		
	Licensing Law Apply	Other Requirements Prior to Diagnosis/ Evaluation	Supervision Required	Effective Date of Prescriptive Privileges	Licensing Law Apply	Certification Required/ Licensing Law Apply	Effective Date of Licensing Law	Licensing Law Apply	Effective Date of Licensing Law	Licensing Law Apply	Licensing Law Apply	Licensing Law Apply
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

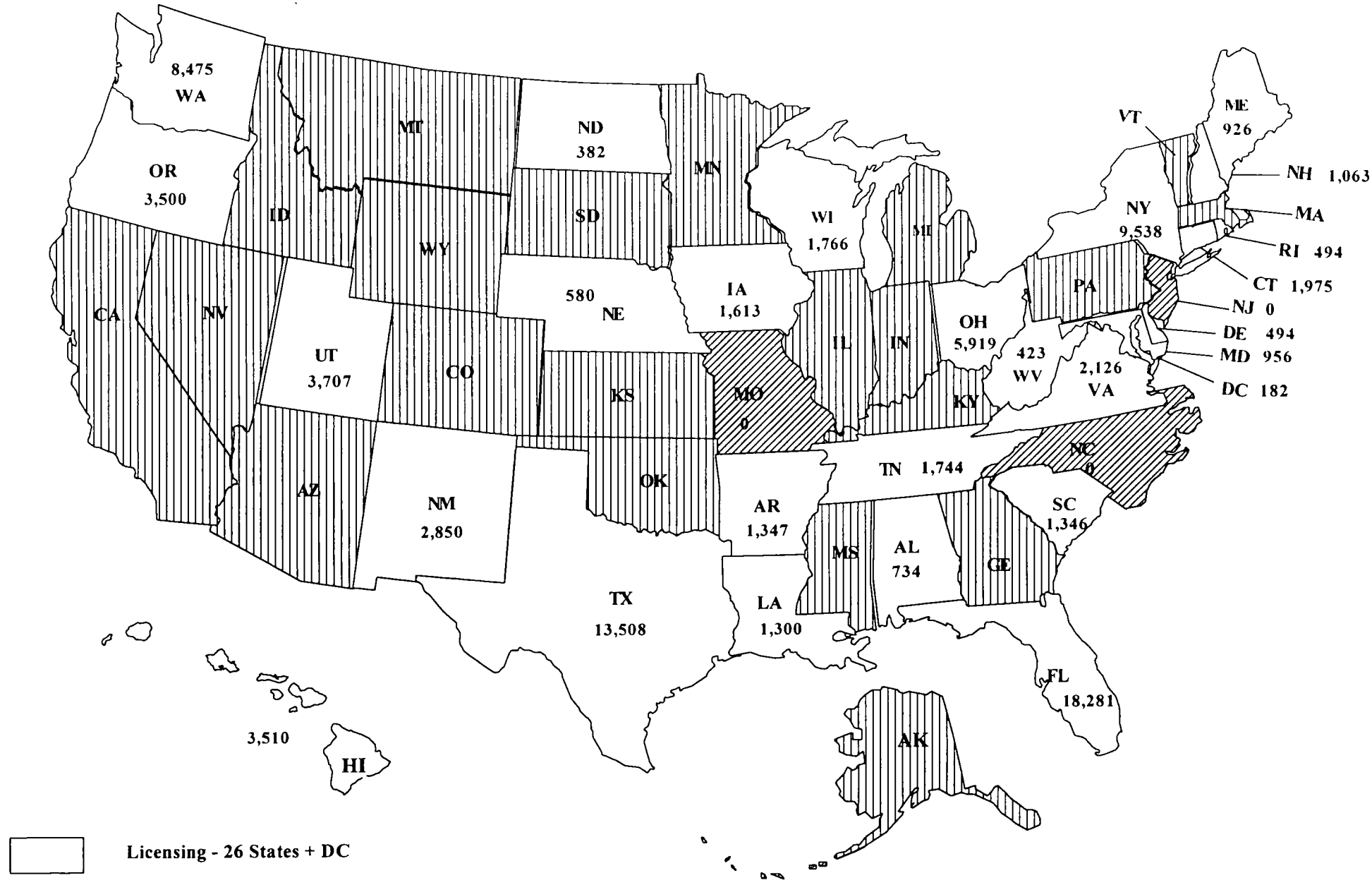
MO - Regulations are being drafted. Expect to issue first licenses in early 2001.
NJ -Regulations are being developed. No estimated date for licenses yet. Mid-2001?
NC - Applications issued. No licenses yet. License required by 01/01/2001.

Massage Therapist Licensing - Status by State

AcuMap revised 08/24/00 by B.Fennen

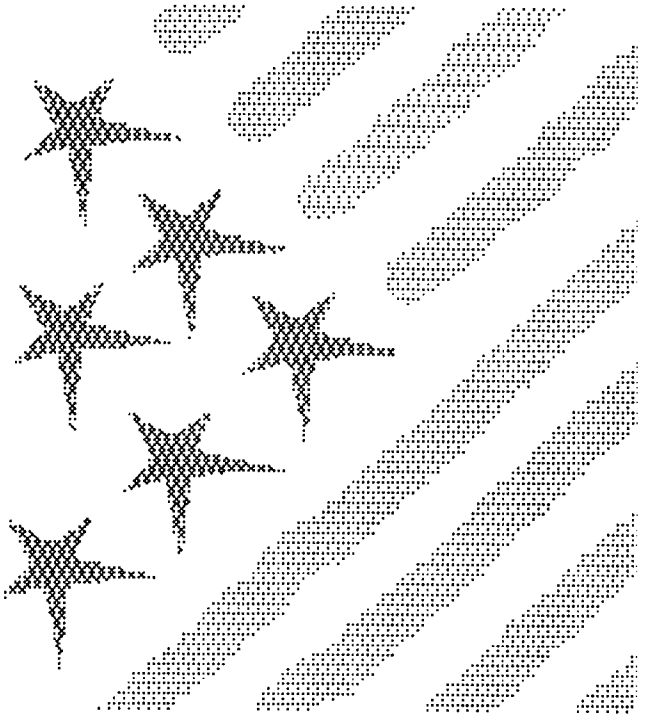
Massage Therapy - Licensing by State

State	Law Passed	Regs on File	Number of Licensees		Title Granted	Licensed / Certified	Facility License	Education (Hours)	Written Exam	Practical Exam	NCETMB Accepted
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 Sweency, 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.

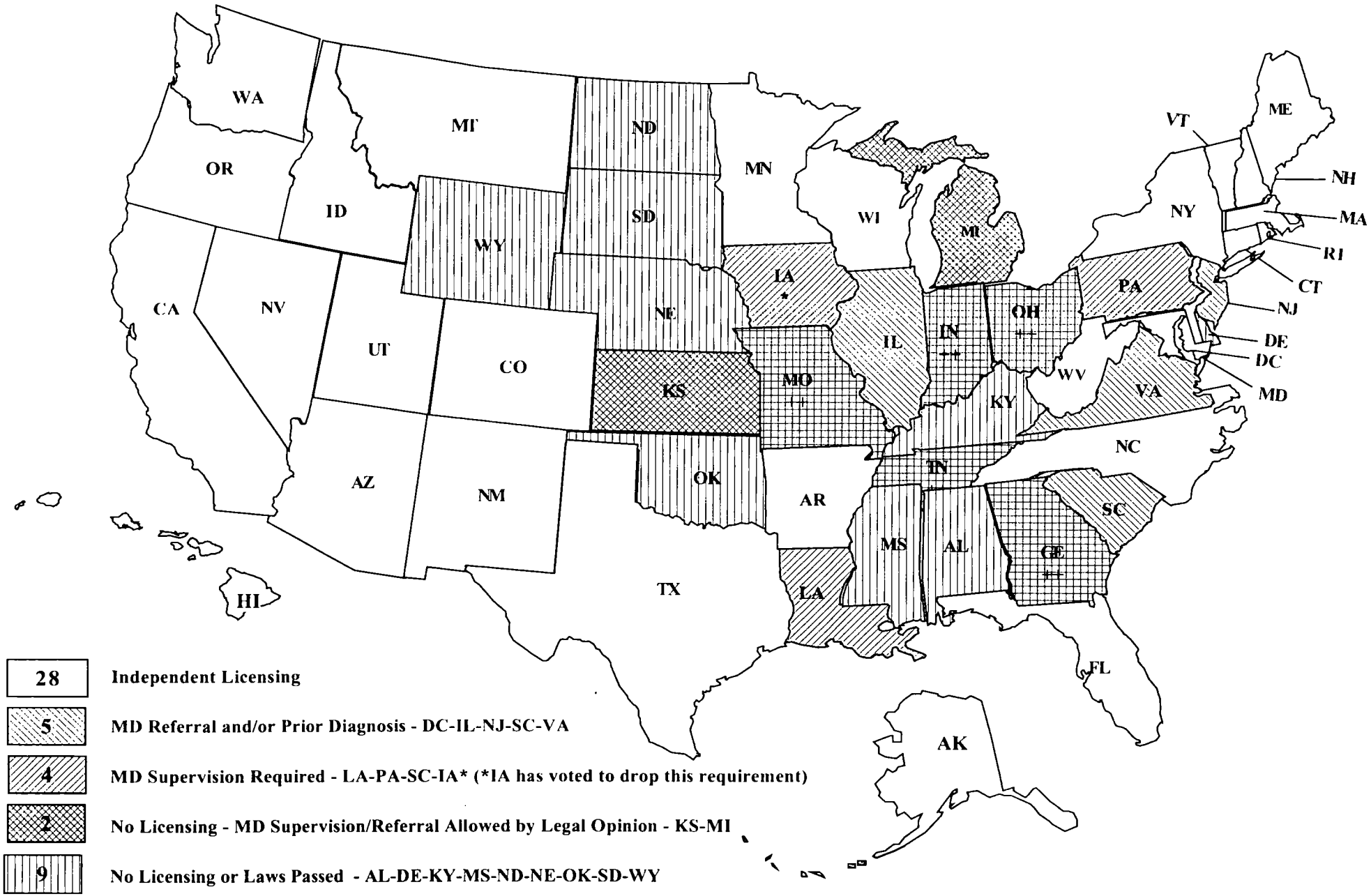
Protects the unlicensed practice of complementary and alternative health care practices from education, examination, and other standard licensing requirements.

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.

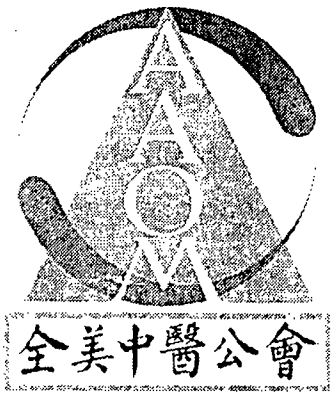


28	Independent Licensing
5	MD Referral and/or Prior Diagnosis - DC-IL-NJ-SC-VA
4	MD Supervision Required - LA-PA-SC-IA* (*IA has voted to drop this requirement)
2	No Licensing - MD Supervision/Referral Allowed by Legal Opinion - KS-MI
9	No Licensing or Laws Passed - AL-DE-KY-MS-ND-NE-OK-SD-WY
5	++Recent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

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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.

AAOM
433 Front Street, Catasauqua, PA. 18032
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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

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.

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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
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Acupuncture Examining Board
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Office of Acupuncture Registration
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Dept. of Public Health
Div. of Medical Quality Assurance
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Division of Acupuncture
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Board of Medical Practice
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Helath Professions Bureau
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State Board of Healing Arts
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Kentucky Board of Med. Licensure
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Louisville, KY 40222
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State Board of Medical Examiners
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New Orleans, LA 70130
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Board of Registration in Medicine
Acupuncture Unit
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Board of Acupuncture
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Div. of Licensing/Enforcement
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Dept. of Health Services
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State Board of Medical Practice
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Minneapolis, MN 55414
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State Board of Regulations
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Public Health & Human Services
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State Capitol-Judicial Wing
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Health and Human Servces System
Regulation and Licensure
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State Medical Board of NY
Professional Licensing (Acup.)
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Albany, NY 12230
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State Medical Board of Ohio
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OK Board of Medical Licensure
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Medical Examiners Board of Oregon
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State Medical Board of WA
Dept. of Medical QAC
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State of Wisconsin Board
Regulation & Licensing Division
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Madison, WI 53708-8935
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Board of Medicine, West Virginia
Licensing Division
Crystal Lowe
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Board of Medicine
Health Department
Don Rolston
117 Hathaway Bldg.
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Cheyenne, WY 82002
307-777-7656

Comprehensive Listing of Schools

American Association of Oriental Medicine
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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 **
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Samra University of Oriental Med. *
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web site: www.emperors.edu

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web-site: www.fivebranches.edu

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(941) 955-4456 / Fax: (941) 330-1951
e-mail: info@acha.net / web-site: www.acha.net

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Fax: (954) 463-3878
e-mail: atom@atom.edu / web: www.atom.edu

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(407) 366-8615 / Fax: (407) 366-8648
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web site: www.holistichealthconcepts.com

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(407) 888-8689 / Fax: (407) 888-8211
e-mail: info@acupunctureschool.com
web-site: www.acupunctureschool.com

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(305) 228-0380 / Fax: (305) 221-7972

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Sarasota, FL 34236
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Fax: (941) 954-8991
e-mail: fcnh@acun.com / web site:
www.fcnh.com

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Merritt Island, FL 32953
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Florida Health Academy - Naples
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Naples, FL 34102
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(808) 536-3611 / Fax: (808) 537-5821

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web site: www.ncnm.edu

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

State Acupuncture Associations (In Order by State)

American Association of Oriental Medicine
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Dan Martin
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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

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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

from the Seattle town hall meeting

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Mary Ann Douglas to Jane Guiltinan (partial) (1 page)	02/09/2001	b(6)

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

OA/Box Number: 43234

FOLDER TITLE:
Seattle Testimony and Talking Points [October 30-31, 2000] [5]

2011-0568-S
kc848

RESTRICTION CODES

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

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b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[007]

Please File: Seattle Meeting

Thanks
Glen

(b)(6)
Shoreline, WA 98133-5639

February 9, 2001

Jane Guiltinan, N. D.
Dean of Clinical Affairs
Bastyr Center for Narural Health
1307 N. 45th Street
Seattle, WA 98103

Dear Dr. Guiltinan:

I am one of the patients who testified before the White House Commission on Complimentary and Alternative Medicine Policy at Bastyr Clinic on October 31, 2000.

Enclosed is a reiteration of my successful experience at the Clinic and some thoughts I have about Complimentary and Alternative Medicine. The memorandum has also been sent to The White House Commission and to Group Health Cooperative, my allopathic health agency.

I hope this will assist the Commission and Bastyr University in their missions. The physician who has followed my progress the longest is Lise Alschuler, N. D. I have had excellent care from the doctors and student clinicians alike.

Sincerely,

Mary Ann Douglas

Mary Ann Douglas
cc: Lise Alschuler, N. D.

To: The White House Commission on Complimentary and Alternative Medicine Policy
From: Mary Ann Douglas Mary Ann Douglas
Subject: My Experiences With and Some Thoughts About Wellness and Improving Health Care

I am an individual who has worked with allopathic and naturopathic physicians to achieve a positive outcome. I believe most individuals could achieve the same. I am a retired registered nurse who has a Master of Nursing Degree and who was a nurse educator for 27 years.

I was diagnosed with hypertension a number of years ago and was treated by allopathic physicians with atenolol 50 mg. twice daily and spironolactone 25 mg twice daily. With this treatment my systolic pressure ranged between 145 and 172 and diastolic pressure stayed within normal limits at 65 to 80. I swam three-fourths of a mile 5 days a week, did Tai Chi, quit smoking and was careful about my diet. My blood pressure worried me so I went to Bastyr Clinic to consult with a naturopathic physician and started treatment there. I told my allopathic physician what I was doing and why, and asked for her cooperation. She agreed and stated that she knew very little about naturopathic medicine. She was certainly cooperative and willing. My N. D. and M. D. communicated with one another about my progress by mail. I stayed on the treatment plan from my M. D. and started taking the herbs that the N. D. at Bastyr Clinic ordered. I took my blood pressure at home twice daily and had regular visits to the physicians. My blood pressure stayed the same for a couple of months and then slowly started to return to normal. Once my systolic pressure was within normal limits I started decreasing the atenolol by small amounts every month or so with the knowledge and guidance of my M. D. In 6 months my blood pressure was 110/65 to 128/78. After the six months of slowly decreasing the atenolol I was able to discontinue it completely. It is now 3 months later and my pressure is still within normal limits. I'm delighted. Soon I will start the process of decreasing the spironolactone. We'll see what happens. I will be happy to supply you with the specifics if you wish.

Bastyr Clinic used some methods which were different than I was used to. A few are as follows:

1. Each visit was started by shaking hands and welcoming me. Shaking ones hand can give a health care person a good deal of information. I also felt like they were pleased to see me.

2. I was always asked what I had eaten and drank in the previous 24 hours. Based on what I told them I was given information as to what else I could do. It was given in such a way that I knew it was up to me to do. There was no pressure, but the rational/s for the change/s were explained in plain language so that I understood why I was being asked to do them. I always went away with a treatment plan in writing. At the next visit if I had made some changes and not others, I was given positive reinforcement for the changes I made. I was not made to feel like a failure if I hadn't achieved everything which was recommended. It was explained to me in a different way so that it was up to me to do what I thought best. I believe that change is difficult for most people, and life style changes are usually very difficult. I believe the continuity and steadfastness of the follow-up process helped me make the decisions which were necessary. The successes I have had have all came about gradually. I feel better. I look better. My friends and family say I behave as though I am enjoying life much more. I am. I think the people at Bastyr had a great deal to do with it too.

3. **The history, physical and progress were done in a different way than I was used to. How I felt was given a good deal of attention. The history was exceptionally thorough. It seemed that nothing was taken for granted. When I arrived, my chart had already been reviewed and relevant questions were asked.**

The following are some changes I would like to see in the health care system:

1. Naturopathic Physicians, N. D., be employed in all health care facilities.

a. Prior to cataract surgery I was interviewed by the anesthesiologist. I gave her the list of medications and herbs I was taking. She said that since she didn't know what the herbs were, or how they would react with the anesthesia, I should stop taking them for a week before surgery. They were specific for hypertension and I was in the middle of decreasing the atenolol I was taking. I explained that to the anesthesiologist that and she again said not to take them. If an N. D. had been employed at that facility perhaps he/she could have clarified the matter to the anesthesiologists satisfaction and I could have continued on the herbs. As it was, I did continue the herbs, and everything was fine. I never told the anesthesiologist what I had done and I didn't feel good about it. It could have been dangerous.

b. I have heard physicians and other personnel in emergency rooms talking about people coming in who are taking herbs and such and they don't know anything about the herbs or how they effect the person. If an N. D. was there, it would very likely be easier to triage, diagnose and treat the patient. At the very least, the health care team would have an instant resource to more information not to mention more treatment options.

c. I believe naturopathic physicians should have the same admitting privileges in all medical facilities as medical doctors do and should be an active member of the health care team for all patients. I believe that when the M. D. and N. D. get to know what one another really does and how they think, the patient and family will have significantly improved care. They both have the health of the public as their goal, but go about their missions differently. Different is not better or worse, just different. I believe that they each have strengths and many similarities. By collaborating, the health of the community would be significantly improved.

Good morning. My name is Dr. Lise Alschuler. I am a naturopathic physician and the clinic medical director of the Bastyr Center for Natural Health. I would like to discuss what type of training and training resources are needed to facilitate appropriate referral and co-management techniques among conventional and CAM providers.

The basis for building successful relationships is the establishment of mutual respect and openness to new ideas.

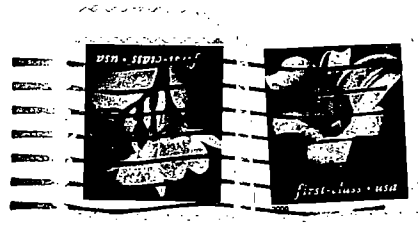
The foundation of a functioning referral network between CAM and conventional medicine providers is a better understanding of each other's language and philosophies. These values and concepts must be integrated into the educational training models of all providers.
Recognition of areas of mutual interest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

Research is a top priority.
Research is needed to develop clinical guidelines and condition-specific care pathways that will assist CAM providers in conveying clinical rationale to conventional providers.
We need to initiate pilot projects to study the role of practice guidelines in determining entry points for referral.
We need to gather outcome data on "best practices," based on tracking patients who have received specific treatments for specific conditions. We need to conduct comparative outcomes studies for different CAM approaches, conventional approaches and multidisciplinary care.
We need to enhance funding (national, state, local, and private sector) for research on CAM clinical efficacy and cost effectiveness.
Training of providers must emphasize several areas.
CAM and conventional medical training must stress the development of multidisciplinary integration in the management of specific conditions. CAM and conventional medical training must delineate appropriate redundancy of interventions.
Conventional medical training must include discussion of the credentialing and care standards for licensed Cam providers, particularly related to scope of practice.

In sum, a foundation of trust ad openness will form a collaborative relationship between Cam and conventional providers.
This relationship will utilize national and local funding to research CAM clinical efficacy, cost-effectiveness, and referral criteria in order to promote coordination of care.
The training of CAM and conventional providers will promote cross-fertilization and understanding of multi-disiplinary care.
Promotion of the health and well-being of the patient remains as the basis of all forms of healthcare. Thank you.

4708 Linden Ave N
Seattle WA 98103

SEATTLE WA 981
PM
21 MAR
2001



WHCCAM
6701 Rockledge Dr
Ste 1010, MS 7707
Bethesda, MD 20817-7707

20817/1813


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
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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:

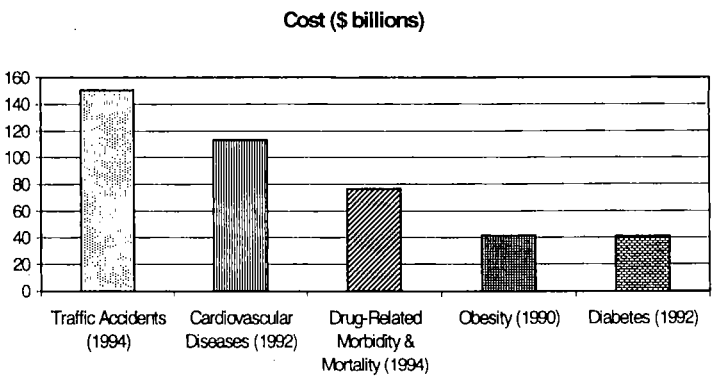
As health care costs spiral out of control and public tolerance dwindles, policy makers must make tough decisions about how to manage health care costs. Many of these decisions, however, are hugely unpopular with the American public when they perceive that their quality of care is being compromised.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

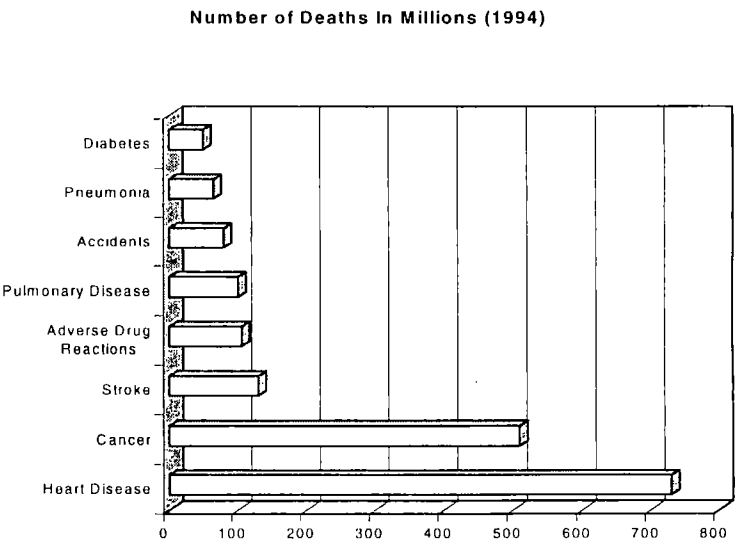
However, it is a little-known fact that drug-related problems frequently occur, often with costly or devastating effects. Drug-related problems include:

- 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.



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.

#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.

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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