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III

Divider Title: _____

SESSION III:

Use of CAM for Selected Health Conditions

Speakers' Questions for Session III:
Use of CAM Services for Selected Health Conditions
3:00 p.m. – 4:30 p.m. on Monday, December 4.

1. Provide a brief, one page summary of your treatment program.

2. Describe how your program compares with conventional treatment of the same or similar health condition. Specifically, is your approach better than conventional care? If so, how and why? Please include outcomes, cost-effectiveness, and patient satisfaction data (if available). Please submit any other relevant program descriptions, documentation, or other materials to the Commission.

3. What are the barriers to access to and delivery of your program and what policy recommendations can you suggest to eliminate those barriers?

4. To whom should your type of program be accessible and where, how, and by whom should it be delivered? Should your type of program be a stand-alone program or should it be integrated with conventional care and why?

5. What other policy recommendations would you like to make to translate your lessons learned into policy?

Questions for patient panelist*

1. Briefly describe why you choose to use unconventional approaches to treat your health condition and what health results you have experienced.

2. What were the barriers and obstacles you faced or still face in trying to obtain this care?

3. What recommendations would you make to make it easier for you to receive this care?

*These questions apply only to those practitioners who have been requested to bring patient to testify.

Speakers' Questions for Session III:
Use of CAM Services for Selected Health Conditions (Hospice Care)
3:00 - 4:30 p.m. on Monday, December 4.

1. Briefly (no more than one page) describe your program and how it differs from conventional hospice care. Include some description of the health conditions most usually presented by your patient population.

2. Briefly describe the operational process involved in delivering CAM approaches in a hospice setting. Specifically, which CAM products and practices should be available, how should they be selected, and who should deliver them?

3. What is the rationale for using such approaches rather than more conventional approaches?

4. Describe any data, even anecdotal, to illustrate the clinical or cost-effectiveness of such approaches in a hospice setting, especially as compared with more conventional approaches. Provide patient satisfaction data if available.

5. What barriers have you encountered and how have you overcome them?

6. What policy recommendations do you have for the Commission?

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Divider Title: Wexler

PROJECT ARRIVE

AIDS RISK REDUCTION AMONG IV DRUG USERS ON PAROLE

FINAL EVALUATION REPORT

EXECUTIVE SUMMARY

July 1991

prepared by:

Harry K. Wexler, Ph.D. - Principal Investigator
Stephen Magura, Ph.D. - Co Principal Investigator
Mark M. Beardsley, Rh.D. - Project Director

and

Howard Josepher, CSW - Program Director

This Report was supported by a research grant (R01 DA04833) to Narcotic and Drug Research, Inc. by the National Institute on Drug Abuse. Points of view or opinions in this document do not necessarily represent the official position of the U.S. Government or of Narcotic and Drug Research, Inc.

- 1/7 Addicts in USA get treated
- Coercion mandates are used to get addicts into treatment programs

EXECUTIVE SUMMARY

Project ARRIVE (AIDS Risk Reduction for IV Drug Users on Parole) was funded by the National Institute on Drug Abuse from September 1, 1987 through August 31, 1990. The primary objectives of the project were to design, implement, and evaluate an innovative AIDS prevention model appropriate for parolees with histories of intravenous (IV) drug use who were recently released from prison. Parolees who completed the ARRIVE Training Program were compared with a control group consisting of persons who never attended on a range of risk reduction outcome measures (knowledge, attitudinal, and behavioral). Since treatment (ARRIVE training) and no-treatment (no ARRIVE training) groups were formed by voluntary self-selection, the two groups were equated by controlling statistically for background differences. The research design also permitted an assessment of the extent to which prior, prison-based residential drug treatment contributed to more positive risk reduction outcomes.

The ARRIVE Training Program was designed in response to the critical need for effective AIDS risk reduction approaches relevant to the target population. Thus, the Training Program utilized a social learning approach to prevention (emphasizing behavioral skill training and learned resistance techniques); a self-help orientation (which placed responsibility for problem-solving with the individual); and therapeutic community principles (such as credible role models, clear behavioral consequences and a strong sense of community). These elements were combined into a structured 8-week, 24-session program that included didactic information on: AIDS transmission, prevention, and risk reduction; AIDS, condom use, and drug-related paraphernalia; clinical symptoms of AIDS; pharmacological treatment of AIDS; and HIV testing. The ARRIVE Training Program also offered participants job readiness preparation for entry-level employment in the AIDS prevention/outreach field.

MHRA

Medical and Health Research Association of New York City, Inc.

Promoting the Health of the New York Community for 40 Years

Medical and Health Research Association of New York City, Inc.
[illegible] Street, Suite 720
[illegible] NY 10013-2988
[illegible]-0220

Creating Networks of Care with Rigorous Program Management

In 1988, Howard Josepher launched one of the first programs in the nation to provide HIV education and prevention services to drug users and their families. At that time, the prevailing wisdom was that substance users must first get sober to benefit from rehabilitation services. Josepher proved otherwise. Teaching recovery readiness through skills building and stress management, his program helped participants reduce risky behaviors and make the transition to healthier living.

In the decade since then, Exponents, Inc., the community-based organization founded by Josepher and his wife, Marie, has expanded to include 31 full-time staff members and hundreds of volunteers providing substance users and ex-offenders with AIDS services from job-readiness to leadership training. A former heroin addict, Howard Josepher stresses peer participation and individual responsibility in all Exponents programs and fosters a powerful sense of community among participants and staff. The agency's citywide programs have been acclaimed by everyone from participants to policy makers, and are used as models by AIDS service providers across the country.

The story of the Josephers' work is remarkable, but no longer unusual in the city. AIDS has done its worst in New York—nearly one out of every six Americans infected with HIV lives in New York City. But New Yorkers have responded with some of the nation's best, most creative and effective initiatives to help cope with the consequences of the illness. Many of these programs are operated by small,

Patient's Testimony
Presidents Committee on Alternative Medicine

Denise Drayton,
Exponents Inc.

1. Briefly describe why you choose to use unconventional approaches to treat your health condition and what health results you have experienced.

Alternative therapy has been especially beneficial to me in dealing with dual disease

I was first introduced to holistic medicine when I was admitted into a detoxification center for heroin addiction. The method that was used for inpatient treatment was conventional but included acupuncture for stress and pain. I continued with my acupuncture treatment in an outpatient program. My next encounter with alternative therapy was as a student in the ARRIVE program. We were taught visualization and deep breathing meditation. I incorporate several methods in maintaining my sobriety. I have been clean for 10 years as a result of holistic treatment and self help programs.

I choose to use a holistic approach to dealing with HIV in the form of massage, meditation, visualization, acupuncture and deep breathing. I surround at myself at work and home with a stress less environment. I have a crystal fountain at work, a stone fountain at home and a sound/aroma therapy diffuser. I also attend meditation workshops that help me deal with the stress and burnout pertaining to being positive and in the workforce.

I believe this has had a positive effect on my health. HIV sometimes affects my memory I feel by playing meditative music in combination with aromatherapy I have experienced being more centered and focused on the job.

After testing positive, I wanted to quit smoking to try to clear up my lungs. I knew that pneumonia was a possible opportunistic infection that is a reality for HIV+ people. I quit smoking with acupuncture. I had sessions over the course of approximate 3 weeks and wore press beads on weekends. I have been smoke free for 8 years now.

Although I take western medicine, I feel that the therapies are complimentary. Sometimes the side effects of the HIV medications cause body aches, massage is essential in relaxing the body and meditation helps me focus on something else other than the pain.

2. What were the barriers and obstacles you faced or still face in trying to obtain this care?

I am fortunate to have a work place that incorporates and promotes healing through alternative methods employee activities, stress reducing devices, conducting free alternative medicine workshops and encouraging wellness care. However in my community this type of therapy is not readily available. The clinics don't offer other methods and if they do it is not well promoted. There is a natural distrust of anything that is not traditional. Spiritual healing means different things to different people in my community. If it is perceived as not in accord with religion it is not well accepted. Many people have never experienced some of the alternative treatments available.

3. What recommendations would you make to make it easier for you to receive this care?

I would like to see expanded health care insurance to provide for alternative therapies. I would recommend outreach to communities of color that provide information and education on alternative therapies and how they can work with your HIV medications. Doctors should introduce and integrate these methods into the continuum of care for positive patients.

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Divider Title: Cassileth

Barrie R. Cassileth, PhD
Chief, Integrative Medicine Service

Responses to Questions from the White House Commission on Complementary and Alternative Medicine Policy

Summary of Treatment Program

We provide a broad range of complementary therapies to both inpatients and outpatients at MSKCC. All therapies used are rational and backed by data indicating their value and utility.

Therapies include many mind-body interventions such as relaxation therapies, hypnosis and self hypnosis, meditation, and so on. Several different kinds of massage therapies are available, including foot massage or very light touch massage for patients who are frail or who recently completed surgery. The most commonly requested therapies by inpatients are massage and music therapy.

Our outpatient facility is located approximately two city blocks from the main MSKCC campus. In this spa-like environment, free of all biomedical paraphernalia, we provide a full array of services such as various types of massage, mind-body interventions, acupuncture, and several classes. Classes include t'ai chi, yoga, special exercise regimens such as chair aerobics and pilates, and other programs developed specifically for patients with cancer and their families. Nutritional and herbal counseling is also available to both inpatients and outpatients.

Our interventions are geared to enhance body, mind and spirit, and we remain open to developing new programs and to providing additional therapies on the basis of patients' and family members' suggestions. Patients and others may self-refer, or they may be referred by their oncologists or other health professionals. Outpatient services are available to any cancer patient and family member, regardless of hospital affiliation.

Each intervention is evaluated pre and post by the client using a 0-10 point linear analog scale. Services to inpatients are delivered at no fee; outpatient therapies are appointment- and fee-schedule based. Our service program exists in the context of major research and educational activities, consistent with other MSKCC Services.

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How program compares with conventional treatment of same or similar health conditions

Our complementary therapies do not compare with conventional treatment, because they are given as adjuncts or additions to conventional treatment for cancer. There are no viable "alternatives" to mainstream cancer care. Consequently, we are speaking of augmenting rather than replacing mainstream cancer care; we represent the quality of life arm of mainstream cancer treatment.

We have little doubt that our approach (combining mainstream and complementary therapies) is substantively superior to conventional care alone. Of course the most urgent and important aspect of cancer medicine is to destroy the tumor and bring about cure or prolong remission. At the same time, patients experience distressful symptoms that require intervention. Our emphasis is on managing pain, nausea and other symptoms during and after cancer treatment.

We are a new program; our clinical services have been available for almost one year. During that time, we have provided over 6,000 client visits. We routinely collect data before and after each intervention to determine the extent to which the complementary services ameliorated the patient's problem.

Summary Data for 11 Months
Total number of outpatient visits = 3,439; Total number of inpatient visits = 3,049

Client Evaluation of Therapies on a 0-10 Linear Analog Scale
Reduction in Symptoms Immediately After Therapy for 1,412 MSK inpatients and outpatients*: (includes regular and light-touch massage, foot massage, music therapy, and meditation/relaxation therapies). 0= no problem; 10=most severe problem.

Symptom	Average scores for patients with pre-treatment scores ≥5		
	Before treatment	After treatment	Percent Decrease
Pain (n=368)	6.9	3.4	51%
Fatigue (n=577)	7.0	3.9	44%
Anxiety (n=577)	7.2	2.9	59%
Nausea (n=148)	6.8	3.8	52%
Depression (n=282)	7.0	3.7	47%

* Approximately the same number of inpatients and outpatients reported high pretreatment scores for pain and depression. For anxiety, nausea and fatigue, however, twice as many inpatients as outpatients reported high pretreatment scores.

Acupuncture: Reduction in Symptoms Immediately After Therapy

Symptom	Average scores for patients with pre-treatment scores ≥5		
	Before treatment	After treatment	Percent Decrease
Pain (n=28)	7.4	5.5	26%
Fatigue (n=22)	7.5	6.5	14%
Anxiety (n=23)	6.9	4.5	35%
Nausea (n=12)	6.8	6.7	1%
Depression (n=11)	6.7	6.6	1%

The numbers for acupuncture reflect the view of many acupuncturists that a decrease in symptoms is rarely seen immediately following treatment. We are encouraged by the agreement of our numbers with this idea because these data demonstrate accurate symptom reporting by our patients.

Barriers to access and delivery of complementary therapies and policy recommendations to eliminate them

Several major barriers limit patient access to complementary therapies. A central issue concerns the need for additional data that fully document the efficacy of complementary modalities, including the clinical circumstances under which particular modalities are most effectively applied. Another problem arises from the conduct of poor quality research and the promotion of therapies that lack substantive information that they work. This generates skepticism among healthcare professionals, institutions, potential insurers and potential donors.

To eliminate at least some of the existing barriers, it is essential for government policy to support, guide, and encourage high quality CAM research. It is also essential for government policy to require rational supportive evidence prior to promoting particular CAM therapies.

Further, CAM should not be viewed as competition to mainstream medicine. Rather, complementary therapies should be an integral aspect of mainstream care, especially for seriously ill patients. Healthcare policy should strive to validate the importance of complementary therapies before promoting their use.

To whom should program be accessible? Stand alone or integrated with conventional care?

Complementary therapies in the cancer treatment setting represent an extension of supportive care, which has been a long tradition in cancer medicine. In my view, all cancer patients and family members should have access to complementary therapies that address their quality of life needs while they are going through treatments and thereafter. Cancer medicine represents a unique component of health care in that we are not facing a decision of whether to use mainstream treatments or to use some unproven alternative. Rather, we strive to ensure patients' comfort, to relieve stress, and to decrease or eliminate symptoms.

There is a second reason for the importance of integrating complementary and mainstream cancer care: Cancer represents a massive biological event, and its treatments are often extremely difficult. Approximately 55% of cancer patients in the United States are cured today. This means, however, that many patients will experience progressive disease and require special assistance as terminal stages of illness approach. This also means that numerous patients will face difficult symptoms.

In all stages of treatment and rehabilitation, it is absolutely essential that complementary therapists work along with oncologists to ensure that the particular therapies as well as their administration are consistent with patients' physiologic status. Cancer care requires not only the emphasis on decreased symptoms and enhanced quality of life enabled by complementary therapies, but also ensuring that these often fragile patients receive only care that will benefit them. In complementary as well as mainstream medicine, the guided principle is always " first do no harm." The treating oncologist must be involved to provide essential guidance.

Barrie R. Cassileth, Ph.D.
Chief, Integrative Medicine Service
Memorial Sloan-Kettering Cancer Center
November 29, 2000

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Divider Title: Collins

Alegent Health

Alegent Health
Immanuel Medical Center
6901 North 72nd Street
Omaha, Nebraska 68122-1799
Phone (402) 572-2121

DATE: November 30, 2000

TO: The White Commission on Complementary and Alternative Medicine Policy
Washington, DC

FROM: Richard E. Collins, MD, FACC, FACCP

RE: CAM Services for Specific Conditions – Reply to Questions

1 in Coaching Cardiologist
Firefighter
in
Forest
Ranger

1. Provide a brief, one page summary of your treatment program.

Heart Disease remains the number one killer in America. While the death rate from cardiovascular disease has dropped due to technology, the absolute number continues to increase partly due to new onset of disease, heart attacks, high blood pressure, etc. It is America's most costly illness.

The Dr. Dean Ornish Program for Heart Disease Reversal and Prevention strikes at the very root cause of the disease process, stabilizing plaques, reducing angina by greater than 60%, reducing costly readmssions to the hospital, improving quality of life and well being. The Reversal Program is a lifetime commitment, the program is a one-year investment in time for the participant. The Ornish program is a four-component lifestyle approach of diet, exercise, stress management, and group support. The diet is a vegetarian diet with fat restriction to no more than 10% of calories coming from fat. It is a whole foods diet rich in plant proteins (15%), anti-oxidants, fiber, and controlled simple carbohydrates. Exercise is moderate to 30 minutes of cardiovascular conditioning per day. Stress management is practiced to one hour each day with stretching poses and meditation. Group support is weekly.

Refer to attached supporting documents, Exhibits A and B.

2. Describe how your program compares with conventional treatment.

The Lifestyle Residential Study, published in 1983, documented that heart disease can be managed by intense lifestyle control. It was again confirmed with The Lifestyle Heart Trial in 1990 with a five-year follow up reported in 1995. The Demonstration Project with Mutual of Omaha on matched controls in comparsion to Ornish participants was completed in 1998. All studies confirmed that alternative care was as effective as current technology in outcomes data regarding mortality and complications. In all cases, a greater reduction in angina was observed, the need for surgical intervention was reduced and a cost savings exceeding $29,000 was apparent. (See Exhibit C) These findings have recently been noted in High Mark Blue Cross/Blue Shield of Pennsylvania with their

embracement of The Ornish Program for their insurees in Pittsburgh, a cost savings of more than $17,000 per person.

Improvement in SF-36 well-being scores, cost savings, outcomes, and reduction of angina by traditional and conventional measures can not come close to lifestyle control and chronic disease management of this magnitude. (See Exhibit D)

The future approach to heart disease should focus on lifestyle and behavior control. Conventional therapy should be reserved for those who can not or are unwilling to take this choice, or when the anatomy of the disease dictates traditional medicine. Rather than an alternative, heart disease stabilization and reversal through lifestyle behavior should be listed as prudent, first choice medicine.

3. *What are the barriers to access to and delivery of your program and what policy recommendations can you suggest to eliminate those barriers?*

The barriers to establish Heart Disease Prevention and Reversal programs are the same barriers that continue to perpetuate coronary heart disease in America; denial, time constraints, diet controversies, risky lifestyle behavior, unwillingness to change, and financial concerns. The Behavior and Lifestyle Program of Dr. Dean Ornish needs to become more accessible to all ages and diversity regardless of HMOs and insurance providers.

Those that could benefit from the program are those who resist it the most. Education and medical community support will be required.

4. *To whom should your type of program be accessible and where, how, and by whom should it be delivered? Should your type of program be a stand-alone program or should it be integrated with conventional care and why?*

It will not be the hospital systems where prevention and heart disease reversal begins. Our health care system in America is crisis control and fix-up medicine. In fact, most preventative and wellness programs have been cut due to cost constraints. We are shooting are own feet. We can't afford to treat disease on a crisis basis, yet alone afford to consider managing it on a chronic basis. A new model of wellness needs to be created. I believe we are on the edge of seeing that model with Highmark, the first insurance company to totally embrace heart disease management through lifestyle intervention.

5. *What other policy recommendatons would you like to make to translate your lessons learned into policy?*

Currently, HCFA has started a Demonstration Project with The Ornish Program. When completed, it will hopefully answer the question of whether the federal government should enter into behavior control and lifestyle management to treat heart disease. Future programs will need careful outcome measurement just as if this were a new widget applied to the human body. Policies will need to be established to insure creation of carefully structured programs. The Ornish program has already met those requirements with over twenty-plus years of experience and outcome research data.

Exhibit A

DR. DEAN ORNISH'S PROGRAM FOR REVERSING HEART DISEASE

Published research by Dean Ornish, MD and collaborators have shown that intensive lifestyle modification can dramatically improve the clinical status of patients with moderate to severe coronary heart disease. Dr. Ornish's lifestyle modification program includes following a low-fat vegetarian diet; regular practice of stress management techniques (including stretching, progressive relaxation, imagery, breathing techniques and meditation); moderate aerobic exercise; smoking cessation; and participating in-group support sessions.

Patients following the Program were found to have lower serum cholesterol, reduced chest pain, increased functional capacity, improved blood flow to the heart and elevated psychosocial status. In addition, The Lifestyle Heart Trial provided evidence that comprehensive lifestyle changes can significantly retard or reverse the progression of coronary atherosclerotic lesions in selected heart patients when measured by computer-assisted quantitative angiography.

The Program delivered at the network sites is targeted primarily at three groups of heart patients:

- Individuals eligible for bypass surgery or angioplasty who are seeking a clinical alternative to these procedures
- Individuals who have previously been through one or more revascularization procedures and are looking to minimize the chances of repeating the process
- People who have significant risk factors for coronary artery disease (CAD)

Recognizing that most people cannot make substantial lifestyle changes on their own, the Program sites provide a comprehensive team of health care professionals to help Program participants adopt these positive lifestyle changes into their lives. The teams consist of an exercise physiologist, registered dietician, stress management teacher, group support leader, medical director, case manager and program director.

Periodic testing is used to chart patients' progress and to aid in the risk stratification process. While testing procedures vary according to a patient's clinical status, they are generally designed to track interval changes in functional status, blood lipids, and selected pyschosocial measures.

A growing number of health insurance and managed care organizations are now taking an active interest in supporting the Program as a cost effective treatment alternative for heart disease. As of January 2000, more than forty regional payors were underwriting all or a portion of the cost of Program participation for qualified heart patients both on a contractual and a case-by-case approval basis.

Two health plans have been instrumental in leading the way towards full coverage of the Ornish Program. In 1993, Mutual of Omaha, a national health plan, agreed to underwrite the cost of the Program for their subscribers who resided in areas near regional Program sites. In 1997, Highmark Blue Cross Blue Shield, PA. one of the nation's largest regional health plans, became the first health plan to offer the Program directly to their subscribers at an on-site facility.

While in the Program, patients remain under the care of their own physicians. Physicians receive ongoing progress reports. No changes are made in a participant's medication or other treatments without their referring physician's approval.

Exhibit B

ALEGENT HEALTH
MEDICARE ORNISH PROGRAM MODEL

Stage I: 3 months

Exercise **Stress Management**
Group **Dinner**
1st &12th Week - 3 nights/week
2nd thru 11th Week - 2 nights/week

Stage II: 9 months

Exercise
Stress Management
Group
Dinner

One-year participation followed by Alumni for unspecified period.

ALEGENT HEALTH
ORNISH PROGRAM MODEL

Stage I: 3 months

Exercise **Stress Management**
Group **Dinner**
1st &12th Week - 3 nights/week
2nd thru 11th Week - 2 nights/week

Stage II: 3 months**
(1 night/week)
Exercise
Stress Management
Group

Stage II: 6 months**
(1 night /week)
Stress Management
Group

****Option to pay for dinner**

One-year participation followed by Alumni for unspecified period.

Exhibit C

SCREENING CRITERIA

- Participants are asked to adopt a low-fat vegetarian diet, exercise on a daily basis, incorporate a series of stress management techniques into their daily routine, and be willing to explore their feelings and emotions. The key to adherence is a strong self-belief system.

MULTICENTER LIFESTYLE DEMONSTRATION PROJECT*

- Study Goal: To determine if comprehensive lifestyle changes can be a direct alternative to revascularization for selected patients without increasing cardiac events.
  - Total number of patients: 333 (194 research participants, 139 matched controls provided by Mutual of Omaha).
  - Number of Sites Participating: 8
  - Follow-up Period: Three years

*Am. J Cardiol 1998;82:72T-76T

INCLUSION CRITERIA

- Coronary artery disease, being considered for revascularization OR, previous revascularization
- Strong desire to make lifestyle changes
- Initial time commitment of 15 hours/week (8 on site)
- Supportive spouse (if married)

EXCLUSION CRITERIA

- Bypass in last six weeks
- Cigarette smoker in last 3 months
- Left main disease > 50%
- Unstable angina or cardiomyopathy
- Alcohol/narcotic abuse
- Chronic CHF that is unresponsive to medications
- Non-ambulatory or with life-threatening co-morbidity
- Transmural MI less than one month prior
- Psychiatric disturbances

EXHIBIT C

MULTICENTER LIFESTYLE PROJECT: GROUP DEMOGRAPHICS*

- At baseline, there were no significant differences between experimental group and controls in regard to gender, marital status, employment, HTN, elevated cholesterol, diabetes, smoking, family history, or severity of CAD. Experimental group (Ornish) had a 55% history of prior MI vs. 28% in controls. The experimental group (Ornish) had a longer history of CAD. These figures should bias towards higher mortality in the experimental group.

*Am. J Cardiol 1998;82;72T-76T

OUTCOMES: RELIEF FROM ANGINA*

Percentage of patients with relief of angina:

3 MONTHS	1 YEAR	2 YEARS	3 YEARS
49%	65%	61%	61%

*Am. J Cardiol 1998;72T-76T

EXHIBIT C

OUTCOMES/ADHERENCE - EXPERIMENTAL GROUP*

	Baseline	3 months	1 year	2 years	3 years
Ex. Duration	1.6 hrs.	3.9 hrs	3.5 hrs	2.9 hrs	2.7 hrs
% Dietary Fat	---	6.5%	6.8%	7.4%	8.3%
Exercise (Mets)	9.5	11.1	11.7	10.9	11.0
Stress RX/Week	0.19 hrs	NA	4.5 hrs	2.6 hrs	2.0 hrs
Dietary fat intake	---	6.5%	6.8%	7.4%	8.3%
Weight	187.3	178	177	176.6	179.9
% Body Fat	25.7	22.9	21.3	22.4	23.4

*Am. J Cardiol 1998;82:72T-76T

LIPID RESULTS - EXPERIMENTAL GROUP*

	Baseline	3 months	1 year	2 years	3 years
Cholesterol	202	184	183	187	183
LDL	123	106	104	107	102
HDL	36.7	32.8	36.1	40.1	42.2
Triglycerides	229.8	235.7	228.8	213.0	200.8

*Am. J Cardiol 1998;82:72T-76T

EXHIBIT C

OUTCOMES: CARDIAC EVENTS PER PATIENT YEAR OF FOLLOW-UP*

	Experimental	Control	P Value
Myocardial Infarction	0.012	0.012	NS
Stroke	0.014	0.006	NS
Non-Cardiac Death	0.006	0.012	NS
Cardiac Death	0.014	0.012	NS

*Am. J Cardiol 1998;82:72T-76T

REVASCULARIZATION COST SAVINGS*

- Average cost of Lifestyle Intervention at 1 year: $7,000
- From Mutual of Omaha Data: PTCA with cath $31,000
  CABG $46,000
- Of 194 experimental patients, 31 PTCA's done (0.064 per patient year) and 26 CABG's (0.53 events per patient year)
- Total Cost Per Patient:
  - Experimental Group: (31 x $31,000) + (26 x $46,000) + (194 x $7,000) = $18,119 per patient
  - Control Group: Initially; 66 PTCA/73 CABG. Redo; 23 PTCA/11 CABG (86 x $31,000) + (84 X $46,000) = $47,647 per patient

– *Am. J Cardiol 1998;82:72T-76T

Exhibit C

AVERAGE SAVINGS PER PATIENT WITH LIFESTYLE CONTROL*

- **$29,529 PER PATIENT**

*Am. J Cardiol 1998;82:72T-76T

CONCLUSION OF MULTICENTER LIFESTYLE CONTROL PROJECT*

At three-year follow-up, patients making lifestyle changes can avoid revascularization without increased risks for cardiac events. Angina reduction was comparable to what can be achieved with revascularization. Risk factors for future cardiac events were significantly improved in regard to weight, cholesterol, and LDL reductions. These values were maintained up to three years.

*Am. J Cardiol 1998;82:72T-76T

Dr. Dean Ornish's
Program for REVERSING Heart Disease

Exhibit D

PRELIMINARY CLINICAL DATA

The following tables show changes in participants' mean values for a number of clinical measures at baseline, 12 weeks, one year and two years. The data is current through March 17, 1998.

B. Baseline vs. 12 weeks

Table 5: Changes in Adherence

	N	Baseline	12 Wks.	% Change	P-value
Exercise (times/week)	418	3.40	5.52	+62.4%	.000
Exercise (min/time)	416	28.25	41.83	+48.1%	.000
Stress Mng (times/week)	418	1.33	6.02	+352.6%	.000
Stress Mng (min/time)	417	8.72	52.10	+497.5%	.000

Table 6: Changes in Exercise Capacity

	N	Baseline	12 Wks.	% Change	P-value
Bruce (minutes)	315	9.19	10.57	+15.0 %	.000
METS	388	9.59	11.40	+18.9%	.000
Angina	400	23%	15%	-34.8%	.001

Table 7: Changes in Risk Factors

	N	Baseline	12 Wks.	% Change	P-value
Weight (lbs.)	458	187.28	178.00	-5.0%	.000
Body fat (%)	441	26.61	22.86	-14.1%	.000
Total cholesterol (mg/dl)	398	202.03	183.83	-9.0%	.000
HDL (mg/dl)	386	36.70	32.78	-10.7%	.000
LDL (mg/dl)	377	122.77	105.85	-13.8%	.000
Triglycerides (mg/dl)	393	230.01	235.83	+2.5%	.502

Table 8: Changes in SF 36 Scores

	N	Baseline	12 Wks.	% Change	P-value
Physical functioning	425	0.74	.84	+13.5%	.000
Role physical	425	0.63	0.78	+23.8%	.000
Body pain	423	0.69	0.75	+8.7%	.000
General health	424	0.58	0.69	+19.0%	.000
Vitality	425	0.54	0.67	+24.1%	.000
Social functioning	425	0.78	0.86	+10.3%	.000
Role emotional	422	0.73	0.83	+13.7%	.000
Mental health	425	0.70	0.79	+12.9%	.000

C. Baseline vs. One Year

Table 9: Changes in Adherence

	N	Baseline	1 Yr.	% Change	P-value
Exercise (times/week)	398	3.39	4.98	+46.9%	.000
Exercise (min/time)	396	28.33	41.24	+45.6%	.000
Stress Mng (times/week)	398	1.26	5.38	+327.0%	.000
Stress Mng (min/time)	397	8.36	46.25	+453.2%	.000

Table 10: Changes in Exercise Capacity

	N	Baseline	1 Yr.	% Change	P-value
Bruce (minutes)	210	9.32	10.99	+17.9%	.000
METS	255	9.58	11.99	+25.2%	.000
Angina	261	22%	12%	-45.5%	.000

Table 11: Changes in Risk Factors

	N	Baseline	1 Yr.	% Change	P-value
Weight (lbs.)	307	187.21	181.50	-3.1%	.269
Body fat (%)	271	24.87	21.21	-14.7%	.000
Total cholesterol (mg/dl)	283	199.34	182.96	-8.2%	.000
HDL (mg/dl)	277	37.09	35.78	-3.5%	.017
LDL (mg/dl)	269	121.99	104.59	-14.3%	.000
Triglycerides (mg/dl)	280	216.40	223.86	+3.4%	.384

Table 12: Changes in SF 36 Scores

	N	Baseline	1 Yr.	% Change	P-value
Physical functioning	314	0.75	0.86	+14.7%	.000
Role physical	314	0.63	0.81	+28.6%	.000
Body pain	312	0.68	0.78	+14.7%	.000
General health	313	0.58	0.71	+22.4%	.000
Vitality	314	0.54	0.65	+20.4%	.000
Social functioning	312	0.78	0.87	+11.5%	.000
Role emotional	313	0.74	0.84	+13.5%	.000
Mental health	314	0.70	0.78	+11.4%	.000

D. Baseline vs. Two Year

Table 13: Changes in Adherence

	N	Baseline	2 Yrs.	% Change	P-value
Exercise (times/week)	268	3.45	4.28	+24.1%	.000
Exercise (min/time)	267	27.91	37.66	+34.9%	.000
Stress Mng (times/week)	268	1.28	3.31	+158.6%	.000
Stress Mng (min/time)	268	9.41	32.89	+249.5%	.000

Table 14: Changes in Exercise Capacity

	N	Baseline	2 Yrs.	% Change	P-value
Bruce (minutes)	96	9.52	10.12	+6.3%	.005
METS	105	9.43	10.89	+15.5%	.000
Angina	106	20%	14%	-30.0%	.263

Table 15: Changes in Risk Factors

	N	Baseline	2 Yrs.	% Change	P-value
Weight (lbs.)	88	183.89	177.06	-3.7%	.000
Body fat (%)	80	23.83	21.79	-8.6%	.000
Total cholesterol (mg/dl)	102	205.01	187.79	-8.4%	.000
HDL (mg/dl)	101	38.12	38.85	+1.9%	.469
LDL (mg/dl)	99	127.15	109.85	-13.6%	.000
Triglycerides (mg/dl)	101	223.60	208.20	-6.9%	.349

Table 16: Changes in SF 36 Scores

	N	Baseline	2 Yrs.	% Change	P-value
Physical functioning	123	0.76	0.84	+10.5%	.000
Role physical	123	0.66	0.82	+24.2%	.000
Body pain	123	0.70	0.77	+10.0%	.000
General health	123	0.60	0.69	+15.0%	.000
Vitality	123	0.56	0.63	+12.5%	.000
Social functioning	123	0.81	0.88	+8.6%	.000
Role emotional	123	0.79	0.84	+6.3%	.000
Mental health	123	0.70	0.80	+14.3%	.000

Responses from Walter Czapliewicz : Heart Patient

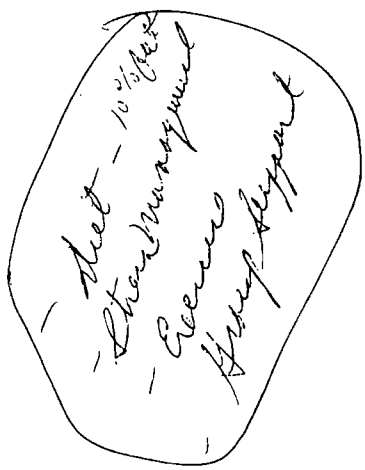
1.) After Heart surgery, I seemed to be doing fine for about 1 and ½ years, but started having chest pain again, and within a few months was using nitrostat daily for angina pain. By December of 1999, I was using this medication sometimes 3 times a day for this pain. My cardiologist said I might be back in the hospital very soon for more surgery. I didn't want that at all, and started to look for other means of contolling my angina pain. I had read in the newspaper about the Ornish Program the Highmark BlueCross/ Blueshield was offering, and asked my cardiologist about it. He agreed that this approach might be beneficial to me, and with that I made the necessary phone calls and got into the program. For me more surgery wasn't an option because with the first bypass surgery they used my mammary artery which will last the rest of my life, but any future surgeries they would have to use an artery from my leg, and that only lasts 10 or 12 years on average and being 44 years old, I could possibly be having this done 2, 3, or 4 times in the course of my life. because of this, I started looking for another way to make myself healthy again.

2.) Luckily for me my hospitalization insurance is through Highmark BlueCross / Blueshield, which made Dr. Ornish's program available to it's subscribers who are at risk of Heart disease.

3.) I think all Insurance companies should make this program available to their members, and that medicare make it available to more people.

Walt Czapliewicz

P.S. in case anyone asks, my last name is pronounced (zaplewits)



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Divider Title: Schumacher

1. **Briefly cribe your program and how it differs from conventional hospice care. Include some description of the health conditions most usually presented by your patient population.**

The Center for Hospice & Palliative Care (CHPC) is a tax-exempt organization that provides a continuum of services providing care to the terminally ill. Originally incorporated as Hospice Buffalo in 1978, CHPC now provides care to over 400 terminally ill individuals through a variety of advanced health care services. ***Home Care Buffalo*** is a pre-hospice home health agency designed to provide services for those unable to accept hospice care. Home Care Buffalo also houses three innovative programs: ***Essential Care***, our pediatric program currently caring for 31 children; ***Medicaring***, a national demonstration on providing care for COPD and CHF patients and ***Support Blue***, a case management end of life program for the pre-hospice subscribers of Blue Cross and Blue Shield of Western New York. The ***Kresge Residence*** is the only Hospice operated skilled nursing facility in the United States. Kresge specializes in providing skilled nursing home care to patients whose length of stay is less than 120 days. ***Life Transitions Center*** is a mental health center focused on providing support for grief and bereavement related services. Recently the Center has purchased a national bereavement-training corporation called the American Academy of Bereavement. This new corporation will provide over 400 workshops nationally on grief and bereavement.

All of these programs demonstrate the innovative and unique care that is offered to patients no matter how far their disease progress has progressed. CHPC provides care to all diseases, the largest being cancer at 70%.

2. **Briefly describe the operational process involved in delivering CAM approaches in a hospice setting. Specifically, which CAM products and practices should be available, how should they be selected and who should deliver them?**

Hospice care is provided through an interdisciplinary team comprised of physicians, nurses, social workers and allied therapies. Each patient is reviewed on a weekly basis with any recommended changes implemented after that meeting. CAM products are available through the members of the interdisciplinary team. They include music therapy, acupuncture, chiropractic care, therapeutic touch and meditation/visualization. Upon the recommendation of the team, these services are implemented. They recommend largely on patient need and these services are provided by professional staff trained in these disciplines.

3. **What is the rationale for using such approaches rather than more conventional approaches?**

The rational for using such approach follows three pathways:

- There are patients who request CAM as opposed to receiving or in conjunction with traditional therapies.
- Those for whom traditional therapies do not work, e.g., a team member might recommend meditation and visualization rather than an anti-anxiety medication.
- For those patients for whom CAM can be used in conjunction with a traditional therapy.

4. **Describe any data, even anecdotal, to illustrate the clinical or cost-effectiveness of such approaches in a hospice setting, especially as compared with more conventional approaches. Provide patient satisfaction data if available.**

Our data consists of patient/family questionnaires that demonstrate the effectiveness of our care. Specific to CAM, many family members report their satisfaction with a non-invasive, non-medicated. but supportive intervention. A recent example includes a family member of a patient who died in Hospice from Alzheimer's Disease. While totally unable to communicate with her mother for several months, this patient's daughter reported a huge success that music therapy had with her mother at the end of her life. The music therapist played many songs that the patient had been familiar with earlier in her life. To the daughter and family's amazement, their mother who had not spoken intelligibly for several years, was able to sing along with songs that touched a part of her brain that had not been compromised by the disease.

5. **What barriers have you encountered and how have you overcome them?**

The largest barrier we have encountered focuses in on the use of CAM therapies with the traditional medical community. Many physicians are uncomfortable with this approach to pain and symptom management and resist their utilization. It is often necessary for family members to override physician skepticism and encourage their inclusion in the plan of care.

6. **What policy recommendations do you have for the Commission?**

Recommendations for the Commission include:

1. Increase research opportunities to demonstrate the effectiveness of CAM.
2. Recommendations of the establishment of a demonstration project to look at these therapies in a variety of traditional settings.
3. Establishment of an educational program that would work to inform physicians and other health care practitioners about the effectiveness of these therapies.

Submitted by: J. Donald Schumacher, Psy.D., President & CEO, The Center for Hospice & Palliative Care, Inc., 225 Como Park Blvd., Cheektowaga, N.Y.

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IV

Divider Title: _____

CONTENTS

SESSION IV:

Issues in Integrating CAM In Service Delivery

Speakers' Questions for Session IV:
Issues in Integrating CAM into Service Delivery
4:00 - 6:00 p.m. on Monday, December 4.

General Questions for Session IV speakers:

1. Should CAM be integrated with conventional medicine and why or why not?

2. What are the keys to successful integration of CAM with conventional medicine; how can they be translated into policy recommendations?

3. What other policy recommendations would you like to make to the Commission?

Additional questions for individual speakers:

PAUL KURTZ

4. Should there be access to and delivery of CAM products and practices? If so, why? If not, why not?

5. If current CAM utilization trends continue, what consumer protections should be implemented?

DONALD KENDALL

4. Given the significant (often conflicting) philosophical diversity among the multiplicity of schools or forms of acupuncture, how has OPEIU/the Guild contributed to improved access to and delivery of not only acupuncture in particular, but also oriental medicine in general?

5. What policy recommendations does OPEIU/the Guild have for the Commission to improve access to and delivery of acupuncture and the spectrum of oriental medicine for populations such as the under-insured, uninsured, poor, and medically underserved?

CANDACE CAMPBELL

4. Why should there be access to and delivery of CAM products and practices?

5. What is the role of CAM products and practices in self-care?

6. From your perspective, what are the barriers to access to and delivery of CAM products and practices and how have (or how should) they be overcome?

MICHELE FORZLEY

7. Briefly describe the purpose and methods of your pilot study of CAM integration (one paragraph), including how and why modalities and providers were selected; and the results, particularly the common themes identified.

8. What are the international laws and treaties which have relevance to the integration of CAM by the US?

9. Based on the above two questions, what policy recommendations can you suggest to the Commission?

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Miles

Divider Title: _____

Commentary for the White House Commission On Complementary and Alternative Medicine Policy Session IV, Integrating CAM Into Service Delivery December 4, 2000

Question 1, Should CAM be integrated with conventional medicine?

My almost thirty years of experience with CAM indicates a strong public interest and growing utilization of CAM services. This has essentially developed outside the institutions of conventional medicine, which has historically functioned as a closed system based in an authoritative ideology which resists challenge and change. Thus, conventional medicine sometimes sees these CAM practices as a negation of, or an attack upon, their exclusive realm of practice. The word "integrated" therefore raises some difficult political and economic issues.

Conventional medicine is not, at this time, an internally consistent coherent system. It has become encompassed by, and beholden to, a payment system fundamentally inconsistent with the interests and needs of professionals and patients. And is also now almost completely dependent upon expensive technology that assumes high cost interventions.

Therefore, the word integrated could mean:

o Included in this payment system.
o Seen as an equal participant in care organization from first visit to case conclusion.
o Seen as adjuncts to, or subspecialists in, the current fragmented situation, under the direction and/or supervision of conventional physicians and compared to technological and abstract data based interventions.

Therefore, I would prefer the question, **Should government policy promote the appropriate availability of complementary and alternative practices? YES**

The basic issue in any integration, which will undoubtedly happen in some fashion, either planned or by default, is the deeper question of world view. Most of the CAM practices are based in a world view which sees the human organism as a functioning system, not just as a host for diseases and symptoms. The work of these practices, appropriately performed, is to seek improved and balanced function of the organism, not necessarily to suppress or correct outward symptoms. Thus, their diagnostic procedures and recommended interventions are difficult to compare to conventional medicine.

If a spectrum was drawn with acute trauma and infection at the left and chronic dysfunction and pain on the right, conventional medicine is most highly effective at the left end of the spectrum. As the presented cases move across to the right, conventional medicine becomes increasingly less effective, mainly because the cases are "systemic" rather than symptomatic. In many cases, CAM practices are the reverse, offering more effective interventions for systemic disorders than for acute, short-term issues. In addition, most CAM practitioners have functioned outside the infrastructure of conventional medicine and are not accustomed to the intensive paper work associated with the "office" and payment systems that have tended to overwhelm conventional care. The issue of "integration" therefore involves planning of useful information infrastructures that facilitate cooperation and improved case outcomes.

White House Commission on CAM Policy

Question 2. What are the keys to successful integration of CAM with conventional medicine and into what policy recommendations should they be translated?

1. Educational programs

   a. Greater professional understanding of CAM practices and the benefits they can provide.
      • Perhaps a template of health problems and how the several CAM practices can benefit them, and how they can work together, usually in a sequential program.
   b. Greater understanding of the human organism as a self-regulating, self-healing system and how best to support organism integrity while treating disorders.
   c. Review of the science of living systems and how humans live within a planetary living system and can not exclude themselves from it. A greater recognition of the key role of environmental contamination in chronic disorders.
   d. Training of care coordinators who have a working knowledge of conventional medicine and CAM practices who can act as advocates and guides for patients during this transition time when most people are unprepared to make informed care decisions.

2. Legislative "relief"

   a. Removal of many restrictive practice regulations that prohibit or interfere with efforts at collaborative practice. Current laws assume that the only reason for practitioners to collaborate is to gain kickbacks or promote one another's income potential. This is not necessarily true in the rapidly changing field. Current legislation also frequently arose out of attempts to limit access to "unrecognized" professionals.
   b. Templates for improvement of benefit programs and other third party payment systems that currently frame and restrict the choices of care based on cost containment rather than patient choice.
   c. Supporting "care coordinators" who are truly patient advocates and guides rather than gatekeepers for payers.

3. Benefit program re-design

Historically, we have linked routine care (formerly "first dollar coverage") with true insurance (catastrophe risk management). This has generated a public attitude that (a) diminishes home remedy lore, (b) minimizes personal responsibility for self-care and care decisions, and (c) builds an unnecessary dependency upon high-tech medicine. Health "insurance" was offered as a benefit that one expected to gain from rather than as a protection against excessive losses.

In both government programs and private benefit programs, we must find a way to separate these two issues - - - provide people with protection against catastrophe, but return to the family and individual the capacity for making choices about the care they will use . . . and offer them support for self-management and low cost interventions rather than just promoting high cost high-tech interventions through legislative and benefit program restrictions.

Question 3. What other policy recommendations should be made?

Groups of professionals and leaders in the field are gathering around the country in ad hoc "think tanks" whose purpose is to "redesign" the health care system. The theme of many of these groups is (a) improved focus on the patient rather than the disease, (b) research on outcomes rather than only on technologies, (c) relationship centered care rather than technology centered care, (d) information systems based in patient understanding and control, (e) third party programs that return more responsibility to the patient and the community.

My recommendation would be that the Commission find a way to become a clearing house and "gatherer" of these groups, communicating their activities throughout the field and fostering more of this ad hoc innovation. Successful new plans are not, in my view, likely to emerge from within the established institutional "leadership," which tends to be entrenched in its own perpetuation and survival . . . and has a hard time "seeing" solutions which would diminish their institution's power.

A key shift for our times is from "control over" to "collaboration with." From the perception and treatment of disease to the organization of care systems and professional practices, this shift is at the core. We can no longer maintain the misperception that we can "manage" nature and disease. Healing is from the inside out rather than from the outside in.

Memo to Jim Gordon **26 Sept 00**
White House Commission on Complementary and Alternative Medicine Policy

Jim:

I regret that I did not hear about your San Francisco hearing until far too late to become involved. In fact, when I did hear about it, the person said it was being convened by the NCCAM at NIH, which is something else altogether. I am keenly interested in health care policy and the trends and forces that shape it, so I'm sorry I missed the meeting. From the list of people from the Bay Area who did appear, the policy wonks were lightly represented.

As we look at the tasks charged to the commission in the presidential order, we notice important factors of education of both the public and professionals, which has been a focus of my interests for some time. Especially in regard to task number (3) guidance for appropriate access to and delivery of CAM, some more complex issues arise.

Looking at **economic and political policy** regards health care, some questions appear:

1. Is there a trend toward complementary and/or integrative care?
2. What factors propel this trend?
3. What factors impede this trend?

In the almost thirty years I have been involved in this process, the trend toward "acceptance" of unorthodox practices and new approaches to health has been persistent and steadily growing. In fact, the public is in some areas far ahead of the care "system" and devising ways to get around it through fee for service interactions.

What propels this trend?

a) Dissatisfaction with the mechanization and depersonalization of conventional medicine - - "customer" dissatisfaction; b) The continuingly rising cost of technological medicine; c) The inability of conventional medicine to successfully address the major health problems many people face, i.e., chronic disorders, (which may be due to point (a); and d) The significantly changing social and scientific paradigm of Western thought from technological dominance of nature to realization of nature as a wise, self-regulating life system that supports its own integrity - - hence many of our interventions meant to "help" produce unwanted consequences.

In my view, this last issue is the underlying impulse behind all the others, though not recognized as such. This makes it a significant policy question.

What inhibits this trend?

Lack of understanding of the complementary practices is certainly a pervasive question. However, we do not have a "health care system," we have a payment system. This payment system is the template against which almost all professional and public decisions are made. The question which might be "Will this help me?" is most frequently converted into "Is this covered?" Thus, the pervasive bias of the entire system is toward "authorized" procedures.

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Which raises the second major issue . . . that the payment system does not pay for health or for care, it pays for procedures. Thus, all treatment plan and care decisions are biased in the favor of "doing something," especially if that something is authorized and paid for. Physicians and other care providers have not, until recently, been paid for simply seeing and counseling patients, but are more easily paid for procedures. Unfortunately, while capitation contracts might have shifted those priorities, most of these are arranged at a group or HMO level. This leaves the physician in the place of acting under "time and motion study" rules that preserve the cash flow of the HMO or PPO, but have little relationship to patient improvement and may actually inhibit patient interaction and support.

Almost all discussions of "health care reform" which might involve inclusion of CAM, including that engaged in by the current administration, are based in rearranging this payment system, not in reforming the structure of health care or discussing the factors which drive the demand for high-tech health care services. These discussions continue to see health care as a "business system" delivering products to "consumers." The main question is "How will this expensive system be paid for?" A better question might be, "How can we design a system that supports and maintains individual and community health and diminishes demand for expensive services?" Until this issue is addressed at the policy level, the whole question of the introduction of complementary services will be cast in economic and profit-driven terms rather than patient improvement and health outcome terms.

Until about 40 years ago, almost all hospitals and care organizations in the US were operated by churches, public agencies, or community organizations. They did not base their social worth on profit margins, gross revenues, and cost/benefit analysis of each type of service. The change that this shift to "corporatization" has wrought in the organization of emergency services alone has been profound, yet it is rarely brought into the discussion. We no longer live in a society, we live in an "economy," and every aspect of the society is now measured by its contribution, or lack of same, to the economy. This is not a productive yardstick for health care. In a sense, the most effective health care system would include hospitals that were almost empty, but ready to serve in a community emergency. They, like the fire department, would not be expected to make a profit.

Another base for the current template is that the research system is primarily a "procedure validation" system rather than a study of how people improve their health. In other words, a certain procedure is proposed to "fix" a problem when it becomes critical. The success of that "fix" is then assessed, and the protocol of the research places all responsibility for that success in the procedure. This discounts or negates any role that professional or patient intention, or community support systems, might play in health improvement. Thus, the research system is primarily one of product development, again in the corporate mode. Since complementary practices are usually much more based in personal services rather than abstract procedures or products, and since these services may vary more widely by practitioner than the assumed "standard" in conventional medicine, which is usually monitored more by procedure rather than professional variations in skill, complementary practices become very difficult to research in the current model.

Thus, in my view, the discussion of how CAM can most productively be integrated into any system of care must, of necessity, address the dynamics of the research and payment system that is assumed to be in place.

I recall attendance at an alternative and complementary care conference in Washington, D.C. about

five years ago. There were about 400 practitioners of various techniques in attendance. They could easily be divided into two "schools of thought": (1) Those who wanted to "get legal and get paid," and (2) Those who saw the principal issue as a review of the world view assumptions and social contexts in which care was offered and delivered.

I was, needless to say, firmly in the second perspective. My sense is that unless we address the world view issues about our societal fear of illness and death, our societal expectation for quick fixes from technology, and our societal dependence upon "entitlement systems' based in "benefits" rather than self-responsibility, the CAM movement will be relegated to a mistrusted adjunct to the current dysfunctional system that costs too much, hence will be seen as an added expense (which is how many insurers now view it).

One of the major components of this dilemma is this notion of "benefits." When health insurance was first introduced during and after WWII, it was called "insurance," but was marketed as "first dollar coverage." Hence, it was not just insurance, it was also "prepaid care." Much of the current political discussion about "coverage" centers in "access." What is frequently at issue is people's access to general community medicine, not necessarily to catastrophic coverage for major costs. These are two different animals that have been locked into the same cage, thought they normally wouldn't live together.

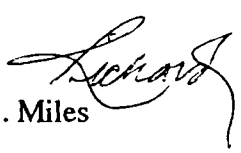
In my view, what drives the fear about "coverage" is the issue of catastrophic loss of life savings, etc. in a major case. That is truly a question of insurance and can be addressed as such. However, access to general community care is a completely separate problem and can also be addressed as such. The emergence of the Medical Savings Account concept is a kind of side door acknowledgement of this idea, but perhaps with a hidden motive of avoiding "general pool" responsibility for community health.

However, the separation of concepts about routine care and catastrophe insurance may be essential to resolve the problem of escalating costs. Primarily, "How can we return the capacity for decisions about routine care and the process of care to the receiver (not user) of care?" If we're talking about health care as a marketplace, how can the true buyer of services be the receiver rather than a third party payment system? If such a system were in place, and included provision for catastrophe "insurance," the inclusion of CAM would suddenly cease to be a political question. The public is already moving in that direction in spite of the current system.

If the receiver of care became an operant force in the system, the changes in the organization of care would be profound. At first, there would no doubt be some confusion, which some would then use as a reason to revert to a more controlled system. Give this a bit of time, however, and some powerful and productive changes would occur in our society. These would include the return of much of a our self-care lore that was lost when one could go to an "expert" with no cost or responsibility attached to the decision.

I'd enjoy the opportunity to discuss these ideas with people involved in the arena of discussion.

Blessings



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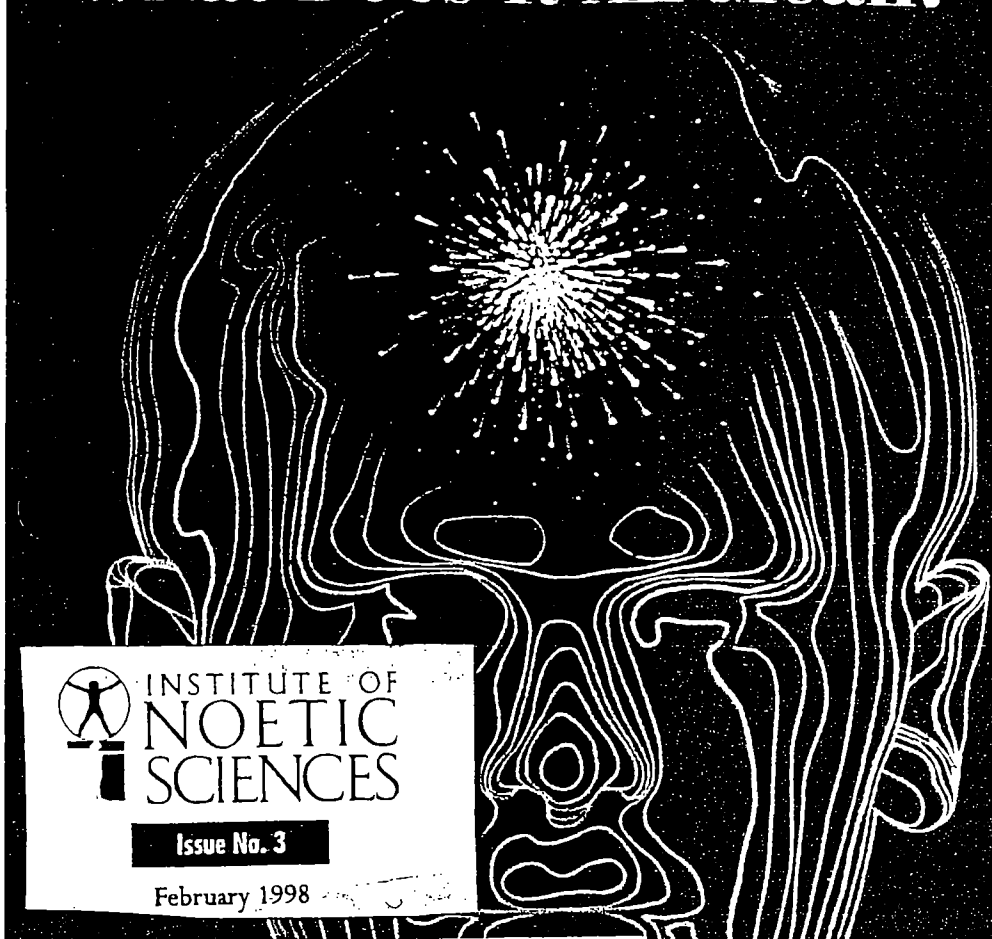
Our Evolving Views of Health and Illness:

What Does It All Mean?



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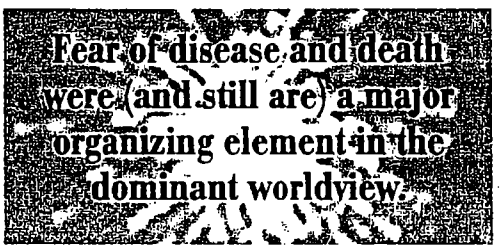
HEALTH FRONTIERS

As today's technology produces cloned sheep in England, and induces septuplets in the United States, it is difficult to realize that less than one hundred and fifty years ago we had absolutely no idea what even caused disease. Between the end of the US Civil War (1865) and the turn of the twentieth century, massive changes took place in how we perceived our world and our "power" in it. If we explore these changes, and the subsequent ideas they have generated, we can see that our beliefs about health and disease are shaped by the larger meaning systems, or worldviews, of the culture we share. The emerging noetic view places consciousness and self-awareness as an organizing principle for human experience, including health and disease. How might all this fit together and what can it mean?

By Richard B. Miles

The boundaries of our life experience have undergone

. a Charles Shultz "Peanuts" cartoon, Lucy, Linus, and Charlie Brown are lying on a hillside gazing at the clouds in a summer sky. Lucy: "Linus, what do you see in the clouds up there?" Linus: "That cloud on the left looks like a map of British Honduras. The cloud in the center reminds me of a bust of the famous artist Thomas Eakins. The cloud on the right shows the stoning of Stephen, you can see St Paul standing there." Lucy: "What do you see in the clouds, Charlie Brown?" Charlie Brown: "I was going to say that I saw a horsie and a duckie, but I've changed my mind."



This insightful cartoon illustrates that when humans look at their world, they impart it with meaning—meaning shaped and bounded by the orldview of the perceiver. We seek what we can grasp and understand within the boundaries of our life experience. The boundaries of our life experience have undergone some profound changes in the last one hundred years . . . and our perception of the meaning of health and illness has therefore shifted to grasp these changes.

The Supernatural Model

In the late nineteenth century there were essentially three explanations for disease and dysfunction. The Divine Theory proposed that illness resulted as a punishment for sin and misbehavior, still evident in the AIDS epidemic. The Demonic Theory proposed that people could become possessed by evil forces. The Miasmatic Theory suggested there were hidden entities lingering in the air, the soil, etc., ("noxious exhalations from putrescent organic matter") that emerged en people "had the miasmas," that is, re feeling poorly.

The common theme of these explanations is a potentially hostile supernatural universe over which humans have little or no control. Fear of disease and death were (and still are) a major organizing element in the dominant worldview. A deep desire to understand and overcome this fear drove human exploration.

The Warrior Model

In the late nineteenth century and early twentieth century, a fundamental revolution occurred in this worldview. Two major aspects of this revolution are woven together: (1) The explosion of industry and technology which was "taking over" the world—ships, railroads, steel, mechanized agriculture, manufacturing—all illustrating human capacity to master and manage the forces of nature to create expanding wealth and comfort; (2) The emergence of laboratory science which revealed the "miasmas" as identifiable bacteria and viruses, not supernatural forces beyond our knowledge.

It is valuable to remember that this second factor came about in the context of the first. Thus, science and technology promised an answer to the fear of death and disease. They were no longer supernatural unknowns over which we were helpless. We might actually learn to master and overcome them in comparable fashion to the amazing feats we were witnessing in other areas of industry. *We might actually learn to master the world!*

Concurrent with this vision was the widening separation of science and religion and the growing dominance of the "outer rational" view of life and diminution of the "inner subjective" view of meaning. Events, rather than being supernaturally determined, became the result of random probability and bell curve statistics. The universe became indifferent with no inherent value agenda. Medical information was organized around agents of disease, vectors of attack, and strategies to intervene and stem the disease.

Hence, science and medicine became warriors against disease and death in a quest to overcome nature, and we now participate in the "war on cancer," and the "war on AIDS." The language of medicine is still rife with military analogies.

The Self-Regulating Systems Model

Right at the beginning of the scientific "warrior" model, a profound dialog began between Louis Pasteur, the father of modern bacteriology, and Claude Bernard, the father of modern physiology. In effect, Bernard said, "If a large number of people are exposed to the tubercule bacillus, only a fraction of them become ill, and only a fraction of those who become ill will die. I think it at least as important to study the factors in the lives of those who did not become ill to determine how that came about as it is to study how to treat those who fall ill." Bernard saw disease as an indication of dysfunction in a connected, self-regulating, and self-healing life system. However, since the worldview of the time was based in mastery and domination of the natural process rather than understanding of its self-regulating framework, his comments were ignored, although some historians report that Pasteur acknowledged the wisdom of Bernard's view in later life.

A factor to consider is that this new understanding of the origins of disease *within the interconnected systems of nature* generated massive public health measures in the early twentieth century. Refrigerated foods, cleaner water systems, improved sewage disposal, mosquito abatement, antiseptic control in hospitals, and electric indoor lighting (as compared to gas and kerosene lamps) essentially diminished the impact of the major infectious diseases such as tuberculosis, diphtheria, smallpox, malaria, by 1923. The effective clinical treatments for these diseases did not become available until the

profound changes in t ıe ast one hundred years . . .

940s. Therefore, the public belief that clinical medicine was the "conqueror" of infectious diseases is not validated by history. The current realization of the growing ineffectiveness of antibiotics as the natural system adapts in response to them is a clear illustration of the self-regulating system's model.

Concurrent with the wane of the infectious diseases in the 1920s was the rapid rise of chronic and degenerative disorders—heart disease, cancer, diabetes, and arthritis. The inadequacy of medicine's attempt to treat these conditions in the adversary (germ theory) model has become increasingly evident. Since these disorders are systemic functions in the whole organism, attempting to stem the disease as a separate "entity" can prove difficult, if not counterproductive.

In addition, the emergence of mind-body medicine and psychoneuroimmunology, and the importance of subjective factors in illness and dysfunction, illustrate that viewing disease as "an adversarial thing," that is, an enemy to be overcome, may not be an appropriate view.

A major plus emerging in the systems model is the realization of our interaction within our natural and manufactured environment, and how our physiological systems respond. In just the past fifty years, we have introduced thousands of new materials into our lives, homes, offices, and foods with little awareness of their cumulative effect on our bodies. In the "disease as enemy, technology as victor" model, these effects tend to be denied. We are only now beginning to recognize the extent of the systemic effects they may be generating.

In the systems model, rather than seeking causes to be fixed or symptoms to be modified, the investigator seeks patterns that result in dysfunction. Once the patterns are known, they can be changed and the potential consequences avoided. We have a growing awareness of "lifestyle" medicine and the importance of nutrition, exercise, smoking, and substance abuse, because of our increased knowledge about how life systems operate.

Emerging Consciousness (Noetic) Model

What is the role of human consciousness and intentionality in our interactions within the system of natural life? Is the universe a self-organizing, self-revealing intelligent life process seeking expression through human evolution? Joseph Chilton Pearce once questioned whether we can honestly believe that the evolutionary process that generated human intellect intended for us to become its adversary and try to outsmart it. And Einstein was reputed to ask, "Is the Universe friendly?" rather than hostile or indifferent.

If we considered the life system to be self-regulating and self-revealing, how might we perceive disease and dysfunction? What function would they serve in such a system? If the universe is self-revealing, how can we explore the answers to our deepest questions?

Einstein was reputed to ask, "Is the Universe friendly?" rather than hostile or indifferent.

Today's practitioners of somatic psychology, "focusing," inner journal work, and other self-exploration techniques say that if we can clarify our inner questions, "the universe will answer them." Perhaps disease and dysfunction have encoded within them (in both a metaphoric and literal sense) the message available to us about how best to respond. This shifts the emphasis in healing from "doing to" to "being with."

A potential pitfall in this view is the misdirection of "self-blame." People who explore the cause or meaning of disease should not look upon this process as "creating their own disease," but rather as an insight into the inner process of their life. If the "aha" can be gained, new directions can emerge. This is quite different from "fixing" the problem or placing the blame. Healing becomes a matter of a shift of personal perspective rather than a rescue achieved.

New Power and Responsibility in Our Lives—Intentionality

Looking at the evolution of these ideas in just this century, we perceive a profound shift in our sense of what disease is and how we can respond to life circumstances. Just a few generations ago, we felt helpless and victimized by supernatural forces when illness appeared. We are now learning the deeper patterns of living systems, and how our hopes, fears, intentions, and desires may be woven into our lives and our bodies. In this new, more inclusive perspective, we have not only our inner awareness, but all of the knowledge of history and science from which to choose to heal and improve our lives. This is both a new responsibility for becoming more self-aware and intentional and a possibility of new levels of health, well-being, and human achievement. IONS

Richard B. Miles has been a pioneer in consciousness and health exploration since the early '70s. He wrote IONS' first membership brochure, Exploring New Perspectives of Humankind, *in 1973, illustrating that many of the pioneer scientists we revere also wrote as mystics. Richard was the founder of the graduate program in holistic health education at John F. Kennedy University and now teaches in the Public Administration graduate program at California State University at Hayward. He is also contacting health professionals through the Health Frontiers Professional Network to create a new paradigm for the healthcare system.*

Changing Perspectives

in American Health Care

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Discovering the Integrated Universe

"Discovery is the unexpected revelation

of the obvious - the 'aha' experience"

Prepared for

the Institute of Noetic Sciences

Richard B. Miles
Health Frontiers

December 1998

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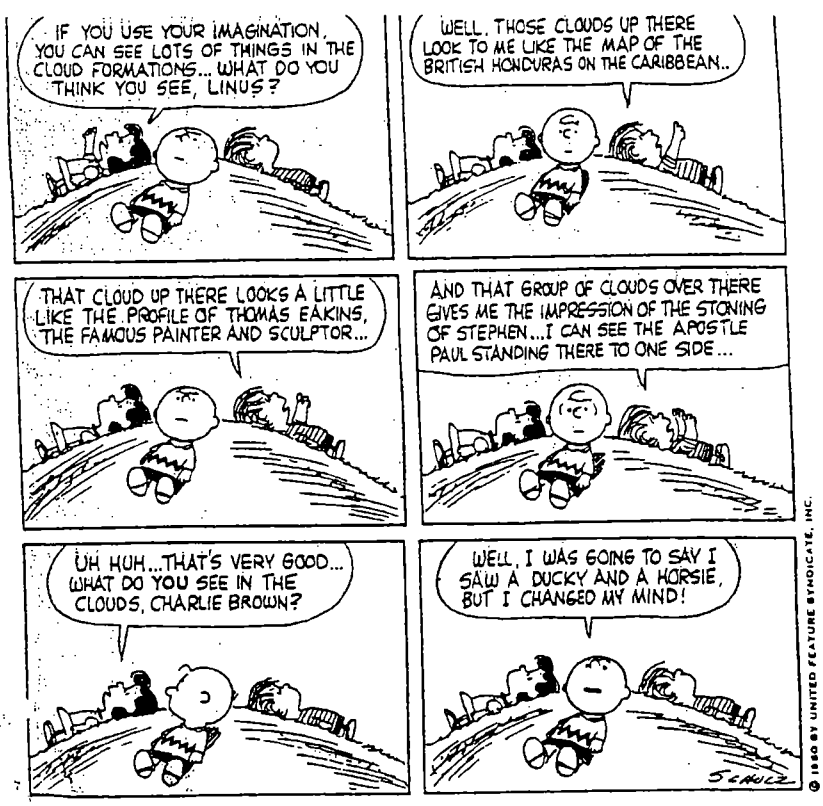
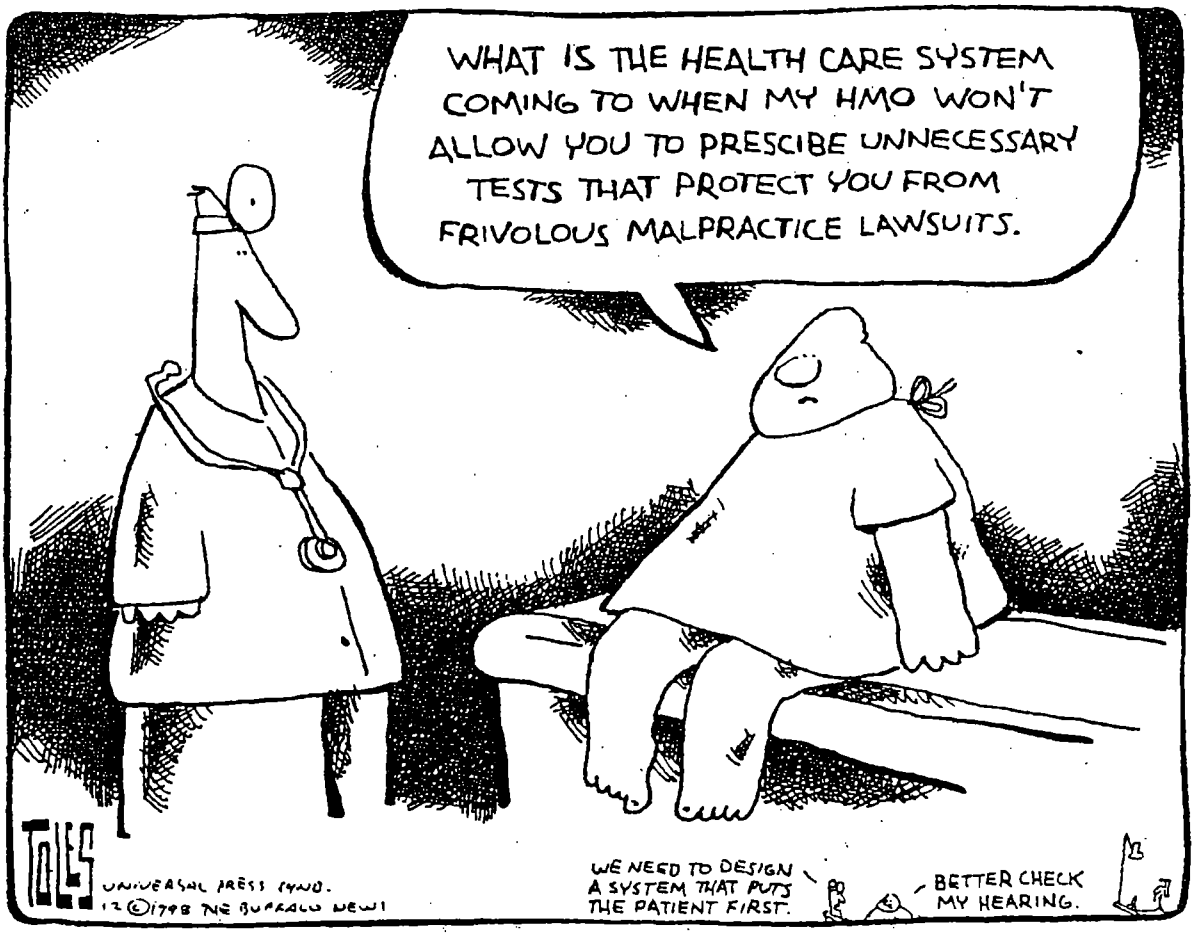
HEALTH FRONTIERS



WEDNESDAY, DECEMBER 2, 1998



Every age but ours had its model, its ideal. All these have been given us by our culture: The Saint, the hero, the gentleman, the knight, the mystic. About all we have left is the well-adjusted (normal) individual without problems, a very pale and doubtful substitute. Perhaps we shall soon be able to see as our guide and model the fully growing and self-fulfilling human being, the one whose inner nature expresses itself freely, rather than being warped, suppressed or denied.

Abraham Maslow

The real voyage of discovery consists not in seeking new landscapes, but in having new eyes; in seeing the universe with the eyes of another, or of a hundred others. And, in seeing the hundred universes each of them sees.

Marcel Proust

Introduction

The health care system in the United States is in the midst of a most profound and rapid change, seen to be caused by attempts to control excessive costs. However, this change involves much deeper and more significant questions about how we perceive health, healing, and the organization of professional services.

In this current process of change, there are four interwoven factors. Some of these are acknowledged within the major institutions, others are frequently unseen. Thus, the core of this process of change is the issue of perspective, i.e., what is seen, who sees it, and why they deem their perceptions important. This is fundamentally the question of human consciousness and our capacity to enlarge our perceptions through imagination and inquiry.

Interwoven Factors

1) The emergence and economic growth of unconventional therapies. most of which are based in world views seeking system balance and function within an integrated life process rather than technological dominance over nature.

2) The widespread professional and public acceptance of "life-style" factors in health conditions, i.e., nutrition, substance use, environmental toxins, lack of exercise, emotional stress.

3) A reevaluation of the objective professional stance as an "expert authority" who issues instructions to be "complied with." (doing to) This is moving toward a realization of the importance of connection, trust, and relationship in the process of healing and recovery. (being with)

4) A fundamental world view shift. Our society has cast medicine as a warrior that can "conquer" disease and dysfunction through the application of science and technology (doing to) to overcome nature. Replacing this is an emerging understanding of an integrated, self-healing life system and the role of internal self-regulation, personal attitudes and beliefs, and the healing relationship (being with) in health problems, especially chronic disorders. A significant aspect of this emerging world view is the role of human consciousness, both individual and interconnected, in the events of life and nature.

The basic premise of this essay offers that this fourth factor, the world view shift exploring the basic nature of human consciousness, is the real driver of current change in health care . . . and in many other aspects of change in Western society.

Setting the Stage for Technological Dominance in Medicine

Historical factors that built the foundations of our current high-tech "medical industry."

Imagine yourself in the middle-late 19th Century. Western society had little insight into the causes and development of disease. Many thought it was a punishment by God for disobeying His rules of behavior. Others thought it was caused by evil spirits. The general functions of nature were poorly understood. Infections and transmission of disease by parasites and insects were unknown. Death and disease were deeply feared.

Consider the times. Mechanization and industrialization were exploding on the scene. Dams were being built, railroads crossed America, farms were being mechanized bringing great leaps in productivity, cities and factories appeared, steam engines overtook sailing ships. The face (and pace) of the world and the shape of people's lives were being changed by industrialization and technology.

The underlying promise was that we could learn to *master nature* and greatly improve our lot in life through engineering and technology. There were numerous world fairs held in the late 1800s attended by millions who gazed in awe at the marvelous new machines. Nature was seen as a resource to be managed and exploited for human progress.

Into this context place the growing use of the laboratory microscope and the discovery between 1850 and the early 1900s of tiny living organisms that were involved in the dread diseases of the day - - - malaria, tuberculosis, cholera, smallpox, diphtheria, typhus fever, etc.

In 1858 Rudolph Virchow began to systematize disease causes and stated that "disease is nothing but the reaction of the cells to the causative agent of the disease." Between 1850 and 1910:

- Pasteur discovered that the organisms that caused putrefaction in wine and milk could be killed by heating - thus was born "Pasteurization."
- Pierre Roux and G.A.E. Yersin isolated the diphtheria bacillus, Yersin the bubonic plague bacillus.
- Pasteur isolated the rabies virus and devised a rabies vaccine.
- Robert Koch isolated the tubercle bacillus.
- Carlos Finlay identified the mosquito that carries yellow fever.
- Charles Alphonse found the cause of malaria - a parasite carried by mosquitoes.
- Charles Nicolle found the louse that transmits typhus fever.
- Pasteur discovered the anthrax bacilli and devised an inoculation to prevent anthrax in farm animals.

Virchow, Pasteur, and colleagues became the heroes of the Century. The "cause" of disease had been found after lifetimes of mystery. Laboratory science, reducing life events to observation of tiny objects in test tubes, had opened the door to mastery of disease and death. The "germ theory" of disease became the dominant perspective.

If we could but marshall our forces, the "war" to master nature and disease could be won through science, technology, and the superior force of human ingenuity. Thus was born the "warrior" ethic in medicine, a battle for long life and survival based in objective, reductionist, laboratory science.

Significant side note:

As Pasteur rose to prominence a colleague, Claude Bernard, took another perspective. Bernard, in effect, said: "If a large number of people become exposed to tuberculosis, only a limited number become infected, and a smaller number die. I think it as important to study why some do not become infected, and how some of those infected manage to overcome the disease, as it is to study how to identify and treat the disease."

Bernard is the father of modern physiology. He saw the human body as a complete system responding in a systemic way to the events in its environment. He developed the concept of homeostasis and the innate tendency of a living system to restore itself to optimal function if given the resources it requires. He saw living systems as inherently wise and self-managing. His view did not flourish in the reductionist "dominator of nature" view of the times.

It is reported that Pasteur, after many years of debate with Bernard, agreed late in his life that a larger, more systemic approach was needed to fully understand health and disease.

In line with the growing world view that science and technology could provide answers to the many problems of mankind grew a parallel belief in the power of the scientifically trained physician. Other practices, such as homeopathy, osteopathy, chiropractic, or an array of folk practices began to be seen as "unscientific" because they could not verify their theories in the laboratory at the cellular level, which became the focal point of study.

In addition, medical education and licensure became much more specifically codified and standardized throughout the U.S. Although European physicians were seen as competent (note that all the discoveries mentioned previously were accomplished in France and Germany) and admired professionals, the wide variation in quality and requirements in American medical education had left the public with doubts about the validity of a physician's advice. By 1918 the Federation of State Medical Boards had been established, and the American Medical Association's Council on Medical Education had gained acceptance of their requirements for more prerequisite studies and two years of university to obtain an M.D.

In 1914, the Flexner Report's "Bulletin Number Four" recommended a drastic overhaul of medical education based on a model established at Johns Hopkins University. That recommendation and $91 million from the Rockefeller General Education Board launched the preeminence of the flagship medical schools in the U.S. and the rise of physician status and respect based in "scientific" medicine.

Of worthwhile note in the "world view" context of this discussion is that this expansion of medical education and the subsequent growth of physician social status and power was supported by the extant world view that through science and technology we could "conquer" disease and overcome the risks of life. The physician was destined to become an expert hero who knew all about disease and could rescue those in distress, who were deemed to be ignorant of their bodies. Self-care became "dangerous" as the doctor was cast as the authority and the patient as the compliant obeyer of technical instructions. The disease was seen as a "thing" (which could be seen in the laboratory microscope) separate from the person's life to be identified, isolated, and removed.

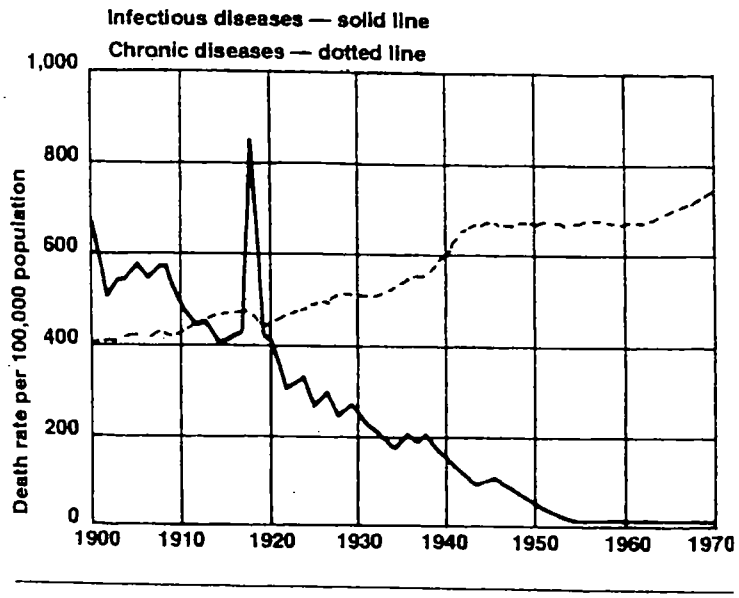
Interestingly enough, as we learned through science *how nature worked*, a dramatic shift occurred that has, in recent years, almost been forgotten. **As we learned to understand nature, and *operate within its inherent balance and order*, rather than "conquer" it, the infectious diseases literally disappeared as the major causes of morbidity and mortality.**

The prevailing belief is that we "conquered" infectious diseases through clinical medicine and pharmaceuticals. However, as a result of **key public health measures:** Cleaner water systems, mosquito abatement, better sewage treatment management, refrigeration of foods, electrification of interior environments (consider that all interior lighting before electricity was provided by burning kerosene or candles in closed spaces), and greater cleanliness in food processing, **the incidence of infectious diseases declined remarkably by the mid-1920s.**

The first antibiotic (sulfanilamide) was not introduced by Gerhard Domagk until 1935. Fleming, Florey, and Chain introduced penicillin in 1940. Streptomycin followed in 1944. The infection control value of these drugs was widely illustrated in the military surgeries of WWII. Thus, the assumed power of the germ theory and of clinical medicine to overcome nature was further reinforced on a grand scale. The success of the polio vaccines in the 1950s added to the mystique.

A look at the chart below illustrates that while this mystique was growing, another phenomenon was not adequately noted. The infectious diseases upon which the cellular germ theory model was based were rapidly declining. The chronic degenerative conditions which were replacing them as the primary concerns of medicine did not fit this reductionist, cellular, single-cause, single treatment model. They are essentially disorders of system regulation and function rather than "attacks" by outside disease entities. For decades, however, because of the dominant belief in the cellular model, we continued to treat chronic disorders with pharmaceuticals and surgery as though they were similar to infectious diseases. The treatments modified the symptoms, but rarely improved the basic disorder.

Figure 2.1: COMPARISON OF DEATHS
PER 100,000 POPULATION, 1900–1970



Comparison of Deaths per 100,000 population, 1900-1970
From *"The Task of Medicine,"* William Glazier, *Scientific American,* April, 1973

Priming the Pump

Scientific, economic, and social factors that developed the current "medical-industrial complex."

In the context of the growing acceptance of the heroic model of scientific medicine, a number of factors combined to set the U.S. on a course for the massive growth of the medical system:

Scientific

• A large skill base, and a vast expansion of technical expertise and equipment, grew out of military surgery in WWII, the Korean War (ala MASH), and the Vietnam War. Medicine gained invaluable knowledge and practical expertise regarding treatment of trauma, burns, restorative surgery, and rehabilitation. These advances were seen as miracles, and they were, considering the significant reduction in disabilities and dysfunctions compared to previous wars. This progress added to the medical mystique. It continues today in the "911" rescue programs on television that imply that high-tech medicine can save someone in almost any circumstance. (people rarely die or are permanently crippled by the events on those programs, not necessarily the reality of life)

• The pharmaceutical industry launched an ever expanding research process to develop treatments for all major health concerns. The expectation was this effort would eventually match the success of the polio campaign and science would "conquer" disease. As mentioned earlier, the pharmaceutical approach to the current problems, systemic disorders, has not been effective. However, as noted below, massive economic support of the "warrior" paradigm lacked adequate feedback on outcomes, hence continued to grow exponentially though it was not producing the desired results. *This was partly due to the professional resistance to the necessary change of the dominant world view of science as manager of nature . . . and the resultant change this would require in the authoritative role of the physician.*

Economic

The notion of providing financial support for medical and hospital services for employees started in the 19th Century among companies with operations remote from urban centers: Mining, lumber, and railroads. It grew quite slowly until two major factors came into play: The government limitation of wage and price increases during WWII, and the rising power of labor unions during and after that war. Health care "benefits" became rapidly accepted.

Between 1942 and the end of WWII, as employers sought ways around wage increase limitations by offering benefits, enrollment in group health plans grew from less than 7 million to more than 26 million, mostly management and "white collar" workers. By 1954, after unions had gained the right to bargain for health benefits, "blue collar" enrollment in health plans grew beyond 29 million "covered lives." By 1954, over 60 percent of the U.S. population had some type of health care insurance.

In July, 1965, the federal government added to this growing trend toward financing of health care with the Medicare / Medicaid programs for seniors and those in need.

Between 1950 and 1970, national health care expenditures rose from $12.7 billion to $71.6 billion. By 1997, they had reached $1.1 *trillion,* with $585.3 billion covered by private insurance and most of the rest covered by government programs.

This massive injection of financial support for scientific medicine produced some society-changing economic effects:

• Economic stability and substantial growth in size, status, and prestige for hospitals, diagnostic centers, extended care facilities, and the like. In 1920, after the first major expansion of hospitals due to new knowledge of infection and antiseptics, there were about 300,000 hospital beds in the U.S. By 1980, there were almost a million.

Anthropologists frequently examine the core values of a society based on the monuments it builds. Since WWII, America has built freeways, shopping malls, sports arenas, and hospitals. As a friend once said as we walked through Grace Cathedral in San Francisco, "Things are a bit slow in the cathedral business these days."

• Explosive growth of medical technology, diagnostic devices, and pharmaceuticals. The guarantee of available funds fed this "growth industry."

• Significant expansion of medical education and the number of available physicians. Our emphasis on the warrior model and the dominance of technology and large medical centers biased this growth in the favor of highly paid specialists rather than generalist family practitioners.

• The coming to prominence of the economic and political power of health insurance companies, and more recently, Health Maintenance Organizations (HMOs), as they sought to obtain and retain access to the immense flow of dollars through the system.

• Eventually, a concerted effort by government and private industry to contain health care costs which were perceived to be "out of control."

Social

The inexpensive or "free" availability of health care services to a growing percentage of the American public generated some fundamental changes in public attitudes and expectations:

• Use of "home remedies," family, and folklore approaches to self care quickly receded as people realized they could consult an expert physician at little or no cost. Many minor health issues became "medicalized" and expectations were raised that scientific medicine could offer a "quick fix" for almost every condition. Antibiotics were seen as the wonders of modern medicine and became widely utilized.

• The self-correcting "customer satisfaction" processes of the usual marketplace were lost, since the user of the service (the patient) had little to do with the payment of the bill (the insuror). Criteria for bill payment were based on accepted standards of practice rather than feedback by the patient. This loss of internal quality control opened the door for substantial system abuse and patient dissatisfaction.

• More became seen as "better." Because of the dominant world view of science as warrior and technology as the key tool of science, every time a new technology was developed, it had to be widely applied. The professionals and the public began to measure competency and effectiveness not by outcomes or practitioner skill, but by the extent and elaboration of technical intervention. Even in case of death, the by-word became, "We did everything we could do."

• This expectation became the standard of defense in disputes between patients and doctors, patients and hospitals. The lack of patient satisfaction criteria in the system left the patient with one principal route for complaint - - the malpractice suit. Thus physicians began to practice what became known as "defensive medicine," conducting tests and engaging procedures simply because they feared reprisal if they did not.

Side note:

This fundamental shift of professional and public expectations is illustrated by a direct experience in my medical history. Just before age 12 in 1941, as a resident of Rochester, Minn., the home of the Mayo Clinic, I was seriously injured - - - falling off my bicycle and run over by a truck. I was attended by the orthopedic, urology, pulmonary, pediatric, internal medicine, and surgery departments of the Mayo Clinic. The extent of their intervention was catheterization to relieve pressure on a burst bladder, and insertion of a needle to remove liquids from my right lung. This limited intervention was not "diminished care" or the like, but was the consensus judgment of the attending physicians that my "vital signs were stable and improving and this young, healthy body would heal itself."

We find it hard to imagine that a badly injured boy in Rochester today would not become a major intervention, high-cost case within hours. Not necessarily because it might be the "best" medicine, but because it is "expected" in the current situation *and it will be paid for.*

There is no way for anyone to predict, including highly trained professionals, whether "doing very little" or "doing everything that can be done" will produce the most desired outcome. The current public and professional expectation is that "more is better." I call this the INTERVENTION IMPERATIVE. What can be done must be done.

Cost Containment

The combination of the intervention imperative, the public expectation that this high-tech rescue system was inexpensive or free, and the growth of the health care "industry," led to the explosive growth in health care costs mentioned earlier.

As early as 1966, Congress passed the Comprehensive Health Planning and Services Act to establish oversight of plans for hospitals and expensive diagnostic devices. The hope was to limit excessive expansion of the system. Hundreds of local and state planning groups sprung up financed by federal funds. However, they had no direct authority over the many private and government organizations making capital decisions, and had little effect on the continuing growth.

The 1974 Comprehensive Health Planning Act took the further step of requiring "certificates of need" from local and state planning groups before major capital expansions could be approved. Hospitals and institutions subverted the plan by having major equipment purchases shifted to private physician groups. By the time the Reagan theme of "defederalization" became the dominant theme of the early 80s, comprehensive health planning died a quiet death as a federal program.

The 70s saw the growth of Health Maintenance Organizations. Their initial intended purpose was to reorganize care around concepts of prevention and self-management to reduce utilization. However, when the immense cash flow they could generate was discovered by their managers, *the emphasis of the entire system shifted from care management to financial management and health care emerged as a profit-making enterprise.*

In September, 1985, in the *Harvard Business Review,* Regina Herzlinger suggested that "the primary cause of health care costs is the mismatch between demand and supply, caused by a reimbursement system that motivates health care organizations to overproduce and health care consumers to over consume." The discussion began to shift from regulatory control to the emerging theme of the Reagan years, "market dynamics."

Strangely enough, the ideas which grew out of that discussion were almost entirely devoid of the most fundamental market dynamic issue Herzlinger had mentioned: Supply and demand. The "managed care" ethic which has come to dominate the current scene is primarily based in the notion that corporate management styles to reorganize the delivery system will make it more "efficient" and hence less costly. This has been accomplished to a degree by a system of "capitation" meant to shift the responsibility for cost control onto the providers of care. In effect, they make more money by providing less care rather than more. Thus, the person who answered the phone to make appointments became known as the "gatekeeper." The draconian effect of this massive effort to turn the practice of medicine into a "time and motion study" has not been unnoticed by the public. Nationwide, the media noted that audiences at the Jack Nicholson movie, *As Good As It Gets,* broke into cheering applause when an HMO was criticized for denying care to a mother with a child who needed care.

The notion of exploring the factors that drove the continuing demand for care were not addressed. And, the prevailing concept was that all that was needed were ways to reduce costs in **an exceptionally effective system.**

Different Voices

"The primary culprits behind the health care crisis: Declining trust between doctors and patients, the thrust toward specialization, reliance on "magic bullets" to treat life-style diseases,unnecessary surgery, lack of social support services for patients . . ."

Melvin Konner, M.D.
Medicine at the Crossroads; The Crisis in Health Care
1993, Pantheon Books, and PBS documentary series.

"There is a kind of virus in discussions of health care, and certainly in politics. This infection produces confident assertions that:

- We can cut waste,
- We can afford whatever we need,
- We are turning the corner on cost containment,
- More research money will cure the expensive diseases,
- Reorganization of the payment system will solve the problem.

I see no reason to believe in these magic fixes, whether scientific, bureaucratic, or financial. All future cost projections for high-tech crisis medicine tell me we are going to have to change . . . not just the mechanics of our (medical and benefit) system, but our complete way of thinking about, and understanding of, illness, health and death.

The health care problem is not quite what it appears to be on the surface. It is a crisis about the meaning and nature of health and about the place that the pursuit of health should have in our lives."

Daniel Callahan, Ph.D.
What Kind of Life ?; The Limits of Medical Progress
1990, Simon & Schuster

"Three theories have been proposed to explain the use of alternative medicine:

1. Dissatisfaction: Patients are dissatisfied with conventional treatment because it has been ineffective, has produced adverse effects, or is seen as too impersonal, too technologically oriented, and/or too costly.

2. Need for personal control: Patients seek alternative therapies because they see them as less authoritarian and more empowering and as offering them more personal autonomy and control over their health care decisions.

3. **Philosophical congruence:** Alternative therapies are attractive because they are seen as **more compatible with patient's values, world views, spiritual/religious philosophy, or beliefs regarding the meaning of health and illness."**

John A. Astin, Ph.D., Stanford University
"Why Patients Use Alternative Medicine."
Journal of the American Medical Association
May 20, 1998, Vol. 279, p. 1548

The Changing Scene - The Threshold of Discovery

This brief historical review illustrates how the perspective of the problem of ever-rising health care costs has changed as the problem continued to grow:

- 1970s, attempts to limit hospital expansion and excessive expenditures for diagnostic equipment (within a presumed to be successful system);
- 1980s, attempts to control payments to physicians and hospitals (cost containment and "utilization review");
- 1990s, a realization that the payment system itself gave incentives to both providers and patients to overuse the (presumed to be successful) system (managed care);
- Now, the emerging realization that the fundamental world view assumptions upon which the system was based are not successful in addressing the primary causes of cost - the chronic, degenerative disorders.

Thus, there is a growing discussion of three aspects of health mentioned in the introduction to this report:

- The rapid growth of interest in "alternative and complementary" therapies;

- The acknowledgement of "life-style" factors in chronic disorders, i.e., nutrition, substance use, environmental toxins, lack of exercise, emotional stress, etc.

It can be noted from the "world view" perspective that until very recently, conventional medicine denied the role of nutrition, smoking, and alcohol in the prevalence of illness.

It can also be noted that the public shift about the "acceptability" of cigarettes is a remarkable example of a growth in self-awareness based on public information provided by science but not yet "adopted" by providers of care.

- Study of the role of the practitioner / patient relationship and its effect on patient attitudes, recovery potential, and case outcomes.

The classic "double-blind" clinical study is designed specifically to eliminate any effects the practitioner's views or the patient's views might have on the process of the study. It is interesting that these potential effects were considered significant enough to design an entire system to "control for them," but not important enough to themselves be studied.

The double blind protocol places all the responsibility for outcome in the technology applied. It is essentially a system to verify technologies as they are applied to a specific "diagnosis," not one which explores how people's health can be improved. The reductionist view it rests upon is inadequate for the evaluation of living systems.

Reactions and Responses - Emerging Trends

An article by Eisenberg and colleagues in the *New England Journal of Medicine* in 1993 became a cornerstone upon which programs for innovation and change have been built. The realization by the financially concerned medical establishment that major sums of money were being spent out of pocket in an insurance-based system awakened their interest.

In addition, in December of 1994, the National Institutes of Health published an extensive report, *Alternative Medicine: Expanding Medical Horizons*. Senator Harkin of Iowa, as a result of his own experience with unconventional treatments, was instrumental in forming the Office of Complementary and Alternative Medicine in 1992 within the NIH that compiled this report. The OCAM budget has grown from $2 million in 1972 to $50 million in fiscal 1999.

As this wave of interest has grown, there has been a spectrum of responses from resistance and protection of conventional perspectives on one end to complete reevaluation of the system of care and thoughtful innovation at the other.

The Clinton Administration's 1994 attempt to redesign the payment system, and subsequent state initiatives to promote "single-payer" insurance systems have shaken up the insurance / HMO world. "Managed care" has attempted to shift the financial risk in the system to physicians and hospitals while retaining fiscal control and dictating clinical protocols. Anyone who has attended professional events in the past few years becomes immediately aware of the uprising of fear, anger, and resentment on the part of physicians, nurses, and other professionals as a result of this trend. The *Healthcare Forum Journal* has already published a series of articles, *The Beginning of the End for HMOs*.

The public has responded to these cost control strategies on the part of HMOs and insurance companies with law suits and hostility.

That's the "bad news." The "good news" is that this major upset in the field has created considerable confusion and a resulting motivation for innovation. There are literally hundreds of innovative centers and practitioner groups springing up across the country, an abundance of conferences and seminars on alternative and complementary medicine, and a widening public discussion of dissatisfaction with conventional medical practice. At the vanguard of this wave are those groups exploring a complete redesign of the care system based in a continuum of patient-centered (rather than diagnosis centered) care centered in the healing process, with the realization that the human body is a wise, self-regulating, and self-healing system. There have been hints of these ideas in employee assistance programs, hospice centers, and community based public health clinics and services.

In other words, rather than exclusively and technologically "fixing disease," how can the health care system support community health, recognize and support people's needs, and guide the patient through his/her journey to vitality? Is there a deeper self-organizing principle built into living systems which can be evoked and supported?

The Spectrum of Responses

The entire health care field is involved in some way in this pervasive change. The response moves across a spectrum from resistance and attempts to co-opt the change back into the current reductionist disease centered paradigm to emerging realizations of the deeper world view change that the entire society is exploring.

The Journal of the American Medical Association, November 11, 1998

"There is no alternative medicine. There is only scientifically proven, evidence-based medicine supported by solid data or unproven medicine, for which scientific evidence is lacking.

. . . . We must focus on fundamental issues - - namely, the patient, the target disease or condition, the proposed or practiced technique and the need for convincing data on safety and therapeutic efficacy. . . . The lack of properly designed and conducted randomized trials is a major deficiency."

George D. Lundberg, M.D.
JAMA Editor
Phil B. Fontanarosa, M.D.
Senior Editor

This is a fairly concise statement of the current warrior paradigm in medicine. Note the term "target disease or condition" illustrating the disease "attacking" perspective. As mentioned earlier, the required random double-blind studies assume that there should be no intentional forces at work in healing, only applied technologies, which are deemed completely responsible for outcomes. The physician is essentially cast as a manager of these technologies. There is little or no recognition of the human body as a living system with its own individuality, integrity and intentions, or of the patient as an intentional person.

Correspondence with Bob Flaws, a Chinese Medicine practitioner who reluctantly participated in the design of the "randomized controlled trial" described in the article *Acupuncture and Amitriptyline for Pain Due to HIV-Related Peripheral Neuropathy* in this issue of JAMA revealed that:: The acupuncture treatment consisted of application of needles at points "standardized" for the purposes of the experiment, i.e. the same for each patient without a work-up by a practitioner.

Those familiar with Chinese Medicine would quickly note that the process of treatment is designed to shift energies within a functioning system, not to "attack" symptoms. Hence, each patient might receive a very different treatment pattern, even though s/he presented similar symptoms. Hence, standardizing the treatment according to a predetermined formula is, by definition, not Chinese Medicine. However, the conclusion was that it "didn't work." The problem is essentially a world view and perception problem, not a research problem.

> "Whenever I mention systems theory (to physicians) . . . or the benefits of outcomes based research . . .I usually get a blank stare. They typically never heard of these things, never thought of these things, and don't care about these things. . . . MDs talk about inter-disciplinary approaches, but as soon as you try to explain your system to them as you actually understand and use it, they immediately want to fit it into their system, validate it in their system, or they stop listening and change the subject,"
>
> Bob Flaws

Centers in Medical Schools

The impact of the changes emerging in the health care system is significant at leading medical schools. Perhaps the most visible is the graduate fellowship program in Integrative Medicine at the University of Arizona founded by Andrew Weil, M.D. Dr. Weil's approach is to offer study in unconventional medicine to post-graduate physicians. This fairly small program plans to develop a practitioner capable of grasping several approaches and selecting those most appropriate for the presented situation. This is a most adventurous and pioneering program.

Several medical universities have opened departments or centers devoted to alternative and complementary approaches. The University of California at San Francisco has received a $10 million grant from the Bernard Osher Foundation. Columbia Presbyterian in New York has received a $5 million grant from a private donor. Other similar projects are appearing nationwide.

Not surprisingly, these projects are most frequently organized around research and professional education. It is a bit early to tell how open the research agenda will be. If the unconventional approaches are evaluated in the warrior paradigm by standardized, reductionist protocols designed to treat systems and show fairly quick results, they will most likely fail the test.

However, there is a rapidly growing interest in research based on outcomes rather than technique validation. Spearheaded in the United Kingdom, where the data is reported through the Health Outcomes Clearing House, this research includes a number of factors not included in the standardized technique validation research: Health related behaviors, measures of service utilization, community health, multidimensional health status profiles, etc. The US Agency for Health Care Policy and Research (AHCPR) has developed a CONQUEST program (the metaphor of the name can hardly be left unnoticed) - - Computerized Needs Oriented Quality Measurement Evaluation System. This emerging trend is a beginning acknowledgement by the overall system that a new research paradigm is needed in order to focus on results and patient experience rather than just validation of technologies.

Self-Standing Medically Based Centers

Almost all of the major hospital systems in Northern California are planning, or have opened, "alternative and complementary care" centers or programs. There are many others springing up around the country.

One of the first and most prominent was sponsored by Mercy Healthcare Arizona in Phoenix. Others of note include the Healing Arts Center by the River in Mishawaka, IN, and the Institute for Health and Healing at the California Pacific Medical Center in San Francisco.

Though these centers are not all operating on the same concepts, they tend to see themselves as ancillary to, and in support of, conventional medical practice. Like the university centers, they offer professional education programs to acquaint physicians and other professionals with the emerging practices.

Clinical services offered, interestingly, are usually those most obviously left out of the conventional paradigm: Social support services and groups, relaxation and meditation exercises, and healing touch or massage services. These are also those least threatening to the direct practice of disease treatment medicine. Acupuncture for pain management is the most frequent step into a true "alternative" practice. However, as in the research projects, Chinese Medicine practitioners may find themselves constrained by "managed care" clinical protocols inappropriate to their most effective means of practice.

Self-standing "Entrepreneurial" Centers

WellSPACE of Boston, American WholeHealth of Chicago, and Complete Wellness Centers of Washington, D.C., are examples of the recent development of corporate ventures bringing together alternative and complementary services.

Ranging from attractive office buildings to merger/buyout arrangements with chiropractic practices, health clubs, and spas, these enterprises have appeared within the past five years in response to the "self-pay" dollars available in the market for unconventional health care services.

There is not yet a common pattern of integration or practice exemplified by such centers. Some of them have a number of complementary practitioners available in a "one-stop shopping" facility. Others specialize in selected services, such as weight management and sports medicine. These centers appear to be market opportunity driven rather than "new paradigm" driven, hence reflect a variety of styles of service depending upon the interests of the entrepreneurs.

The question of patient process and choice, and how best to design a healing pathway for patients in their choices of practitioners does not seem to be as directly addressed in these centers as it is in collaborative practitioner groups. Generally, these centers are physician coordinated, with physicians experienced in several disciplines managing the intake process and referring patients to selected practitioners.

The most comprehensive reporter of activity in this arena, and in the hospital/university related arena, is John Weeks, publisher of *The Integrator*, a thoughtfully prepared newsletter for tracking field developments. (3345 59th Avenue, Seattle, WA 98116 -- pihcp@aol.com)

Real Estate Model

In this process, some backer or group will rent a building, then seek practitioners to sublet practice space. In the late 70s, I served on the boards of the earliest examples of this model: The San Andreas Health Council in Palo Alto and the Berkeley Holistic Health Center.

An inherent difficulty developed in these efforts. In order to assure continued rent payment, practitioners were sought who had established, successful practices. Once they were in the building, discussion began about how they might work together. The fact that each already had a successful practice as a solo practitioner inhibited change. The collaborative process was frequently perceived as a threat to the individual's economic security, and therefore to the center's security. The public and the conventional professionals were just beginning to learn about these options. No one felt well established enough to risk major change.

This model continues to emerge as the desire to have an identifiable space in which to gather is strong. Without substantial initial funding to support development of the joint effort, the inherent difficulty described above will likely arise. All of the procedural questions listed later under collaborative practitioner groups will also always apply if a joint effort is to develop.

Physician (or key practitioner) sponsored center

This can also be, in effect, a real estate model depending on the interests and intentions of the sponsoring practitioner. The inter-professional activities can range among:

- Being co-housed in the same facility with little inter-disciplinary sharing of clients.
- Informal or formal referral systems based on the experience of practitioners and the types of clients they attract.
- Specific inter-disciplinary programs that arise from client needs, i.e, pain management, weight management, chronic fatigue, etc.

The level of attention to client process may also vary from (a) simply gathering a group of technologies or practices to address diagnoses (doing to) to (b) addressing the interests, self-management capability, and personal journey of the client (being with).

It would appear that most of these centers have not yet significantly addressed the issues of joint record keeping, data management, and development of outcome information.

Non-Physician Groups

There are a large and growing number of groups and centers involving body work, yoga, nutrition classes, tai chi, energy healing, meditation and relaxation programs, and the like. They are essentially "outside" the medical and insurance systems and involve only "self-pay" activities.

There is a wide range of offerings at such centers, but they are primarily education based and do not think of their participants as "patients," with some exceptions in intensive body work.

Physicians or other primary care practitioners are rarely involved in these centers except as teachers of classes or leaders of group activities.

The growth of interest in such centers is an indication of the larger societal shift away from the passive patient toward the learning participant.

Collaborative Practitioner Groups

Perhaps the most innovative programs cognizant of the shift in the professional / patient inter-action are the hundreds of groups of practitioners springing up around the country addressing the issue of "patient-centered" care. Generally, these groups will gather outside the major institutions with some recognition of the technology bias the institutions and the insurance system use in evaluation of care. Frequently, they are physicians, complementary practitioners, nurses, physical therapists, body workers, and psychologists who seek a major shift in the context of health care. Also, each participant has usually had some direct experience of success with unconventional care.

They start out addressing:

- Client process, self-responsibility, and the role of empowerment and choice in outcomes.
- The inadequacy of conventional medicine's approaches to chronic disorders.
- The need for collaboration and open inquiry rather than turf protection and fear of liability.
- A greater trust in the innate capacity of self-healing in the human organism.
- An acknowledgement of "holism," i.e., that the human organism is a system and can not be separated into distinct parts.

- The need for trust and relationship in the interaction between professional and client. The notion of the objective scientist applying a fixed technology is questioned.
- That disease and dysfunction can be an important message in the person's life, and that inner growth and self-awareness are involved in one's health.

These are all aspects of human consciousness and how that manifests in health and disease. These groups are seeking a comprehensive revision of how we approach the whole issue of health care - - and what constitutes "quality care."

They usually begin when a group meets in the community or at professional gatherings and each discovers that s/he "has always wanted to be part of a collaborative center." Informal meetings begin to explore how that might work. Some lead to the establishment of centers, some continue to be dialog groups supporting participants in the difficult process of change, others reform themselves into subsequent groups or associations.

Since these groups usually arise fairly spontaneously, most likely spearheaded by one or a few keenly interested professionals, they initially lack any established organizational structure. They therefore face similar issues and challenges:

- Structure - profit or non-profit? Corporation? How governed?
- Why are they gathered? What types of services do people envision?
- How will practitioners communicate with one another? What kinds of clinical records should be developed and who will maintain them?
- What process will the patient / client follow? How will decisions be made about appropriate care? Who will make them?
- Since many of the proposed services are "outside" the existing HMO / insurance system, how will practitioners be paid? Will attempts be made to interact with the insurance system?
- How will practitioners be selected for participation? How would an "unsatisfactory" practitioner be removed and by whom?
- How will the billing be handled, and who will handle it? Will each practitioner bill on his/her own or will there be central billing?
- How will appointments be arranged, by a central system, or individually by each practitioner?
- How will outcome and "research" data be accumulated? What type of computer system might be required?

This is not to assume that the more established institutions do not also face these questions, but these spontaneous groups usually address them more inquiringly and directly as they are forming. In view of the fact that most professionals involved in this process have little or no business organization experience, their devotion to purpose and resolve to have the organizational form be consistent with their clinical philosophy should be acknowledged. Many meet for more than a year wrestling with these organizational questions before actually offering services.

A procedural idea that has been proposed for some time is emerging in some of these centers: The notion of a health guide / advocate / counselor who becomes the care coordinator. This person is not a practitioner or diagnostician who "manages care" or serves as a "gatekeeper." Rather s/he is a individual program designer, tracker of progress, provider of resources and support. The guide / counselor coordinates the efforts of whatever practitioners are involved, keeps joint records, keeps client activities on track, and guides the client toward useful community resources, classes, etc. This guide supports care decisions in conventional medicine as well as complementary care and provides advocacy and guidance in the "mix."

A parallel idea has emerged in conjunction with the guide - - the intake practitioner panel. In this model, still in the exploratory stages in several centers and groups, the client's initial interview would be with a guide / counselor who would provide an orientation to the several approaches available. Based on the client's interests, practitioners of several disciplines that might meet the need are chosen to meet with the client in an initial program evaluation. Discussion among the client, the guide, and the several practitioners in a one hour to hour and a half session can produce some exceptional insights and motivations for the client, and valuable inter-disciplinary connections for the practitioners.

The Health Medicine Forum in Walnut Creek, CA, is convening such panels each week to gain experience and develop protocols for their effective use. They frequently consist of a conventional physician, chiropractor, nutrition counselor, Chinese Medicine practitioner, psychologist, biofeedback practitioner, and the like. The Mayacamas Healing Network in Calistoga has also begun to explore this approach.

Many ask, "Isn't that quite labor intensive and costly to bring all those people together?" In comparison to many high-tech tests, and in light of the major insights and motivation the process provides for the client, this is actually not an excessive cost to design a productive course of action in a difficult case. Current examples of this exploration usually involve patients who have already undergone extensive diagnostic and treatment procedures with little success. The panel experience can "turn their world around" and provide options and hope. Of course, it doesn't fit too well into the current insurance billing system.

The care guide and the panel interview concepts are direct examples of the shift from "the application of technology to a defined problem" toward the design of an empowered "learning journey" for the client. This is a comprehensive shift of paradigm from a base that mistrusts the self-healing capacity of a living system (hence depends on technology to "rescue") to one that acknowledges and supports that self-healing capacity and conscious intention.

The Comprehensive Program Model

As long ago as the 60s and early 70s, "holistic" pioneers such as Evarts Loomis, M.D. of the Meadowlark Center in Hemet, CA, and Arthur Kaslow, M.D. of the Kaslow Self-Care Center in Santa Barbara, CA, proposed the "self-regulation capacity" model for chronic disorders.

Kaslow stated that the several issues he addressed at his clinic, primarily multiple sclerosis, arthritis, diabetes, and heart disease, were "all the same problem." His perspective was that these disorders were excessive distortions of the body's inherent capacity to maintain its integrity, and the "disease" was evidence of the weakest link in the system. Hence, the appropriate approach was not to "treat the disease," but rather to evaluate the picture of the person's life and (a) reduce excessive demands on the system, and (b) provide support (nutritional, emotional, inspirational) for areas of deficiency. The assumption was that offering balance and support to the person and the physiological system would create the potential for self-healing. Kaslow was also an early pioneer regarding issues of allergies, food sensitivities, and emotional responses that resulted in auto-immune responses.

Hence, programs of this kind offer a designed "life reevaluation" looking at many aspects of the patient's situation.

More recent examples include the Pritikin Program and the Ornish Program for heart rehabilitation based in exercise, nutrition, and social support. Ornish has recently expanded into cancer care as the realization arises that these kinds of programs are systemic rather than disease specific.

These programs are not universally successful, primarily because they require a major change of life patterns and personal responsibility for the improvements to persist. However, their remarkable success in many cases validates the principle of self-healing and the self-regulatory concept and, in a way, places the choices for potential improvement in the hands of the client.

The Emerging Paradigm

The conventional medical paradigm until recently has been based, as described earlier, in faith in science and technology to predict, control, and manage the processes of nature. It assumes that events in living systems occur at random according to statistical probabilities. This perspective leads to fear and mistrust of natural processes and the need to use human intelligence to "outwit death and entropy" in order to supposedly improve life.

Through this perspective, we have learned a great deal about structural function in the body. Through miraculous advances in surgery and trauma care, we have given new life and new options to many. However, in regard to understanding basic physiological function and chronic processes in the body, this highly specialized and fragmented paradigm is fundamentally inadequate and literally blocks perception of the function of living systems.

The several responses to change described in this report represent a spectrum from minor adjustment of the current paradigm to complete reevaluation. The comprehensive program model which has emerged from a number of sources represents the most "holistic" approach so far in that it is based in a belief in self-regulation and self-healing rather than the application of technologies to fix the problem.

A frequently asked question is how Eastern perspectives of medicine and Western perspectives may somehow merge and become collaborative. What is needed for this to happen is a Western paradigm based in physiology and biomedical terms that can be seen as parallel to Eastern perspectives. A barrier is the esoteric and metaphysical language used by Eastern perspectives - - chi, chakras, energy systems, etc. - - to describe phenomena in the organism. The emerging paradigm desribed here is based on a self-regulating system similar in all ways to Eastern systems, but using Western language to describe the phenomena. The basic notion is to look at two facets of the organism: 1) What factors in the person's life are overwhelming its self-regulating capacity (In Eastern language need sedation), and 2) What factors need support and nurturance (in Eastern language need tonification). As described here, these are expressed in terms of beliefs, attittudes, personal habits, etc., rather than in energetic terms. However, the principle is the same: Recover balance and function in the system rather than "attack disease."

An important factor to note is that in the comprehensive "life change" model, any and all of the available technologies can be used, according to the needs of the individual situation. The difference is that less interventive, "low tech" approaches would most likely be used **first,** in order to assess the person's capacity to respond. Only then, would high-tech, intensive interventions be used as a later resort. This is the opposite of what tends to happen now, as patients tend to arrive at the low-tech life-change approaches only after the conventional treatments have failed. Such a change could dramatically reduce total health care costs.

If we adopt the perspective that the human organism is a self-healing, self-regulating, and intentionally directed process, (A noetics point of view), then we ask a different set of questions about health and disease. Instead of "what's wrong and how can we fix it?" we would ask, "What are the factors in this person's (family's, community's) life that: (a) Support well being, self-expression, and personal fulfillment, and (b) Diminish the capacity of this person (family, community) to function optimally?"

C. Norman Shealy, M.D., a pioneer in the field and a founder of the American Holistic Medical Association, likens this process of self-regulation to a "container of system potential for self-management." When cumulative factors (from the list below) fill the container, the container begins to overflow. The system them proceeds into considerable dysfunction, incapable of maintaining regular operations. We identify this as a chronic disorder.

Factors that Effect Optimal Self-function

1. Attitudes and Beliefs

Ranging from helplessness and victimhood at one end of a spectrum over to connection, a sense of purpose and destiny, and inner motivation at the other.

Suzanne Kobasa's work in "psychological hardiness" illustrated that elders with (a) A positive attitude about the future (hope), (b) Involvement in activities which brought a sense of meaning and purpose (connection and service), and (c) A sense of control over the events of each day (competence and self-esteem), *rarely become ill*, and when they become ill, quickly recovered unless these traits were compromised.

Edwin J. Kepler, M.D., of the endocrinology department of the Mayo Clinic, published in 1943 that 200 patients with known chronic conditions improved when they undertook a simple exercise that brought to mind the sources (or lack of same) of inspiration and motivation in their lives: Worship, Service, Relationship, and Creative Play.

In the current rhetoric, this is the aspect of "spirit," i.e., what are the sources of motivation and inspiration that bring a sense of purpose and meaning to one's life. Without these, or without exploration of these aspects of a person's life, a major potential for positive life change is overlooked.

Rachel Naomi Remen's work illustrating the power of listening to people's stories and how important they are in motivating self-awareness and change is another example of this aspect of inner self-management.

Another important factor in our attitudes and beliefs is the connection (or lack of connection) to nature and community. Our cultural beliefs in materialism and individualism have left many isolated and disconnected from basic sources of emotional and spiritual nurturance which may be essential to optimal function.

Emotional Conflict and Indecision

All of Hans Selye's work on the effects of stress on the autonomic nervous system, and the more recent work on psychoneuroimmunology, tell us how built up emotional conflict in the person's life diminishes the capacity of the system to maintain integrity.

Richard Rahe's work on the effects cumulative stress events (The Holmes-Rahe Stress Scale), whether considered positive or negative, points out the limits of the system to endure excessive arousal without appropriate awareness and relaxation.

Nutritional Imbalance

There is a literal and virtual flood of data and research about the relationship between nutrition habits and chronic disorders. Unfortunately, much of this information is presented in the

reductionist paradigm, suggesting direct links between certain nutrients and specific symptoms and diseases, therefore suggesting "avoiding certain foods, or taking supplements like drugs." The fearful confusion and self-doubt this can cause at the individual and community level may contribute more to the emotional conflict and indecision factor than is relieved at the nutritional level.

A major aspect of the new paradigm is biological individuality rather than statistical or formulary prescriptions. Therefore, what is emerging is the need for understanding basic nutritional support of vitamins, minerals, and trace elements through good foods, perhaps supplemented by elements which may be lacking. If this balanced approach can be found by the individual, within the context of balance in the other factors explored here, then extensive "prescriptions" of supplements, herbs, etc. may not be needed, except as an initial remediation.

We are linked to the natural living systems of the planet, and we operate within the limits of the high-tech agricultural system which is as far off base as the medical paradigm. So, balancing one's nutritional resources does require considerable self-awareness and attention in order to discover "what's best for me."

Food Allergies, Sensitivities

There is also a considerable flood of articles and suggestions about food sensitivities and auto-immune responses. A simple thing to remember, regardless of complex testing procedures, is that any food causing major reactions *will almost certainly be among foods eaten habitually.* The simplest test is to change habits, remove habitually eaten foods, and monitor changes.

There are thousands of edible substances on the planet. A well-stocked supermarket may offer a few hundred, usually those most easily processed and packaged, not necessarily those that offer the best nutrition. Many people habitually eat fewer than fifteen. If there are foods among that fifteen that this person's system does not like, reactions will occur.

Designing a well balanced nutrition regime, with rotation of foods to avoid habitual exposure, especially with exclusion of those known to cause reactions, is not necessarily a complicated process, and may be as effective as information gained from any "diagnosis."

Environmental Contamination

This is the factor perhaps most difficult for people to manage. In the past fifty years or so, we have introduced many chemical products into our living environment. A significant number of them have been especially designed to effect living systems, i.e. pesticides and herbicides. Others may have unintended effects. In the reductionist paradigm, each of these events and products are evaluated separately, with little recognition of their cumulative effects, especially on water and soil systems.

In addition, the technology approach to medicine has relied heavily on antibiotics (consider the meaning - against life), steroids, and analgesics. Only recently are we becoming aware of how extensively the natural systems adapt to these interventions, eventually rendering them counter-productive or useless.

Hence, cleaning up our water supplies, agricultural practices, and overall relationship to the planet may become a cornerstone in our growing understanding of living systems. In addition, finding life supporting medical interventions rather than life manipulating interventions may prove to be the research horizon of the future.

The rise in chronic disorders is on a curve directly matching the rise in environmental contamination. This issue is very controversial simply because it challenges the very basis of technology, science, and the free market system as the designer of the "better" future.

This factor also includes smoking and substance abuse.

Oxygen Capacity

We can exist for some time without solid food, for a shorter time without water (unless we are in an arid, hot environment), but only a few minutes without oxygen. Sedentary lifestyles and lack of exercise reduce the total capacity of the body to absorb oxygen. It is no coincidence that the test of lung capacity is called a test of "vital capacity."

The upsurgence of interest in exercise and aerobics is an example of the rising awareness of this source of vitality. And, we discover that *recovery* through exercise of a larger capacity to absorb oxygen is readily available, even in the elderly. The system is "regenerative" rather than degenerative if given the resources it needs. And, recovery of that capacity is something only the person can do for her/himself.

Marginal Dehydration

The majority of our culture exists on coffee and soft drinks. Very few drink much clean water. We live on the "water planet." Water is the basic building block of almost every living system on the planet.

In our bodies, water plays two key roles: Cooling and waste disposal. Cooling can not be postponed, waste disposal can . Hence, if one is not drinking adequate amounts of water, unwanted materials may accumulate in the system. When this factor is combined with the environmental contamination factor, serious distortion of the self-regulating capacity of the body can result. The significant increase in the utilization of bottled water is an acknowledgement of awareness of this factor, and a recognition that our public water systems are becoming overloaded.

Postural and Structural Alignment

Growing out of the perspectives of Wilhelm Reich regarding "emotional memory" stored in the tissues of the body, a number of body work practices have sprung up centered on emotional release and realignment of body posture. Especially in cases involving major physical or emotional traumatizing life events, remarkable improvements have been achieved through this work.

Pioneers Feldenkreis, Rolf, Alexander, Trager, Hanna, Keleman, and others have furthered this perspective. As these practices developed over the past three decades, they have become more aware of the importance of linking release of "body memories" to counseling and other supportive processes to avoid the tendency for regression back to stored patterns of emotional fear and self-protection.

Infection

This, of course, was the foundation of the current "attack" paradigm in medicine. And, conventional medicine can be exceptionally effective in addressing major infection. In the emerging paradigm , this process would be undertaken in the context of the larger objective of supporting the vital processes rather than just "conquering the disease."

Traumatic Injury

Burn therapy and reconstructive surgery are the most effective achievements of conventional medicine. In the new paradigm, they would continue to be honored and used effectively.

Summary

The emerging paradigm, in ways similar to historic Eastern perspectives, recognizes the interwoven function of all aspects of the person, family, and community. Reductionist focus only on the symptoms presented in each individual becomes an inadequate view for bringing about real improvement and healing.

If the whole spirit, mind, body perspective is realized, then we would look at the factors that (a) Provide the spirit, mind, and body with the resources they need, and (b) the factors which distort the capacity of the spirit, mind, and body to self-manage and optimally function.

The spirit needs:
- Purpose and meaning.
- Connection to others and community.
- Relationship to nature.
- Expression of joy and intention.

In other words - **Inspiration and Motivation**

The mind needs:
- Definition and direction.
- A sense of self-esteem and self-capacity.
- Understanding.
- Inner peace and quiet.

In other words - **Competency**

The body needs:
- TOUCH and connection
- Oxygen.
- Water.
- Nutrients.
- Clear action instructions (lack of internal conflict).
- Movement and flexibility (freedom of action).
- Rest and relaxation.

In other words - **Support and resources**

The new paradigm of health care assumes that given the resources they need, the spirit, mind, and body will act as an intentional expression of that person's inherent gifts and potential, the definition of the "new ideal" expressed by Maslow at the beginning of this report.

Disease, rather than an enemy to be conquered, is seen as part of the natural self-regulating process of the system, requiring attention and support for self-healing.

Research will focus on systemic function in addition to biocellular events. Human health will be seen in relation to the living system of the planet.

Assumptions of conventional reductionist medicine	Assumptions of the Emerging paradigm
1. Nature is a random process. Through scientific manipulation, we can improve life.	1. Nature is intelligent and purposive. Through self-awareness and understanding of living systems, we can improve life.
2. Disease is results from "causative agents." By learning to control these agents at the biocellular level, we can "conquer" these adversaries.	2. Disease is caused by dysfunctions in the innate healing capacity of living systems. By becoming more aware of how our lives effect these systems, we can reduce disease.
3. A function of effective medicine is to manage and suppress symptoms to "normalize" function.	3. Symptoms are feedback messages within a self-managing system and can be important guides to appropriate action.
4. The purpose of diagnosis is to identify the "cause" of disease and eliminate it.	4. The purpose of evaluation is to identify those factors in the person's life which that are "overloading" self-healing capacity and also discover deficiencies in nutrition and system support. (This can include the reductionist "cause")
5. The purpose of treatment is to modify or remove symptoms of disease.	5. The purpose of "treatment" is to educate the client, re-balance the self-regulating functions, and establish new life patterns that will support innate self-healing. (This can include conventional interventions)
6. The focus of concern is disease, disability, and limitations. "Side effects" from interventions are acceptable risks in the realm of statistical probabilities.	6. The focus is on self-awareness, healthy system function, and positive alternatives. There are no side effects, only effects.
7. There is an expectation of rescue and the "quick fix" based on the assumed power of technology to manage nature.	7. There is a realization that a process which took years to develop may require some time to reverse, but the living system is capable of self-healing if given the resources it needs.
8. Responsibility for outcome is placed in the technology. The basic approach is prediction and control of events.	8. Responsibility for outcome is placed in the interaction with practitioners and in the client's choices. Outcome can not be "controlled" in a living system.
9. The patient is dependent upon professional authority and can experience feelings of loss of control and personal incompetence. Failure is frequently judged to be "non-compliance" rather than inadequacies in the system.	9. The client is given knowledgeable support, caring, and the belief that she/he can and will improve as a result of personal action.
10. Consciousness or self-awareness is an epiphenomenon of brain chemistry.	10. Consciousness is an organizing principle for all living processes.

I suspect that by not merely accepting an unforeseeable future, but by building it into my life, I may come closer to living a true life than those who struggle against it.

E. B. White

Some mornings I must get away, away from living's din;
And so I rise at break of day to watch the sky begin.
I stand beneath a maple tree, touch its emerald lace,
Or maybe spot a bumblebee intent on saying grace.

Sometimes I hear a wren in song, just pouring out;
I sniff the honeysuckles, then I stand . . . or walk about;
Till suddenly my life is whole, I'm ready, come what may!
Some mornings I must feed my soul before I start the day.

Nova Trimble Ashley

Where is the joy of life?
That fleeting sense of glory filling my soul with heaven's story?
Where in the world can I find the peace to still my rushing mind?
Who is there to hold me, loving all that is within me moving,
Offering me the world to see as a garden meant for me.

Is my joy in rainbow skies?
In flowing curls or laughing eyes?
In butterflies and autumn leaves, or perhaps in all of these?
Deep within me, gently rising, is a feeling quite surprising . . .
That the key to joie de vivre is hidden here inside of me.

Richard B. Miles

Little boy lost in search of little boy found,
You go a-wandering, wondering, stumbling, tumbling round.
When will you find what's on the tip of your mind?
Why are you blind to all you ever were, never were, really are, nearly are?
Little boy false in search of little boy true,
Will you ever be done traveling, always unraveling you?
Running away can lead you further astray.
And, as for fishing in streams for pieces of dreams,
Those pieces will never fit, what is the sense of it?
Little boy blue, don't let your little sheep roam.
It's time, come blow your horn, meet the morn,
Look and see can you be far from home?

Alan and Marilyn Bergman
Pieces of Dreams

Resources

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Medicine at the Crossroads: The Crisis in Health Care, Melvin Konner, M.D., Pantheon, 1993

Reclaiming Our Health,: Exploding the Medical Myth and Embracing the Source of True Healing, John Robbins, H. J. Kramer, 1996

Whole Healing, Elliott S. Dacher, M.D., Dutton, 1996

Manifesto for a New Medicine, James S. Gordon, M.D., Addison-Wesley, 1996

Web pages:

leeds.ac.uk/nuffield/infoservices (UK Clearing House on Health Outcomes)

ama.assn.org/sci-pubs/journals/archive/jama (Journal of the American Medical Assn.)

hcfa.gov.stats/nhe-oact (Health Care Finance Administration)

ahcpr.gov/ (Agency for Health Care Policy and Research)

Periodicals:

The Healthcare Forum Journal, The Healthcare Forum, San Francisco

Alternative Therapies in Health and Medicine, Innovision Communications, Aliso Viejo, CA

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Bedell

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The National Foundation for
Alternative Medicine

November 23, 2000

Members of the White House Commission on Complimentary and Alternative Medicine
6701 Rockledge Drive
Bethesda, MD. 20817

Dear Friends,

I have been asked to answer the following questions prior to my testimony on December 4th.

1. Should CAM be integrated with conventional medicine and why or why not?

Yes. Conventional medicine is good at some things, and not so good at other problems. The system should be opened up so that alternative treatments can be tried particularly for those problems for which conventional medicine offers only limited effectiveness.

2. What are the keys to successful integration of CAM with conventional medicine and into what policy recommendations should they be translated?

The keys to successful integration, better treatments, lower costs, and better health for all our people is to open up the system, so that treatments that are administered in other countries with proven success and no evidence of danger to the patient could be used in our country.

3. What other policy recommendations would you like to make to the Commission?

We have a closed system of medicine here in our country. In most all other areas of our society competition improves quality of products, and lowers cost. Here, the FDA, and State Medical Boards serve to prevent anything new better and lower cost from getting into the system unless produced by a pharmaceutical company or other organization with the funds needed to go through the costly FDA approval process.
This commission should recommend that non-toxic treatments administered by a properly licensed practitioner should be able to be used without FDA approval so long as there is no evidence of danger to the patient and the patient is properly informed of the contents of the treatment, and any possible side effects.

Berkley Bedell

Berkley Bedell, President
National Foundation for Alternative Medicine

Volume 1
Issue 4
Fall, 2000

EDITORIAL

Love Is Good Medicine

The NFAM has now visited 57 clinics in 16 countries and at this juncture we are beginning to develop a composite picture of some of the ways in which cancer patients are treated differently in other countries. We will address a number of those differences in coming issues. As an appropriate starting point, this issue takes a look at love. It dawned on us as we took earlier looks at featured clinics such as Park Klinik Julius Hackethal and The Hufeland Klinik for Holistic Immunotherapy that love is a conscious element in the holistic approach taken at these hospitals. Love for the patient as medicine is likely difficult to scientifically quantify, yet such love is very much a part of the more compelling alternative clinical practices we have been investigating.

In this edition of Alternative Perspectives, we look at the Neue Wicker Kliniken in Bad Nauheim, Germany. There are a number of special things about Wicker Clinic that we found. Yet, what struck us as most compelling was the insistence of the founder, Werner Wilhelm Wicker, to speak of love for the patient as a primary ingredient in his clinic's offerings.

Herr Wicker considers that the new clinic represents the future of cancer and heart disease treatment and likewise the treatment of other very serious

NEUE WICKER AT A GLANCE

ADDRESS:
Ludwigstraffe 41
61231 Bad Nauheim
Germany

PHONE:
From the US: 011 49 6032 9990
Ask to speak to Johanna Kriefall, Patient's Assistant, who is fluent in English. Johanna is available during ordinary business hours, German time, that is six hours ahead of United States Eastern Standard Time.

FAX:
From the US: 011 49 6032 999-550

INTERNET:
Internet http://neue-wicker-kliniken.de
Direct e-mail to: info@neue-wicker-kliniken.de

PHYSICIANS AND STAFF:
Herr Werner Wilhelm Wicker, Owner. Dr. med. Peter Hain, Medical Director. There are 12 doctors under the direction of Dr. Hain. There is a total of 120 support staff.

ACCOMMODATIONS:
The Neue Wicker Klinik has a total of 220 beds available. The average length of stay is 20 days, 28 days in the oncology clinic. The average number of patients on any given day, both inpatients and outpatients is between 60 and 90 patients. The average cost per day, including all requisite treatments, for both inpatients and outpatients ranges from $150 to $550 for oncology.

TREATMENTS:
Neue Wicker Kliniken treatments include: whole body hyperthermia; Dr. Budwig's oil-protein diet; frequency therapy; Dr. Burzynski's antineoplastons; mistletoe; Govallo Russian treatment; PC SPES; angiogenese inhibitor therapy; urea/keratin protocol for liver cancer; enzyme therapy; a complete detoxification department; a complete Ayurveda department; ozone and oxygen therapies, and, other treatments.

The investigation of the New Wicker Clinic in Bad Nauheim, Germany has been made possible through a most generous grant from the Wallace Research Foundation.

(Continued from cover)

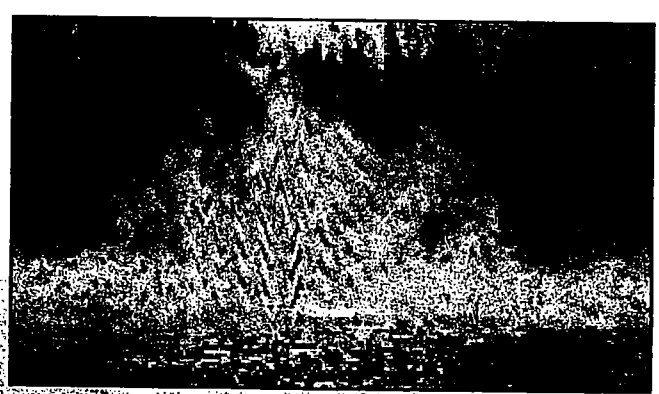
Love Is Good Medicine

maladies. What sets the Neue Wicker Clinic apart from present day conventional practice is the conscious recognition on the part of Herr Wicker and all his staff of the importance of the mind body approach to healing of which love is a necessary component.

As we have found at many other clinics we have visited, the Wicker Clinic does not just treat the tumor, as is done in conventional treatments. The whole body of the patient is treated with treatments and medications that help the body to overcome the disease. A number of treatments are administered at the same time, directed primarily at strengthening the immune system, detoxifying the body and helping the body to overcome the disease. Many of the treatments and medications used at the Wicker Clinic, although used for many years with demonstrated effectiveness with no evidence of toxicity cannot be administered in the United States because of government regulations.

Modern medical practice does run a risk when it views disease as something divorced from those aspects of life that do not specifically have to do solely with the physical. While the rules of sound scientific inquiry evident in formal medical training are necessary and to a degree absolute, there is a most necessary need for consideration of the intangible aspects. We have found approaches that consider a patient with an illness as far more than simply the sum of the physical properties. That patient is also a mind, a spirit and a soul.

Herr Wicker is to be commended for formally introducing love into the confines of a hospital. We find it laudable of him to have done so. We were blissfully optimistic on first finding love being actively practiced in a hospital and we'd like to see a lot more of that. Love may not, of itself, cure any disease of the body. Yet love's beneficial effects upon the mind, soul and spirit are potent medicine in anyone's textbook.



DEAR FRIENDS:

What an exciting year 2000 is turning out to be!

The National Foundation for Alternative Medicine has had wonderful success and the future looks even brighter. I want to share with you some of our greatest accomplishments so far this year.

We are happy to announce that actress Jane Seymour and her actor/producer husband James Keach have agreed to Chair NFAM's International Committee on Alternative and Complementary Medicine. Jane has been a long time advocate of alternative medicine and testified before Congress last year in support of the citizen's right to access alternative treatments. With the help of Jane and James I am confident that NFAM's agenda will steadily press forward over the coming months.

In February, H.B. and Jocelyn Wallace, two original supporters of NFAM, helped the Foundation take a giant step forward in securing its future by making a gift of $200,000 to create the H.B. and Jocelyn Wallace Endowment. The interest from the endowment's principal will be used to help fund NFAM's clinic investigations. We are so thankful for their generosity. We have also been notified that we are in two wills for a total of $4,000,000. Both of these contributions help to insure the long-term health of the Foundation and to set an example of another way others may help.

The primary goal of NFAM is to distribute information to the American public about the incredible medical treatments given around the world to treat disease. Some of NFAM's findings are distributed in the issues of the quarterly newsletter you are holding in your hands—Alternative Perspectives. Since the beginning of the year NFAM's subscriber list has risen from only a few hundred to over 23,000 subscribers.

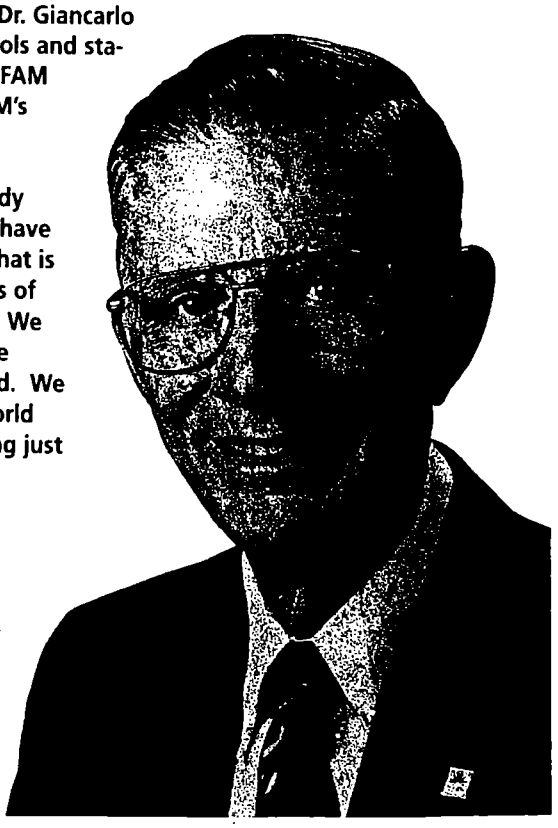
I would like to thank attorney Gail Koff, Sesame Street Producer Emily Squires, and Paraview Inc.'s CEO Sandra Martin who are members of NFAM's International Committee on Alternative and Complementary Medicine for hosting a May cocktail reception for NFAM in New York City. Over 50 people attended the party to hear a presentation by Dr. Michael Gnatt, Dr. Arnold Eggers, and myself on NFAM's clinic investigations. The evening introduced us to some great new friends. I likewise want to thank Jane and Henry Heimlich for hosting an October reception in their home in Cincinnati, OH with co-hosts Sally Dessauer and Susan Kircher, R.N. Additional receptions are planned for Washington, DC; San Francisco, CA; Naples, FL, and London, England. I hope you who live in one of these cities will join us to hear more about our work.

NFAM was a participant in the Washington, DC Cancer Conference 2000 in June. NFAM invited several of the doctors and staff of a few of the clinics we investigated in Europe to present their protocols and information to the conference attendees. Both Dr. Wolfgang Woeppel of the Hufeland Clinic in Germany and Dr. Giancarlo Pizza of the Saint Orsola -Malpighi Hospital in Italy presented their treatment protocols and statistics. Nicole Pfeffer and Sandra Zabel of the Hackethal Clinic in Germany assisted NFAM medical advisors Dr. Arnold Eggers and Dr. Michael Gnatt in the presentation of NFAM's best case series project.

This is a time of amazing opportunity. We wish to thank all of those who have already contributed to our efforts to help bring better treatments to patients. To those who have not yet contributed, we ask that you join us. One of the ways in which you can do that is through a memorial gift, as a tribute to a loved one. You can read about the specifics of a memorial donation as well as other ways to give on page seven of this newsletter. We are confident that we are going to bring better health and innovative medicine to the entire world. We have found that such innovative medicine already is being practiced. We are committed to confirming the effectiveness of these treatments and letting the world know about these remarkable advances in medicine. We are well on our way to doing just that. What mission could be more worthwhile and exciting!

Berkley Bedell

Berkley Bedell
Founder and President



Mr. Bedell is a former Member of the United States Congress who believes his Lyme disease and prostate cancer were cured by alternative treatments.

December 4, 2000

To: Members of the White House Commission on Complementary and Alternative Medicine Policy.

From: Berkley Bedell

I appreciate this opportunity to give you my beliefs in regard to the steps that need to be taken to bring better health, better medical treatments, and lower costs to our health care system.

Some of you served with me on the advisory committee to the Office of Alternative Medicine. The report language establishing that office declared that it was to "investigate and validate" alternative treatments for disease. Time after time our advisory committee passed resolutions calling upon the Office to conduct what we called "Field Trials", where we asked them to go out and conduct scientific trials to "investigate and validate" the treatments being administered at alternative medical facilities around the world. I believe the Director of the Office of Alternative Medicine was supportive of our efforts. Unfortunately the Director and top bureaucracy at NIH would not permit us to "investigate and validate" any alternative treatments.

Three years ago my wife and I decided since the government would not investigate these treatments we would try to do it ourselves. We formed the National Foundation for Alternative Medicine to "investigate and validate" alternative medical treatments. We are starting with cancer. We are sending teams with a medical doctor on the team to visit alternative cancer clinics and go over their patient records. We are finding clinics in Europe administering low cost non-toxic cancer treatments with successes that would not be expected at major cancer clinics here in the United States. These treatments are based upon a completely different concept of how to treat cancer. They treat the whole body, rather than just concentrate all efforts on destruction of the tumor. The tragedy is that some of the non-toxic medications used in these treatments cannot be administered here in this country because of FDA regulations.

In most areas of our society if one develops a better product the product grows in popularity, and the inventor benefits. This is simply not so in medicine in our country. It is no secret that employees of the FDA leave their posts to take high paying jobs with the Pharmaceutical industry and the conventional medical community. The director of NIH that was a party to preventing the Office of Alternative Medicine from "investigating and validating" alternative treatments is now President and CEO of Memorial Sloan-Kettering Cancer Center. The former Commissioner of FDA is now Dean of the Yale Medical School. His deputy Director took a job with a Pharmaceutical Company.

I have a friend who was selling Deprenyl as a supplement. He made the mistake of claiming it could help Parkinson's disease, which was true. He has a wife and young son. He has just been sentenced to 13 years in prison. The government asked that he be sentenced to life. He has not hurt anyone only helped people.

As you know, I served 12 years in the Congress. Most all of the Members of Congress are dedicated to doing what they think is in the best interest of the people. Many are fearless in that regard. However, they cannot be completely informed on all matters. Like most of our society, they are not aware of the restrictions imposed by our government on anyone who would develop a medication or treatment that might challenge conventional medicine and the pharmaceutical industry.

One of your duties is to make recommendations in regard to health policy. You have a unique opportunity. You can take advantage of it, or shrink from it. The public is turning more and more to alternative medicine. I plead with you to have the courage to recommend passage of The Access to Medical Treatment Act. This act would make it possible for these non-toxic treatments to be tried under strictly controlled circumstances. You should also recommend that any medical treatment that has been in use in a foreign country where there is no evidence of it posing a danger to the patient be permitted to be administered here in the United States. It is a crime that our people do not have access to the non-toxic treatments we are finding in Europe.

People all across our land are turning in increasing numbers to alternative medicine. You are in a unique position. You can have the courage to make a statement that will be heard, or you can shrink from this opportunity and come forth with a meaningless statement that ruffles no feathers. In the meantime, people in our country will continue to die because we are unwilling to open up the system to treatments that are being administered in other countries.

Berkley Bedell

Idaho Observer

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Terrorized in Canyonville

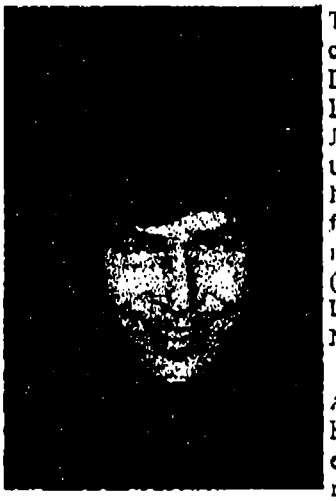
If we run into such debts as that we must be taxed in our meat and in our drink, in our necessaries and our comforts, in our labors and our amusements, for our callings and our creeds, as the people of England are, our people, like them, must come to labor sixteen hours in the twenty-four, and give the earnings of fifteen of these to the government for their debts and daily expenses;

And the sixteenth being insufficient to afford us bread, we must live, as they do now, on oatmeal and potatoes, have no time to think, no means of calling the mismanagers to

Abused in custody: Jay Kimball needs your help now

See links and contact information below.

By The Idaho Observer
http://proliberty.com/observer



TAMPA– After his October 19, 2000 conviction for violating U.S. Food and Drug Administration (FDA) labeling laws, Liquid Deprenyl Citrate (LDC) developer Jay Kimball, 60, while in the custody of the U.S. Marshal's Service, was handcuffed, waist-chained, leg-ironed and, for no apparent reason, transported 150 miles from the Hillsborough County Jail (HCJ) here to the Hendry County Jail in LaBelle. Kimball was returned to HCJ Nov. 20 with numerous injuries.

An HCJ employee reportedly stated that Kimball must have been transported in error as, considering his age and the nature of his conviction, he should never have been sent to LaBelle. LaBelle is a facility that has been described as a deplorable, inhumane and bacteria-infested hell hole.

Kimball was sentenced by Florida District Federal Judge Richard Lazzara to serve 13 years for "misbranding" LDC-a crime which would ordinarily earn a three-year prison stay. On one hand the judge said to the prosecutors, "you had thousands of names and phone numbers, you failed to produce one complaint of harm or loss, to the contrary I have seen testimony and received letters about how good the product is. NO HARM DONE."

account: but be glad to obtain subsistence by hiring ourselves to rivet their chains around the necks of our fellow sufferers.

And this is the tendency of all human governments. A departure from principle in one instance becomes a precedent for a second, that second for a third, and so on 'til the bulk of the society is reduced to be mere automatons of misery, to have no sensibilities left but for sinning and suffering...

And the forehorse of this frightful team is public debt. Taxation follows that, and in its train wretchedness and oppression.

-Thomas Jefferson

Then on the other hand he states "Mr. Kimball does not respect authority. he does not respect the law. "

Lazzara also stated that Kimball's actions were "ANARCHY" in order to justify sentencing Kimball to serve more than four times federal sentencing guidelines for such a crime.

Though the FDA has been persecuting Kimball since LDC became available to victims of degenerative diseases such as Parkinson's in 1990, the federal agency admits that there has never been one consumer complaint or even one reported adverse reaction attributable to LDC. To the contrary, the court and the FDA have been provided with the results of 3,000 clinical case studies conducted by the University of Toronto which proved the product's safety and efficacy. The court was also provided hundreds of letters from LDC users who have had their quality of life returned to them with the help of the natural nutritive plant product derived from the ephedra plant.

After Lazzara arbitrarily passed sentence on Kimball based primarily on his defiance of non-scientific federal authority, U.S. marshals took custody of the 60-year-old man and justified further abuse with a false charging report produced by the Hillsborough County Sheriff's Department.

The report, which follows Kimball through the "justice" system, stated as of 11/20/00 that Kimball had been convicted in federal court for manufacturing, distributing, dispensing and possessing cocaine.

The speedometer in the transport van containing six male and two female prisoners with no seat belts in the vehicle except for the marshals, reportedly reached 100 mph as it careened through traffic en route to LaBelle. Kimball was catapulted out of his seat two times and suffered injuries to his shoulder for which he was denied medical attention when he arrived at the LaBelle facility. He also lost his voice and experienced difficulty breathing but was not allowed to see a doctor the entire time he was behind bars in LaBelle.

U.S. Marshal Vasquez, one of the transport deputies reportedly subjected Kimball to a five-minute stream of extremely profane verbal abuse in front of LaBelle officials immediately prior to Kimball's return trip to Tampa. During the return trip Vasquez caused Kimball to fall again and injured his tailbone. Kimball did receive proper medical attention upon his return to HCJ.

Robin Hill of the U.S. Marshal's Service office in Tampa refuses to comment on her agency's treatment of Kimball but she did see to it that the charging report was changed. The report, which is available on-line at

http://www.hcso.tampa.fl.us/pub/default.asp?/online/qdisp/BN=00064435

has been changed to reflect a conviction for the manufacture, distribution and possession of "synthesized narcotics" – which is also false as Kimball was not convicted of that crime and LDC is not a synthesized narcotic.

The U.S. Marshal's Service is apparently insistent upon incorrectly identifying the nature of Kimball's conviction so that hardened prison

officials who only know Kimball by what the "official" report tells them will treat him in the worst possible manner. In the court of common sense, Kimball was convicted in federal court for helping people to overcome degenerative disease without federal approval. Since his conviction for having the courage to continue helping people regardless of his own safety, he has been physically and mentally tormented by a prison system that believes him to be a convicted drug manufacturer/dealer.

Attached for your consideration are two articles written over a year ago. They serve as an accurate overview of a decade of events that led to Kimball's federal conviction.

Please help us to stop the cruel and unusual abuse of Jay Kimball. The names and numbers provided below should hear about this. Call them. We need to flood these people, particularly the politicians, with phone calls so that they understand Kimball is not alone. For more information or verification of this example of how the federal government really views its citizens, call Don Harkins of The Idaho Observer at: (208) 255-2307.

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The National Foundation for Alternative Medicine

Volume 1, Issue 4
Fall 2000

Alternative PERSPECTIVES

EDITORIAL

Love Is Good Medicine

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(Continued on page 4)