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As a large, decentralized health care system it is not possible to adequately describe all of the integrative health care services currently being offered at our over 100 facilities in 22 states. In order to have a better idea of the services offered it is useful to first briefly describe the history of integrative health care at CHI.

History

In summer, 1997 Sister Diana Bader, Senior VP, Mission and Bobbie Ingram, VP, Chief Nursing Officer started to explore the level of interest in CAM and identify CAM best practice sites within CHI facilities. Meetings were held of interested parties and in spring, 1998 an Integrative Health Steering Committee was formed and chaired by Jerry Broccolo, VP, Spirituality. Also, in spring, 1998 a breakout session on integrating CAM was offered at CHI's first National Leadership Conference with mixed receptivity. In summer, 1998, after reviewing several proposals, a $250,000 grant was awarded by CHI to help launch the Tri-Health Integrative Medicine Initiative in Cincinnati, OH. In fall, 1998 and winter, 1999 resources related to CAM therapies and credentialing were developed by the Integrative Health Steering Committee. In summer, 1999 Carl Middleton, VP, Theology and Bioethics performed an extensive phone survey to assess the understanding of integrative medicine and inventory what CAM services were being offered. What he discovered was that the understanding and definition of "integrative medicine" varied tremendously from site to site and from person to person. He also found that there were numerous services being offered and programs being implemented with differing focuses, settings and levels of evolution or sophistication. It became apparent that with the lack of uniformity in understanding and with the amount of spontaneous activity occurring at multiple CHI facilities that a more formal strategy was needed as well as resources and tools to help those facilities exploring the use of CAM and integrative medicine. In fall, 1999 the Integrative Health Steering Committee reorganized into an Integrative Health Care Advisory Council **with a definite shift in focus from CAM to integrative health care.**

Over the course of 2000 a comprehensive care evaluation tool was developed, and Jerry Broccolo presented the CHI definition and vision of integrative health care at regional CHI meetings across the country. Carl Middleton, collaborating with several contributors, also completed the writing, compiling and editing of the Integrative Health Care Resource Manual (the table of contents of this resource manual is included after the program descriptions to give a taste of its scope and content). In September, 2000 a breakout session on integrative health care was offered at CHI's second National Leadership Conference with very favorable reviews. In November, 2000, at the request of Sister Diana Bader, Dr. Hal Ray, Senior VP, Chief Medical Officer, and John DiCola, Senior VP, Strategy and Business Development, CEOs, CFOs, VPMAs and other CHI organizational leaders from across the country gathered in Chicago for a CHI Integrative Health Care Summit. The purpose of the meeting was to get feedback and receive direction from a more representative cross-section of CHI leaders as to the future direction for integrative health care within CHI including both entry points and potential challenges or points of resistance. There was unanimity in favor of the philosophy of integrative health care as defined by the CHI

Integrative Health Care Advisory Council. There was a clear message that any implementation needs to be market and facility specific based on market readiness and medical staff readiness. There was also a consensus that integrative health care strategies need to be woven into existing CHI educational programs, service excellence initiatives, communications, and product lines or service lines, etc. to avoid duplication of efforts and to better utilize limited resources.

Program Descriptions

Several CHI facilities are offering non-invasive CAM therapies such as massage, music therapy, art therapy, humor therapy, pet therapy, guided imagery, aromatherapy, reflexology, reiki, healing touch/therapeutic touch and Tai Chi or yoga classes. In most instances these services are offered in isolation or with a relatively loose structure and not as part of a coordinated integrative health care strategy or program. St. Elizabeth Hospital in Lincoln, NE offers intercessory prayer for all patients who desire it. St. Joseph in Albuquerque, NM sells a branded line of herbal products and provides an educational resource center through its Women's Care program. Good Samaritan Hospital in Kearney, NE has broken ground on a wellness center and is preparing to offer a Dean Ornish Cardiac Program. Franciscan Health System in Tacoma, WA has a hospice and palliative care program that has won national awards for its innovative office based approach that also incorporates massage and music therapy. The Franciscan Medical Group, in Gig Harbor, WA has developed a working relationship to provide chiropractic services in its primary care offices. St. Joseph Hospital in Lexington, KY provides music therapy in the ICU to help calm patients. The following four pages describe four distinct practice models (showcased in chapter 17 of the Integrative Health Care Resource Manual) with integrative health care programs that are more evolved in their delivery of services:

Practice Model 1: Community-based Integrative Medicine
Bridges in Medicine, Albuquerque, N.M. (established February, 1997)

The premise of Bridges is to integrate conventional and complementary medicine for an individualized health plan. Bridges uses the T.E.A.M. Approach: Trained Experts in the Art of Medicine. After an extensive initial interview conducted by a primary care physician (MD or DO), the patient and the physician select the practitioners who will deliver the patient's ongoing, specialized care. This selection process is based on the patient's specific needs. In this way, Bridges in Medicine provides the patient with the knowledge and guidance to establish and maintain an ongoing program to promote health – mind, body and spirit. The patient is considered the captain of the T.E.A.M. and an equal partner in all the decision-making processes.

Bridges in Medicine provides a full network of conventional and complementary practitioners, including Oriental Medicine/acupuncture, art therapy, behavioral therapy, chiropractic, craniosacral, curanderas, Feldenkrais, herbal medicine, homeopathy, internal medicine, massage therapy, meditation, nutrition, OB/GYN, integrative pharmacy, physical therapy, Reiki, rolfing, therapeutic touch, yoga therapy and zero-balancing.

Bridges serves primarily individual patient divided into three categories:

Tier 1 – patients with chronic, multi-system disease, such as chronic fatigue or fibromyalgia.

Tier 2 – patients with chronic single-system disease, such as migraines and low back pain.

Tier 3 – patients considered to be the walking well who require education and program development for pro-active prevention.

Through an association with St. Joseph Healthcare in Albuquerque, Bridges in Medicine is presently the only fully approved Medicare program allowing Medicare beneficiaries access to a fully integrated medical model, including the modalities mentioned previously. In order to comply with Medicare regulations, Bridges has been on a fast track collaborating with a unique coding system partner. This allows the translation of complementary modalities into HCFA/insurance codes in order to collect and demonstrate cost/benefit information. *To date, it is our understanding that this has not been accomplished anywhere else in the country.* Bridges is also making inroads with private companies and commercial insurance carriers to use the Bridges in Medicine model for their employees/covered lives programs.

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Practice Model 2: Clinic/Wellness Center
Tri-Health's Integrative Health & Medicine Center, Cincinnati, Ohio

The TriHealth Integrative Health & Medicine Center is part of TriHealth, Inc. in Cincinnati, Ohio. TriHealth is a community partnership of Good Samaritan and Bethesda hospitals. Good Samaritan Hospital is a 500-bed teaching facility and Bethesda North Hospital is a 255-bed acute care facility. TriHealth has many other facilities throughout the Greater Cincinnati region. The center is located within the TriHealth Fitness and Health Pavilion, a full service fitness and medical rehabilitation center.

TriHealth's program originally started in 1996 as the Healing Arts Center and in 1998 was redesigned as the Integrative Health & Medicine Center. It was started to offer to the community and the TriHealth system a holistic approach to health care.

Services include acupuncture, biofeedback, Natural Medicine Consults (herbs, nutrition, homeopathy, supplements), Integrative Health Consultation, healing touch (energy therapy), massage therapy, craniosacral therapy, Personal Health Management (individual instruction in relaxation, imagery, meditation, etc.). Numerous education and self help classes (journaling, stress management, centering prayer, newborn massage, couples massage, etc.) are offered as well as movement classes (yoga, tai chi, qi gong, Feldenkrais).

Of those served, approximately 60 percent are persons seeking treatment of a current health condition and about 40 percent are persons who are well and seeking prevention; 75 percent are women and 25 percent are men; 70 percent are between the ages of 31 and 60.

The center has a part-time medical director. A big part of the medical director's role is both informal and formal education and relationship building with the hospital medical staffs.

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Practice Model 3: Hospital-based Service Line
St. Joseph Health Services and Hospice of the Bluegrass, Lexington, Ky.

St. Joseph Hospital, in cooperation with Hospice of the Bluegrass, has developed the Palliative Care Team. The team provides a collaborative model of care to address end of life needs for patients and their families. Palliative care is not designed to replace or duplicate the traditional hospice program already in existence in the community, but provides care for those patients with life limiting disease who may not be candidates for hospice care.

The Palliative Care Team started at Saint Joseph Hospital in January 1999. The team consists of a physician, nurse, chaplain and social worker specifically experienced in palliative care. This service was started to address care issues at the end of life. Too often, patients die in unfamiliar surroundings and in emotional and physical pain. Saint Joseph Hospital, in cooperation with Hospice of the Bluegrass, developed the Palliative Care Team to provide a collaborative model of care to address end of life needs, including symptom management, for patients and their families.

Palliative care involves the total care of patients whose disease is not responsive to curative treatments or interventions. The primary goal of palliative care is the achievement of the best possible quality of life for patients and their families. Palliative care can be a companion to the delivery of acute care services or an alternative to those services as the patient's illness progresses. Palliative care provides for specialized medical management of pain and other symptoms, assists with discussions of end of life care, assists in creating a "healing environment," facilitates communication about goals of care, and educates patients and families regarding all aspects of end of life care. Upon a patient's request, practitioners provide prayer, guided imagery, massage therapy and healing touch therapy.

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Practice Model 4: Center for Preventive and Integrative Medicine

Memorial Hospital, Chattanooga, Tenn.

Memorial Health Care System's Center for Preventive and Integrative Medicine is a department of Memorial Hospital. The center uses Memorial's management services organization to provide fiscal and clinical support. In order to reduce start-up costs, the new practice joined an established internal medicine practice that had historically incorporated a holistic approach to medicine.

Although the clinic opened in December of 1999, the program actually started in June 1998. It was at this time when Dr. Jeff Jump started training in various alternative modalities and developing the practice. The practice was started as a response to the mission of CHI and to provide the local community rational, science-based, physician-driven access to integrative medicine.

Services provided include primary care medicine, acupuncture, massage therapy, relaxation response training, guided imagery, individual exercise training, supplements and herbals. The primary audience is the greater Chattanooga area, with patients traveling from as far as Knoxville, Tennessee

Due to rapid growth other practitioners may be added such as a clinical psychologist, a mid-level provider or another physician and possibly a full-time nurse educator/program coordinator.

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Integrative Health Care: An Emerging Approach to the Art of Healing
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Question 2: **Cost/Clinical Effectiveness Research and Data for Integrative Health Care at CHI**

The use of music therapy in the ICU of Memorial Hospital in Chattanooga, TN was shown to reduce requests for pain medications and reduce demands on nursing staff.

The use of complementary therapies by the St. Joseph Palliative Care Program in Lexington, KY was shown to improve patient satisfaction.

Creating a Tool That Facilitates Data Collection

Collection of comparative data and tracking of outcomes has been an area of weakness to date in the evolving integrative health care services offered at CHI facilities. In an attempt to at least partly correct this weakness the SF-36 questions have been embedded in the comprehensive care evaluation tool developed as a resource for CHI facilities interested in integrative health care. By seamlessly embedding the SF-36 into the standard intake for new patients it is possible to extract this data at a later date for research if desired. The comprehensive care evaluation tool systematically assesses, biochemical, anatomic/structural, functional/movement, environmental and mental/emotional/spiritual issues and makes it easier for practitioners to detect and respond to areas of imbalance.

The comprehensive care evaluation tool has been piloted at four sites. The feedback was very favorable from the outpatient setting. From the inpatient setting the feedback indicated that the form was too lengthy, the patients were too sick and the nurses too busy to fill out the form. In response to this feedback an abbreviated version of the tool was created for inpatient use. A simplified version of the tool was also created for use in long term care facilities.

Creating a Funding Mechanism for Integrative Research

Many of the integrative health care programs within CHI are grappling with start up logistics, political realities and financial challenges. As a result research/data collection has not been as high a priority as everyone would like. If there were funds available to support the time and effort required for research/data collection every single integrative health care program would be involved. Even though the amount of funding for research for CAM has increased dramatically over the past few years, these funds are still very limited and seem virtually inaccessible outside of academic research centers. Most of the funding also appears to be allocated for research of CAM (in isolation) with not nearly as much funding for integrative (multidisciplinary) approaches.

In an effort to address the lack of funding availability and accessibility for research in integrative healthcare CHI has entered into dialogue with pharmaceutical companies as potential research sponsors. By identifying several combinations of supplements and pharmaceuticals that are synergistic (patentable) we have created an incentive and a mechanism for industry funding. The type of research that would be funded through this industry sponsored mechanism is truly integrative and simulates what patients are doing in real life but has been largely ignored due to lack of incentives.

CHI has an existing and very successful clinical trials program at the Franciscan Health Research Center in Tacoma, WA. By expanding the scope of trials beyond simple pharmaceutical trials to research of synergistic supplement/pharmaceutical combinations CHI expects to: collect important data; facilitate development of clinically useful integrative health care products that meet the highest research and regulatory standards; generate a new revenue stream; and, most importantly, dramatically increase funding of research in integrative health care by creating a mechanism whereby the industry that profits from these products appropriately invests in R & D because it is now able to recoup its investments through patent protections. This is an inevitable strategy because with it the FDA wins, consumers win, industry wins and health care providers win. Integrative health care is generally perceived to require collaboration between health care providers with diverse training and backgrounds. It seems every bit as important that there be regulatory, and industry collaboration in order for the robust R & D infrastructure to develop which will support explosive growth in the field of integrative health care.

Question 3: Identifying and Overcoming Organizational Challenges for Integrative Health Care at CHI

The two main challenges that have been a barrier to the advancement of integrative health care within CHI have been philosophic opposition to CAM and financial/logistical constraints. We will deal with the philosophic issues here and address the financial/logistical constraints in question 4.

Philosophic Opposition to CAM*

Within any large organization there is bound to be a divergence of opinions on any given issue. The topic of CAM is no exception.

The opposition to integrative health care comes mostly from conservative physicians who question the scientific merit of CAM therapies and fear that their patients are being taken advantage of and in some cases endangered by the use of CAM. These physicians are well intentioned but often not fully informed of the available data supporting specific CAM interventions. Typically these physicians say that they will embrace any therapy that has been validated by rigorous scientific research. Sometimes this is true but often it is possible to share data until blue in the face and they will still not believe. However, when these physicians experience first hand the benefits of CAM therapies they typically sing a very different tune. As frequent observer of this behavior and as a physician who has personally undergone this change in perspective I can vouch for the fact that sometimes first hand experience is the most persuasive tool in overcoming this type of opposition.

Another group of physicians is resentful of CAM or integrative health care because it is another change and they've had just about as much change as they can tolerate. With increasing information overload and an overwhelming number of changes in health care regulations, reimbursement, autonomy, authority, the patient-physician relationship and easy access to health care information on the internet (both good and bad), integrative health care is the "last straw." Sometimes showing these physicians that integrative health care may offer adaptive and competitive advantages in the rapidly changing health care environment is persuasive. Often these physicians are too overwhelmed to even hear what you have to say, much less accept it.

Some physicians will oppose anything related to CAM or integrative health care on the basis of a bad past experience (either personal or with a patient). These physicians are "once burned and twice shy" and tend to generalize and demonize, by association, the entire field of integrative health care on the basis of one questionable practitioner, therapy or product. The most effective approach here tends to be to point out that patients are much more likely to be hurt if there is not some degree of medical involvement or oversight to guarantee safety.

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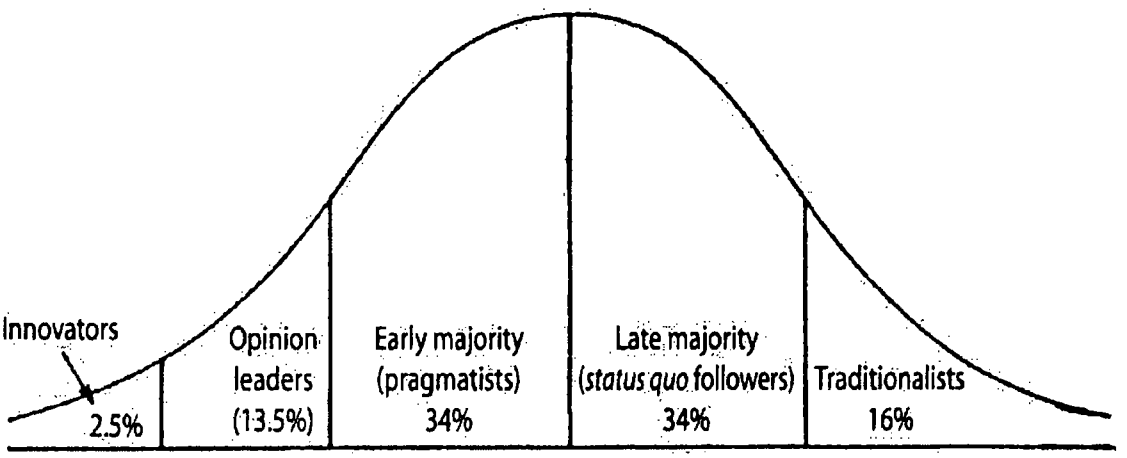
* Not philosophic opposition to integrative health care as defined at CHI (see pages 18 and 26)

Yet another group of physicians may oppose integrative health care on the basis that they perceive it as promoting spiritual beliefs or philosophies inconsistent with their strongly held religious convictions. The most useful strategy here seems to be sensitivity to this issue and respectful anticipatory education/guidance. It needs to be very clear to everyone in advance that clinically effective therapies are being offered and not belief systems or metaphysical baggage. Integrative health care, like any other clinical encounter should be free to offer patient-centered metaphysical/spiritual support if needed without imposing the beliefs of the practitioner. If this type of sensitive and respectful approach is not made clear in advance unnecessary opposition can be avoided.

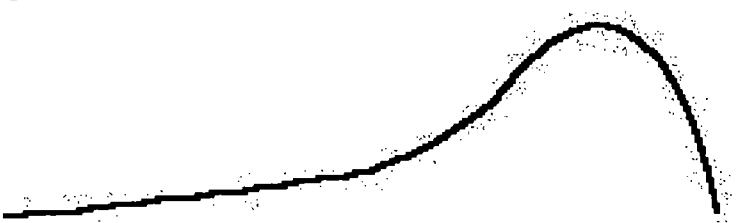
A small but distinct group of physicians also exists that will oppose integrative health care on the basis of financial reasons. Their opposition is rooted in the fear that integrative health care will somehow compete with them and reduce their income. This tends to be the most recalcitrant group. Occasionally the "if you can't beat them join them" argument persuades these physicians to embrace integrative health care (for entirely wrong reasons).

Whatever the underlying reasons for opposition, the following distribution curve illustrates the varying degrees of readiness (or resistance) for change in a group of individuals.

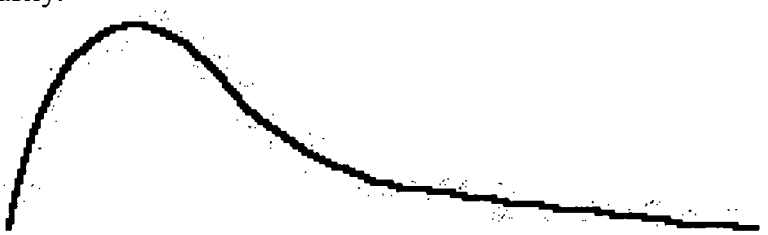
FIGURE 1 Categorical and percentile breakdown of an adoption network [Modified Rogers[7]]



If the distribution curve in your organization or facility is skewed to the right on the issue of integrative health care, progress will be slower and more painful.



If, on the other hand, the distribution curve in your facility or organization is skewed to the left relative to integrative health care then progress will proceed more easily.



Another way of looking at the philosophical opposition to change in general and to integrative health care specifically, is to revisit the stages of death and dying as described by Elizabeth Kubler-Ross. Death is, after all, the ultimate process of change and the stages of death and dying are equally applicable to the death of an old way of doing things and the acceptance of a new way. The physicians in **denial** think that integrative health care is just another fad like the pet rock and can't be bothered with it. The physicians that are raging with **anger** are upset that non-medical practitioners are stealing away the hearts, minds and wallets of patients while the income, authority of, and respect for physicians slowly erodes. The physicians who are **bargaining** think that by trying harder, prescribing better medicines and applying better technology they can somehow avoid or negate the impending consumer demands for integrative health care. Physicians who are aware of the inevitable nature of the consumer trend toward integrative health care but feel overwhelmed and unable to adapt or learn the new skills needed enter into **depression**. The physicians who understand the inevitable consumer trend and embrace it by adapting and learning new skills epitomize the **acceptance** that is needed for a change in how we deliver health care.

Whatever the reasons for opposition or whatever stage or category of opposition exists the most successful strategies I have found for overcoming opposition are:

- "*Embrace the Opposition*" -- Resist the natural urge to respond in kind to opposition, it is almost always counterproductive. By agreeing with and responding to the legitimate concerns of the opposition in a non-defensive manner the strongest opposition can sometimes become the strongest allies.
- "*Find the Common Ground*" -- If you can get the opposition to agree to what they can't possibly disagree to (at least in public), their opposition can be significantly neutralized and they may be persuaded to begrudgingly move a little more to the left of the distribution curve. In the case of integrative health care the common ground or "highest common denominator" is patient safety. Given the statistics that estimate multiple millions of Americans are having potentially dangerous interactions between supplements/herbs they are taking and their prescription medications it becomes apparent to even the most conservative physician that an open dialogue informed by credible information needs to routinely occur between patients and physicians regarding the use of CAM. Having a conservative physician admit that informed dialogue regarding CAM use needs to routinely occur with patients is a huge shift to the left on the change distribution curve.

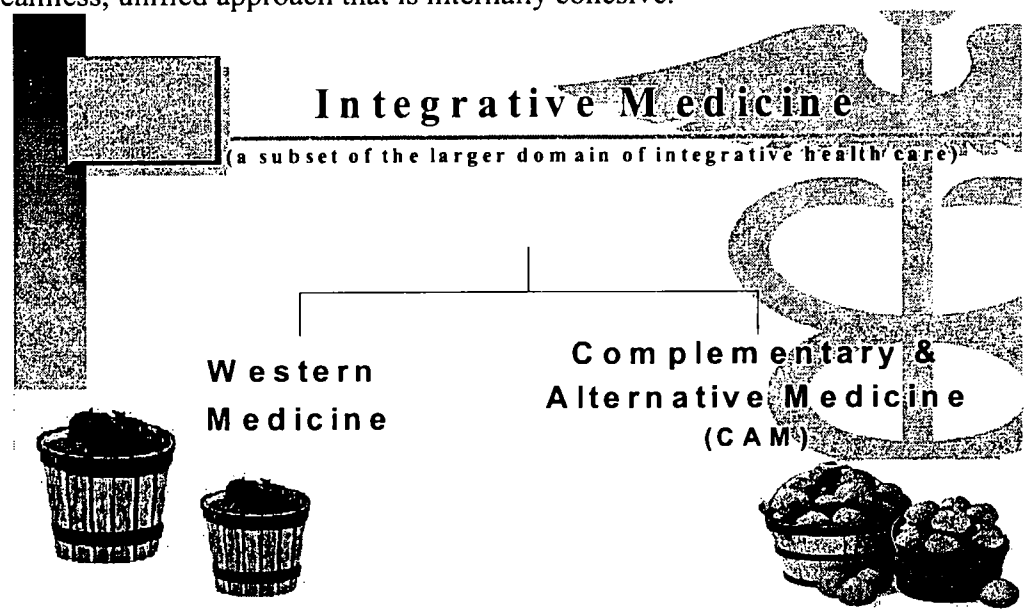
- "*Education/Credible Information*" -- If the conservative physician who has just admitted or recognized the need for informed dialogue with patients is provided with the necessary, credible sources of information their eyes are often opened to what they were once unwilling or unable to see. Education with credible information at a teachable moment can be a powerful persuader. The fact that there actually is credible data on many CAM therapies is a revelation to many physicians that allows them to move further to the left on the change distribution curve.
- "*Experience*" -- Providing opportunities for physicians or their family members to experience first hand the benefits of integrative health care can change perspectives like nothing else. Of course, if the experience is bad the damage will be hard to undo.
- "*Clearly Define an Unassailable Philosophy*" -- Some opposition occurs because what you are advocating is not clear and compelling. If your message is not understood and valued you are exposing yourself to unnecessary opposition that is based on misunderstanding. Your intelligence and motivation will likely be questioned out of misunderstanding, not out of malice. Respond to this type of opposition with clarification and reframing of the most persuasive and well thought out (in advance) philosophic reasons for integrative health care. A thick skin won't hurt either. Often when clarifying and reframing a compelling philosophy the light bulb goes on and the opposition is switched off.
- "Systematically Equip and Enable" -- Sometimes you can succeed in moving a person or an organization from the right of the change distribution curve to the left but there is still resistance. The philosophy has been accepted but the practical tools for rational implementation have not been provided. The opposition is not a disagreement about why integrative health care is valuable and necessary. The opposition is over a lack of understanding of how to proceed.

Every organization, facility and individual will be at different places on the change distribution curve for different reasons. By understanding the dynamics of change and the strategies needed to remove opposition (shifting the distribution curve to the left), the changes needed to advance integrative health care will come much more easily.

To illustrate the next to last strategy listed for avoiding or overcoming opposition the next ten pages describe the painstaking efforts of the Integrative Health Care Advisory Council to clearly define an unassailable philosophy of integrative health care.

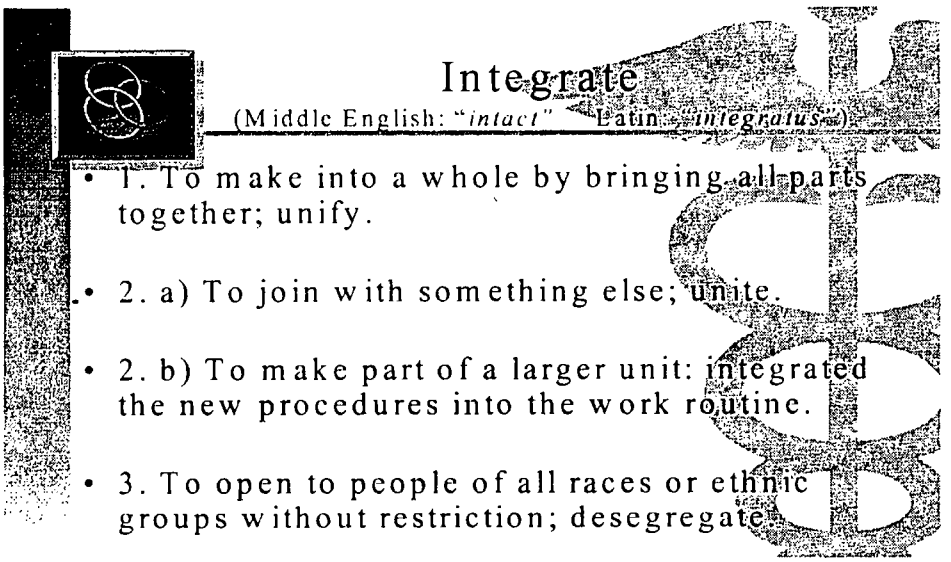
Defining Integrative Health Care at Catholic Health Initiatives (CHI)

The most common use of the term integrative medicine is to describe the combination of Western medicine with complementary and alternative medicine (CAM). The problem with this popular definition is that it does not say anything about **why** or **how** these therapies should be combined and seems to imply that Western medicine and CAM are somehow fundamentally different (thereby creating an unnecessary division between them). A more useful definition of integrative medicine would include the philosophic and intellectual rationale for combining differing therapeutic approaches into a seamless, unified approach that is internally cohesive.

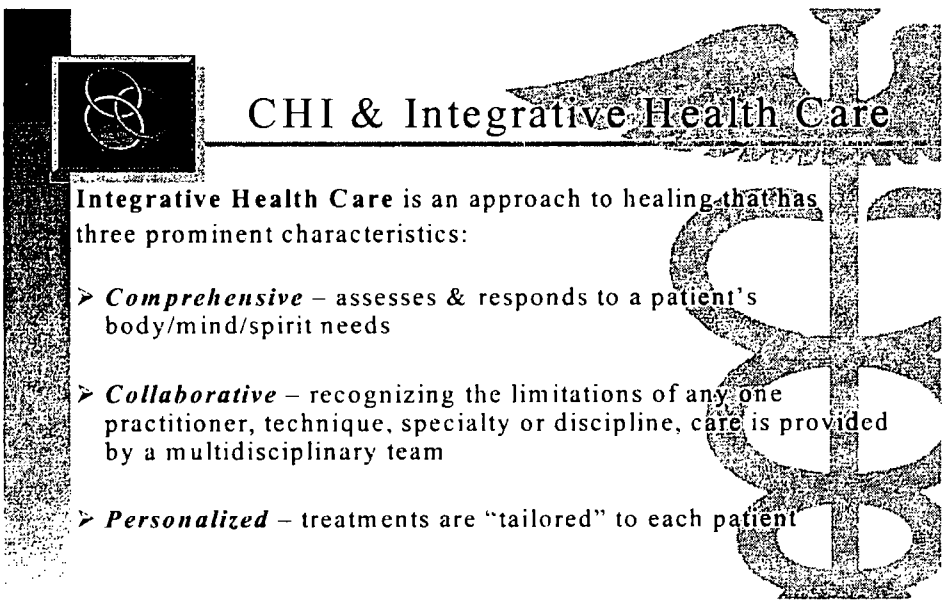


The result of integration based on a divisive taxonomy and the absence of a persuasive underlying philosophy or a logical strategy leads to results that may be interesting and unique but are also likely to be confusing and dysfunctional. Without delineating a persuasive philosophy (**why**), or a logical strategy (**how**), integration is unlikely to succeed. The painting illustrated below ("Apples and Oranges" by George W. Hart), from an integrative medicine perspective, could be just as well be called "Random Acts of Integration."

The dictionary definition of "integrate" tells us that it is a process that desegregates and brings together all parts, unifying them into wholeness. This seems particularly applicable and desirable in a highly segregated and fragmented health care delivery system that often attends to patients as if they themselves were fragmented.



At CHI our history and our mission is one of attending to the body, mind and spirit needs of the patients and communities we serve. Caring only for the body and neglecting the mind and the spirit is an artificial, fragmented approach that is inconsistent with our vision for health care. On the other hand, attending to the whole (integrated) person is entirely consistent with our mission, vision and values. Keeping this in mind, **we have framed the philosophical basis of integrative health care as care that is comprehensive in scope, collaborative by necessity and personalized by design.**



The Why of Integrative Medicine at CHI

Comprehensive

To provide comprehensive care for a patient means that their physical, emotional, social and spiritual dimensions are all adequately assessed and responded to. Sometimes the word holistic is used to describe this type of health care. Unfortunately, the use and abuse of the term holistic over the years has attached baggage and unwanted connotations to this term in the minds of many. "Comprehensive" is a more neutral term that conveys the same concept without making the hair bristle on the back of many people's necks. There can be no legitimate opposition to the provision of comprehensive care because it is "good medicine." If we were to find ourselves in the unfortunate position of needing medical care we would want comprehensive care for ourselves. The only area of debate around providing comprehensive care nowadays is whether it is cost effective and practical to do so. There are differing views in this debate, which ultimately can only be settled by research which has yet to be done and data that has yet to be collected. However, it must be perfectly clear in our minds that the debate on cost effectiveness and practicality has little or no bearing on what constitutes comprehensive care.

Personalized

While Western medicine has made remarkable advancements in the treatment of disease, there are still many chronic conditions in which it cannot adequately prevent or relieve suffering. While many of the CAM therapies have been used for millennia with good results, there are many serious conditions that they cannot adequately treat. Therefore, no one therapeutic approach has all of the answers. Whereas Western medicine has undisputed superiority and effectiveness in managing acute medical crises, CAM therapies may be more appropriate in some chronic conditions. Having an expanded array of therapeutic options allows the clinician to more effectively match the therapy to the clinical situation. Furthermore the availability of an increased number of therapeutic options also gives the patient an increased ability to make choices that he or she is comfortable with. While the power of patient preferences and beliefs may confound interpretation of clinical research there is convincing evidence that harnessing the power of patient beliefs in the clinical setting is advantageous. In light of this we can no longer afford to treat patients despite their beliefs. Also, responding to consumer expectations is a basic element of good customer service and thus makes good business sense. The spectrum of pathology and the diversity of the human condition guarantees that one size will never fit all. Having a broader array of therapeutic avenues to pursue enhances the ability to individualize or personalize therapy.

The How of Integrative Medicine at CHI

Collaborative and Multidisciplinary

"You can do what I can't. I can do what you can't. Together we can do great things." This quote, attributed to Mother Teresa, embodies the spirit of collaboration for a higher purpose. Given the exceedingly broad scope of both Western medicine and CAM

it is difficult for any one practitioner to gain mastery in all disciplines. To maintain a certain level of competence there needs to be a degree of specialization. Without specialization there is the danger of being "*a Jack of all trades and a master of none.*" In order to avoid clinical mediocrity, which compromises patient outcomes, it is important for practitioners to recognize the boundaries of their expertise and to be able to collaborate with other practitioners and other disciplines in the best interest of the patient.

Collaboration may not always mean that there is entire agreement between all of the involved parties. However, clinical collaboration does mean that all parties and disciplines involved agree that finding ways of working together is vital to improving patient outcomes. Historically conventional Western medicine practitioners and CAM practitioners have not collaborated. In many cases they haven't even talked to each other except to throw stones. It is becoming more and more obvious that patients are the ones caught in the cross fire and it is the patients who are hurt by the historic lack of collaboration. When differences of opinion or perspective tend to divide health care providers the best interest of the patient is the common ground that will allow a unity of purpose to prevail. The patient is the cure!

Patient/Community Empowerment and Responsibility

The role of lifestyle, including such things as diet, exercise and stress reduction, can have a profound effect on health. To deny this is to ignore an impressive body of research and to provide care that is anything but comprehensive. To only treat patients with interventions and therapies that they must passively submit to, disempowers them, disengages them and compromises outcomes. Western medicine tends to place patients in a more passive role while CAM often encourages a more active role by patients and communities. Integrative health care recognizes the important role patients play in their own health and attempts to engage patients and communities, whenever possible, to be an active part of the healing process and health promotion. This engagement can occur more easily through a partnering process than through a more traditional and authoritarian model of care.

Evidence Ranked Therapies

Given that both individuals and society have limited time and resources to expend on health care, the recommendation to use any therapy should be based on evidence that the therapy is safe, effective (improves favorable outcomes) and/or reduces side effects and negative outcomes (improves the margin of safety). There are many types of research and many standards of evidence that can help clinicians decide whether a particular therapy is worthy of inclusion or exclusion.

The lack of randomized clinical trials (often referred to as the "gold standard" of research), showing statistically impressive outcomes, should not necessarily exclude a therapy from consideration. Dramatic (Western medicine) interventions studied in drastic situations can more easily provide unequivocal data than can less-aggressive (CAM)

interventions studied in chronic conditions. Recognizing this may allow some CAM therapies to be used in less dangerous conditions in the absence of what some would consider unequivocal data. This is not an excuse to lower the evidentiary bar for CAM, but rather recognition that the aggressiveness of the intervention and the magnitude of the pathology have an undeniable and significant effect on the data collected.

The other factors to consider are the financial cost of "being right" (unequivocal evidence documented through the most rigorous research) and the clinical risk of "being wrong" (equivocal evidence obtained through less rigorous research) in different situations. The ease and cost of statistically proving the effect of an aggressive intervention in a drastic situation tends to be lower than the cost of statistically proving the effect of a subtle intervention in a chronic condition. Conversely, the clinical risk of being wrong in a drastic situation is much greater than the risk of being wrong in a chronic condition. The combination of these two factors suggests that higher evidentiary standards should be demanded in drastic clinical situations and that lower standards of evidence may be clinically and financially justifiable in chronic or less serious conditions. In other words, higher clinical stakes require higher evidentiary standards. Once again, this is not an excuse to lower the evidentiary bar for CAM, but rather recognition that limited resources should be used in a way that maximizes clinical benefits. Spending 100 million dollars to prove unequivocally that an aggressive intervention saves the lives of patients with coronary artery disease is probably justified. The risk of being wrong in this clinical situation is great. Spending even more money to prove, beyond a shadow of doubt, that using a dietary supplement prevents dry skin is not justifiable. The consequence or risk of being wrong in this clinical situation is negligible.

Scientific evidence does not appear in a social and clinical vacuum. Therefore it makes sense to rank scientific evidence in terms of financial cost and clinical risk. An analogous situation exists with respect to the double standard of evidence in criminal versus civil trials. Because a wrong verdict in a criminal trial has greater consequences (life and liberty) than a wrong verdict in a civil trial (monetary), the standard of proof in criminal trials is higher ("beyond a shadow of doubt") than the standard of proof required in civil trials ("more likely than not"). This is as it should be. Similarly, it does not make financial or clinical sense to expect the same standard of scientific evidence in all clinical situations. High stakes requires high standards.

If the clinical situation suggests that ironclad data unequivocally proving the efficacy of a therapy is not absolutely essential, there should still be strong evidence of safety, favorable evidence of efficacy and some plausible mechanism of action. In the absence of these three elements a therapy should be excluded from routine recommendation by clinicians.

Rational and Judicious Selection of Therapies

The classic stepped-care model of Western medicine guides selection of therapeutic choices in a way that minimizes risk. This is in keeping with the Hippocratic dictum to "*above all do no harm.*" In this model of care less aggressive (less risky and less

costly) strategies are preferred initially unless the clinical situation is more urgent—in which case more aggressive strategies are warranted. The process of taking a history, examining the patient and running any necessary tests allows a clinician to appropriately triage (risk stratify) the patient to either less aggressive (non-urgent) or more aggressive (urgent or emergency) interventions. When less aggressive therapies are chosen, then their effectiveness is monitored for a reasonable period of time. If the initial strategy has failed to achieve the desired results then the next "step up" is more aggressive. In this model treatment failure is either a lack of improvement or any evidence of progression/worsening of the condition. Therapies are categorized or ranked according to a hierarchy of steps that range from safe, simple and inexpensive on one end to risky, complicated and expensive on the other. Obviously if safe, simple and inexpensive will do the job this would be preferable. On the other hand if the preferred choice is ineffective then the risk/benefit ratio justifies a change in course.

The "risk stratified stepped-care" model of integrative health care is similar to that of conventional Western medicine. The main difference is that with the inclusion of (evidence based) CAM the hierarchy of therapeutic choices has been expanded at the lower (less aggressive) steps. The availability of increased options at the lower levels of the hierarchy of clinical interventions may obviate the need to "up the therapeutic ante." The other difference is that the assumed risks and side effects of more aggressive interventions may be reduced or mitigated by using CAM strategies synergistically along with Western medicine. This, in effect, allows the therapeutic benefit to be "stepped up" while the risk is "stepped down". The expanded array of options available in the risk stratified stepped-care model of integrative medicine allows practitioners to rationally and judiciously select which interventions are most appropriate based on the risk/benefit ratio of therapies deemed suitable for a given clinical risk stratum. It also seeks to favorably alter the risk/benefit ratio of necessary therapies that may be more aggressive.

Unifying Taxonomy Based on Presumed Mechanism(s) of Action

In order to understand when it is appropriate to use a given therapy, and just as importantly, when not to use a given therapy, it is vital that we group therapies according to how we think they work. This allows us to see similarities and differences between therapies and also enables us to match the mechanism of the therapy to the mechanism of pathology. The same classification scheme should be used for all therapies whether conventional or complementary. Western medical therapies and CAM therapies are both subsets of the larger domain of therapies available in an integrative model. To apply different classification schemes to Western medicine and CAM is neither logical nor productive when seeking integration.

There are many possible ways of grouping the multiple hundreds of existing therapies. There is no one classification scheme that is complete, authoritative or universally accepted. A potential disadvantage of a classification scheme that is based entirely on mechanism of action is that some therapies or systems of healing invoke multiple, complex mechanisms that require them to be listed under several categories.

The most recent classification scheme from the National Center for Complementary and Alternative Medicine (NCCAM), which is affiliated with the National Institutes of Health, is a hybrid approach that has most categories (domains) based on mechanism of action and a separate category for "Alternative Medical Systems" (presumably to not compromise the integrity of these healing systems by reductionistic thinking). The Alternative Medical Systems domain includes such diverse approaches as traditional Chinese medicine (TCM), homeopathy, naturopathy and ayurveda. Several of these healing systems work by multiple and distinctly different mechanisms of action. Therefore, in terms of how we think these therapies actually work, there is little reason to group them together.

NCCAM Domains				
Alternative Medical Systems	**Mind/Body Control**	**Energy Therapies**	**Biological-based Therapies**	**Manipulative and Body-based Methods**
Anthroposophically extended medicine Ayurveda Community-based health care practices Environmental medicine Latin American rural practices Native American practices Naturopathic medicine Shamanism Tibetan medicine Traditional Chinese medicine	Art therapy Biofeedback Counseling Dance therapy Guided imagery Humor therapy Hypnotherapy Meditation Music therapy Prayer therapy Psychotherapy Relaxation techniques Support groups	Acupuncture Electromagnetic fields Electrostimulation an neuromagnetic stimulation devices Polarity therapy Reiki Therapeutic touch Qi Gong	Dietary changes Supplements: vitamins, herbs, minerals, specific nutrients Orthomolecular medicine Chelation therapy Oxidizing agents	Acupressure Chiropractic medicine Feldenkrais method Massage therapy Osteopathy Reflexology Rolfing Trager method

The classification scheme currently in favor at CHI is based entirely on mechanism of action and as a result some systems of healing or therapies (such as naturopathy, ayurveda and TCM) appear in several categories, depending on the specific therapy and how it is used. This scheme refers to the NCCAM domain of "Biological-based Therapies" as "Biochemical." The "Energy" and "Mind-Body" categories are essentially the same in both classification schemes. The "Alternative Medical Systems" domain does not appear in our classification scheme, with specific systems or therapies appearing in other categories depending on their specific mechanism(s) of action.

In the classification scheme used at CHI anatomic/structural interventions can be explained by their effect on the anatomic structures of the body. Biochemical interventions can be explained on the basis of the biochemical changes they cause in the body. The effect of movement therapies can be attributed to movement or correction of imbalances in dynamic activity. Environmental therapies are based on avoidance of harmful or imbalanced influences in the environment. Mind-body therapies can be explained, at least partly by their actions on the hypothalamic-pituitary-adrenal axis. Energy therapies, usually the most difficult for Western trained physicians to accept or embrace, can be attributed to correction of electrical or electromagnetic disruptions associated with pathology. Also of note is the inclusion of Western medical therapies (shown in italics) in the relevant categories of this classification scheme.

CHI Therapy Classification (based on presumed mechanism of pathology and intervention)		
Anatomic/Structural Therapies	**Biochemical Therapies**	**Movement Therapies**
Osteopathic manipulation	Herbalism	Exercise
Craniosacral	Nutritional interventions	Alexander technique
Chiropractic	Vitamins	Feldenkrais
Neuropathy	Minerals	Tai Chi
Applied Kinesiology	Diet	Yoga
Massage	(Traditional Chinese medicine)	Edu K
Rolfing	(Ayurvedic)	(Naturopathy)
Reflexology	(Naturopathy)	Dance
STR	chelation	
NMR	(Aromatherapy?)	
(Naturopathy)	Oxidative agents	
Physical Therapy	***Pharmacology***	
Surgery		
Environmental	**Mind/Body Therapies**	**Energy Therapies**
Avoidance of:	Psychology	Traditional Chinese medicine
Allergens	Guided imagery	Acupuncture
Irritants	Pet therapy	Tai Chi
Toxic substances	NLP	Qi Gong
Air	EMDR	Ayurvedic
Water	PNI	Yoga
Soil	Biofeedback	Therapeutic/Healing touch
Food additives	Hypnosis	Reiki
Implants	Humor	Polarity therapy
Structures	Music	Biomagnetics
EMFs	Art	Electrostatic
Correction of:	Dance	Homeopathy
Dysbiosis	Counseling	(Osteopathy – some forms)
(Naturopathy)	Edu K	(Craniosacral – some forms)
	Aromatherapy	(Chiropractic – some forms)
	(Naturopathy)	(Applied Kinesiology)
	Prayer	Reflexology
	Meditation	Iridology
	Thought field therapy	(Naturopathy)
	(Ayurvedic)	(Aromatherapy)
		Phototherapy
		Thought field therapy
		Radiation Therapy
		Electro convulsive Therapy

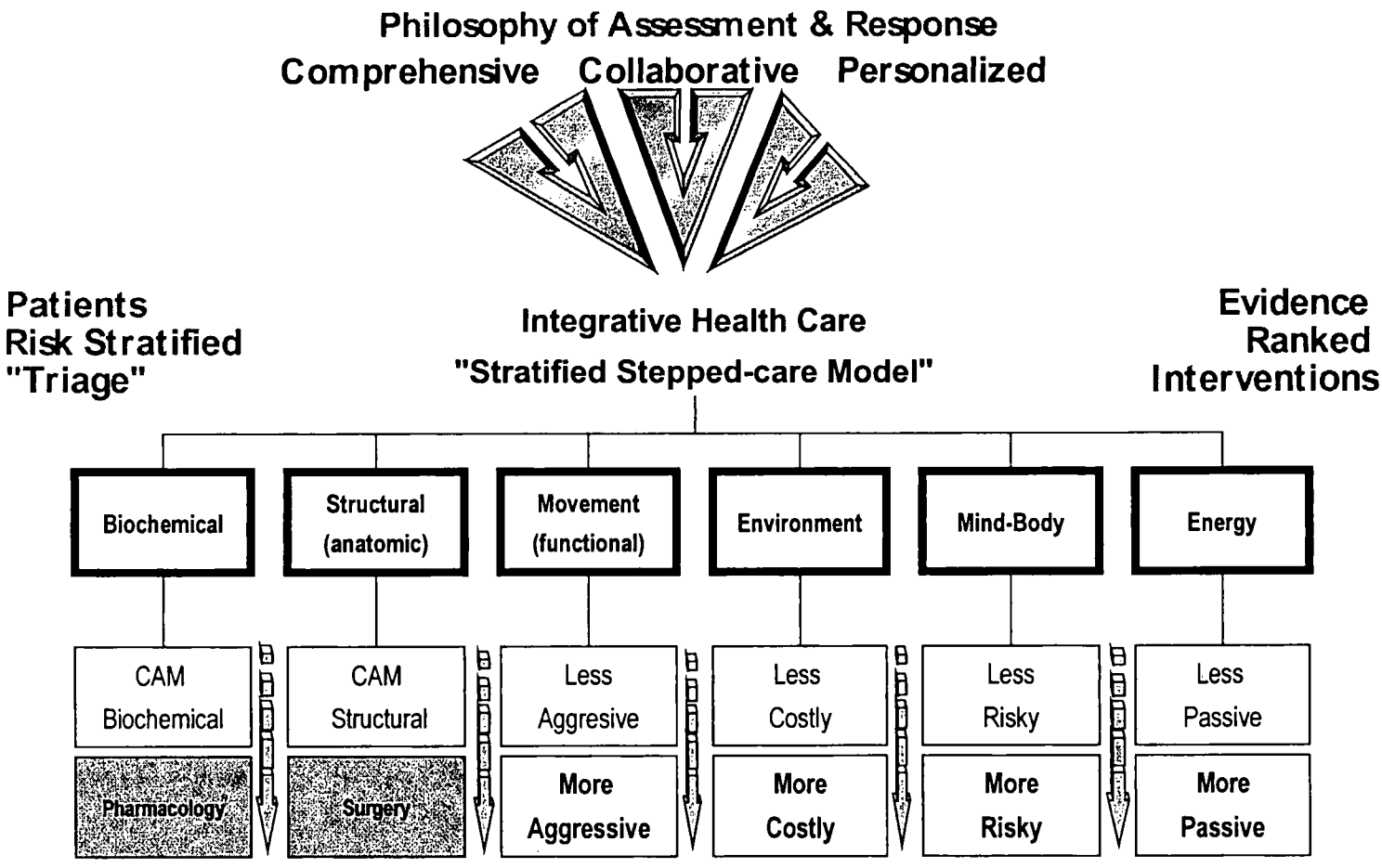
The idea that any therapy works only one way is shortsighted. Although a therapy may have a primary mode of action, there may also be secondary effects. Aromatherapy, for instance, can have a biochemical effect when the essential oils are absorbed into the body, or can invoke a strong mind/body effect when the odor triggers the olfactory nerve that connects to the emotional limbic system of the brain. Acupuncture may be predominantly an energetic tool but is also known to have biochemical consequences. In addition, the energetic and biochemical actions of acupuncture can trigger anatomic/structural changes, which can lead to changes in movement and mind/body interactions. Massage, while predominantly a structural/anatomical intervention, can have biochemical, mind/body, movement and energetic consequences.

The purpose of categorizing therapies according to mechanisms of action is not to be mechanistic, but to better understand how they can be used and which conditions/pathologies are most responsive to which therapies. Also, within any category it is possible to create a hierarchy of therapies (from less aggressive to more aggressive, less risky to more risky, less expensive to more expensive, etc.) that allows patients and physicians to make rational choices.

A Conceptual Template for Integrative Health Care

The following template illustrates graphically both the "why" and the "how" of integrative health care as we understand it at CHI and as has been described in the preceding pages.

"Conceptual Template"
(for organizing both diagnostic and therapeutic options)



Unifying Taxonomy based on presumed mechanism(s) of action

By weaving together the foundational philosophy, the clinical rationale and a unifying taxonomy the conceptual template illustrates a new approach to health care that is unified, internally cohesive and seamless. In stark contrast with the "Random Acts of Integration" depicted earlier, the convergence of concepts in the template suggests that integrative health care can offer us entirely new and innovative possibilities for improving health care.

Summary/Definition of Integrative Health Care at CHI

Integrative health care is a collaborative, multidisciplinary approach to providing comprehensive and personalized health care that encourages patient participation on the road to wellness. Choices of therapeutic recommendations, from among a continuum of interventions, are guided by clinical risk stratification as well as evidence of therapeutic safety and efficacy, with the goal of enhancing clinical outcomes and improving the risk/benefit ratio wherever possible.

Integrative health care at CHI is not about promoting complementary therapies. Integrative health care is a philosophy that, consistent with our mission, vision and values, provides comprehensive, collaborative, personalized care by drawing on the resources, skills and perspectives of a wide variety of disciplines, specialties and therapies, including complementary therapies when clinically appropriate.

Defining integrative health care this way is neither polarizing nor divisive. By pairing an unassailable philosophy with a systematic and well reasoned clinical strategy, integrative health care treats illness and promotes health in a manner that always keeps the best interests of the patient and the community in mind.

Integrative health care, by this definition, is simply good medicine.

Question 4. Common Organizational Challenges for Implementing Integrative Health Care

A number of financial and logistical constraints appear to be universally experienced by organizations trying to promote integrative health care.

At the most fundamental level of interaction between a practitioner and a patient, integrative health care is a time intensive process. To provide this type of health care in an insurance driven reimbursement model that does not adequately compensate physicians for the increased amount of time spent to provide more comprehensive care may require altruism, deep pockets, great creativity or all three.

Altruism Despite Decreased Income

The current insurance driven reimbursement model reimburses much better for focused care that is procedurally or technically oriented. Spending more time with patients to provide a comprehensive, multi-dimensional assessment and treatment is financially disadvantageous. In other words it is easier to make more money providing less comprehensive care with the current insurance reimbursement model. Benefits are defined and paid by very defined and constrained, reductionistic parameters. It should therefore come as no surprise that many medical practices gradually migrate to a more reductionistic style of practice because that is how they are paid. Despite this, many physicians remain altruistic in their commitment to providing more comprehensive care for patients even though it is not in their best financial interest. The beneficiaries of this altruism are the heart of the physician, the health of the patient, and the bank account of the health insurance company. In a capitated reimbursement model the physician could, in theory, reap the financial reward of less utilization of expensive health care resources by a patient that receives more comprehensive care. Unfortunately in real life the capitation rates are set so low that the only way to survive financially is with a high volume practice. A high volume practice does not lend itself to comprehensive, integrative care.

Even the most altruistic physician needs to pay bills and in many situations either the style of practice will change or the practice will have to close because the style of practice is not financially viable in that reimbursement model.

Deep Pockets

If an organization values the services of an owned integrative medical practice or integrative health care center, how much should they be willing to subsidize when expenses are not being met? While the pockets of organizations are usually deeper those of individual practitioners, inevitably there is a threshold of red ink that is neither justifiable nor sustainable. There are many organizations that have had to reluctantly remove life support from their integrative health care practices or programs after millions of dollars of red ink. With the corpses of these programs strewn visibly across the country it becomes much more difficult to present a convincing business case for

starting a new integrative health care center or program.

Great Creativity

It would seem, on the surface, that if the clinical model is a spectacular success but the business model is a dismal failure then all hope for the future of integrative health care is based on wishful thinking. Nothing could be farther from the truth. Creativity is what enables us to come up with a new, viable business model rather than bemoaning the unfortunate consequences of putting the new wine of integrative health care in the old skins of existing reimbursement and business models.

The assumption that integrative health care must rely on questionable reimbursement from reductionistic insurance mechanisms needs to be challenged. Research shows that patients/consumers are willing to pay for these services out of pocket. We should welcome out of pocket payment for these services. The ethical dilemma of not providing these services to those who are unable to pay can be addressed by making the business model successful enough that the profits can subsidize care for those of lesser financial means. The debate of "mission versus margin" that frequently comes up in mission-driven, not-for-profit health care systems like CHI is clearly depicted here. The answer to the circular arguments (no mission without a margin or no margin without a mission) is "mission AND margin."

To improve the margin means creative ways are needed to both reduce overhead and increase revenue. A recurrent mistake seen in integrative health care centers is to place them in high overhead settings. Aside from the "edifice complex" that invests far too much in an excessively large and luxurious practice setting the other trap is putting CAM practitioners (that generate less revenue) in a high overhead medical practice. The higher overhead of a typical medical practice (even in a less than luxurious setting) is in part a function of relying on insurance models of reimbursement, in part due to equipment and facility requirements, in part due to staffing ratios, in part due to regulatory requirements and so on. Transplanting CAM practitioners into a high overhead setting creates an inherent expense/revenue mismatch. There are many possible creative solutions including appropriate allocation of overhead, creative scheduling to maximize hours of service for the fixed expenses, virtual integration (rather than all being under one roof) and moving out of the high rent medical district. Other ways to reduce overhead include not dealing with insurance (a recurrent theme), reducing staffing ratios, having nurses/mid-level providers/ other practitioners spend the bulk of the time with the patient instead of the most expensive provider (physician).

To increase revenues means that somehow you have to provide a more valuable service that patients are willing and able to pay more for, or that you have greater throughput of the current service or product or that you diversify and add new products and services. Excellence (being the recognized market leader in providing the best of integrative, comprehensive, personalized health care) is one way to increase revenue. Volume (increased throughput of existing service) is another way to increase revenue but at some point this may be counterproductive to the quality and value of service provided,

particularly in integrative health care. Diversification (new or ancillary services and products) is one of the more common strategies used to increase revenue. In integrative health clinics this usually refers to the sale of books, videos, supplements, or other retail health related products or supplies. The fact that this is the only budget item keeping many clinics financially solvent is concerning in light of the efforts of organized medicine to declare this practice unethical and possibly subject to sanctions. Without getting into a lengthy debate on the ethical pros and cons of selling or not selling health related products in a medical setting it is important to understand that the continued efforts of organized medicine in this arena may jeopardize this revenue stream. Other products and services could include phone consultations, classes and research. Clinical research is a valuable service and a viable business strategy for many conventional medical practices. There is no reason why integrative health care research can't be used as an equally viable service and business strategy. Unless affiliated with an academic research center it is unlikely that significant research dollars will be forthcoming from typical foundation or government sources. The solution to this is to either affiliate with an academic research center or to seek other funding sources such as industry. The strategy of sustainable pharmaceutical industry-funded research alluded to in the answer to question 2 is an example of a creative way to increase revenue through diversification. If is a result of that research your patentable, synergistic supplement/pharmaceutical combination proves to be safe, efficacious and marketable, the potential for revenue sharing from patent royalties creates an entirely new revenue stream that can support your mission to provide integrative health care to all comers, regardless of ability to pay. In fact, performing the research actually allows you to provide the integrative health care to those patients for free since the expenses associated with the clinical trial are all covered by the pharmaceutical sponsor.

The financial and logistical constraints associated with the delivery of integrative health care are mostly a function of using old reimbursement models and business assumptions. The altruism of practitioners and the deep pockets of organizations will only go so far and ultimately will not compensate for a lack of creativity. Perhaps at some future date the insurance conundrum will be solved. In the mean time, letting our creative juices flow and challenging all reimbursement and business assumptions is vital to allow integrative health care to thrive.

Question 5 Recommendations To Facilitate Integrative Health Care at CHI

Aside from the many recommendations and strategies already described in the answers to questions 2, 3 and 4, I would strongly recommend that CHI collaborate with other organizations that share the same vision and values. Internally, CHI needs to increase its efforts to provide employee access to integrative health care benefits.

In clearly defining a compelling philosophy for integrative health care, building organizational consensus and commitment through education, providing systematic and practical tools for market/facility specific implementation and creatively challenging current assumptions regarding reimbursement and business models, I feel that CHI is preparing fertile soil in which integrative health care can both have deep roots and reach for the sky.

Milt Hammerly, MD -- Biographical Sketch

Milt grew up in Vancouver, BC and graduated there from Simon Fraser University in 1981 with a BSc in Kinesiology. He went on to graduate from the Medical College of Wisconsin in 1986 and completed Family Practice residency at Grant Medical Center in Columbus, Ohio and Board Certification the summer of 1989.

After residency Dr Hammerly settled down in Denver, CO where he has worked in various clinical and administrative capacities for a number of health care organizations. Other than the important roles of diet, exercise and stress reduction in disease prevention and health promotion (garnered from his undergraduate education), Dr Hammerly was skeptical about the use of CAM and did not incorporate these approaches into his practice nor recommend them to patients.

As a result of a ski-injury in college, Milt had undergone three knee surgeries but was still experiencing chronic pain, swelling and limitation of activities. When medications were not tolerated and the use of CAM (tried skeptically on the advice of a patient) provided dramatic relief Dr Hammerly's perspective on the use of CAM changed significantly. Until then any reports of favorable responses to the use of CAM by others were considered mere "anecdotes." His personal experience, on the other hand, was clearly a "case report." With this change in perspective he vigorously pursued finding data, studying, taking courses and self-experimentation with the use of CAM. Convinced of the data in support of using specific CAM interventions in specific clinical situations he gradually started to incorporate these approaches into his practice and to refer patients to qualified CAM practitioners.

In 1996 Milt opened an integrative medicine clinic in Littleton, CO with a team of over 30 CAM practitioners. As the director of this clinic he gained invaluable experience and insights on the value of collaboration and on the value of integrative health care, particularly in patients with chronic disease. In 1997 Dr Hammerly became Medical Director of CAM for Centura Health, the largest health care provider in Colorado (and part of CHI). In August of 1999 he accepted a position with CHI as their Director of Integrative Medicine. This role involves educating, consulting and developing a research program and implementation strategies for those CHI facilities interested in integrative health care.

Dr Hammerly maintains an active clinical practice. He is also a contributing editor for the AltMedDex and AltCareDex medical databases produced by Micromedex and is a volunteer physician for Colorado HealthSite (**www.coloradohealthnet.org**). He has spoken across the country to medical societies, hospital staffs, the VHA, hospital administrators and lay audiences on a wide array of topics related to integrative health care. He has testified for the Colorado state HEWI committee regarding legislation affecting physicians who practice integrative medicine. He recently authored a series of books for the general public on an integrative health care approach to fibromyalgia, menopause, diabetes and depression. The fibromyalgia book is currently available in bookstores and online. The remaining three books are scheduled for release in 2001. His web site is: **www.healingpartner.com**

Milt can be contacted by phone at 303-778-5818 or fax at 877-897-3993.

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Divider Title: Bios

Jeanne Andrews

Bio-Sketch

I am a 54 year old wife, mother of four, former resource teacher, presently working part time in a home design boutique. My life has revolved around the theater and dance, performing in community and church shows, staging and choreography. I also enjoy painting and photography. I love all sports, not just as a spectator, but as a player, since my childhood growing up in Cleveland. About five years ago I started playing golf, a real challenge. However, my biggest challenge has been battling Stage IV colon cancer. Metastic cancer was discovered March of 1990 after a resection of my colon was performed. While undergoing six months of chemotherapy, I knew there had to be something more. I started to investigate complementary and alternative medicines. My diet changed along with my thinking regarding traditional medicine. I began acupuncture, Chinese herbs, massage therapy, and reiki. Prayer has always been a part of my life, but it was expanded with an "Angel Brigade". When a second very large tumor(too large on which to operate) appeared in the spring of 2000, followed by just six weeks of an experimental drug, I began traveling to New Jersey to practice QiGong over a three month period. I was operated on in mid September and what should have been "the worse case scenario" according to the surgeons, turned out to be "the best case scenario". After a speedy recovery, I continue with my new life changes. I'm completing a series of radiation treatments for preventative measures, but am considered cancer free. I've always been a positive person and remain positive, which is a big part of the battle. My QiGong master has instilled in me that "one cannot fear cancer", we have to "take control of our lives", and that cancer "is not incurable". My hope is that others will realize this.

Robert C. Atkins, M.D.
Biography

Robert C. Atkins, M.D. is the founder and executive medical director of the Atkins Center for Complementary Medicine in New York City. A 1951 graduate of the University of Michigan, he received his medical degree from Cornell University Medical School in 1955, and went on to specialize in cardiology. He has been a practicing physician for over 30 years and has cared for over 60,000 patients.

Along with seeing patients daily, Dr. Atkins continues to champion the natural healing arts as a rational and effective alternative to pharmaceutical drugs and surgery for many debilitating illnesses. Dr. Atkins has helped to bring national attention and credibility to complementary medicine as a serious and effective medical approach. A modern-day founder of complementary medicine, Dr. Atkins also continues to be a prolific writer and sought after speaker.

Dr. Atkins is the author of several books which promote nutritional medicine as an alternative and complementary medical technique. His most recent book, Dr. Atkins Age-Defying Diet Revolution (2000) describes in detail how many of the common diseases of aging can be prevented or reversed through proper diet and nutritional supplementation. Dr. Atkins' New Diet Revolution (1992) has remained on the New York Times bestseller list for over three years. He recently released Dr. Atkins' New Diet Revolution: Revised and Updated (1999), which features three new chapters. His original Dr. Atkins Diet Revolution (1972) is one of the top 50 best-selling books of all time. He and his wife Veronica released Dr. Atkins Quick and Easy New Diet Cookbook (1997). Dr. Atkins' Vita-Nutrient Solution: Nature's Answer to Drugs (1998) is a comprehensive guide to using natural vita-nutrient (vitamins, minerals, herbs, etc.) supplementation to address, prevent and reverse chronic disease.

As a leader in the areas of natural medicine and nutritional pharmacology, he has built an international reputation. He is the recipient of the World Organization of Alternative Medicine's Recognition of Achievement Award and was the National Health Federation's Man of the Year. Dr. Atkins is also the co-founder and past president of the Foundation for the Advancement of Innovative Medicine. He lives in New York City with his wife, Veronica.

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DENNIS V.C. AWANG, Ph.D., F.C.I.C. *

A graduate of Queen's University, Kingston, Ontario [B.Sc. (1960); Ph.D. (1967)], Dr. Awang did postdoctoral studies in organic chemistry at the Universities of Michigan and Illinois in the United States. He was employed as a Research Scientist at Health and Welfare Canada for 24 years, prior to establishing his own consulting business. At the Bureau of Drug Research of the Health Protection Branch, he directed research in support of the regulatory bureaux of the Drugs Directorate, in the areas of drug stability and methodology development for antibiotics, hormones and natural products. He was also, for many years, the official spokesperson in herbal science for the Canadian government. The author of over 100 research and scientific publications, Dr. Awang is on the Editorial Advisory Board of the *Journal of Herbs, Spices and Medicinal Plants*, *Alternative Therapies in Women's Health* Newsletter and the new *Journal of Ethnomedicine and Drug Development*, a contributing editor to *HerbalGram*, the organ of the American Botanical Council (ABC) and Herb Research Foundation, as well as one of the regular authors of the Canadian Pharmaceutical Journal's *Herbal Medicine* series of reviews, and a regular lecturer and media commentator on medicinal plant/natural products science. He is also a member of the ABC's Advisory Board, the USP Advisory Panel on Identification and Standardization of Natural Products, as well as having served on the faculty of Columbia University's annual course on Herbal Medicine for physicians. Dr. Awang is co-editor of *HerbWatch*, a new quarterly review of clinical research on medicinal plants. He also serves on the Advisory Committee of the University of Illinois at Chicago/U.S. National Institutes of Health (NIH) – Botanical Dietary Supplements Research Center (BDSRC), and has recently been appointed Chair of the Advisory Committee of the new NIH BDSRC at Purdue University.

* Fellow of the Chemical Institute of Canada (1988).

BERKLEY BEDELL

When he was 15 years old, Berkley Bedell took $50 earned from his newspaper route and started a business of making and selling fishing flies. This business has grown to where it is now claimed to be the largest fishing tackle manufacturing company in the nation, with plants in the United States, Taiwan, Canada, and Sweden, and offices around the world. The Company, Outdoor Technologies Group, now includes three major brands, Berkley, Fenwick, and Abu-Garcia, producing all types of sport fishing tackle. There has never been any outside investment in the Company, with the growth financed by profits and that $50 investment. It has continued to be a family owned business, now owned and operated by Mr. Bedell's son, Tom Bedell.

Berkley and Company was awarded the National Sporting Goods Wholesalers Fishing Tackle Manufacturer of the Year award 10 times during a recent 11 year period.

Mr. Bedell served as a flying instructor during World War II.

In 1964 he was named the first National Small Business Person of the Year in a ceremony at the Rose Garden of the White House. He has been named Spirit Lake, Iowa Citizen of the Year, and Iowa Inventor of the Year. He serves on the President's Council of the National Academy of Sciences.

He was elected to the United States Congress in 1975, and served 6 terms. He was elected from the then sixth district of Iowa, which consists of roughly the northwest 1/4 of the state, which is the most Republican district in Iowa. He was the only Democrat ever re-elected from that district, and after his first election always won by margins of over 60%. He served on the Agriculture and Small business Committees, where he was chairman of various sub-committees. He was also active in peace and environmental issues, and was responsible for significant changes in military purchasing procedures.

He retired from Congress in 1988 because of contracting Lyme Disease from a tick bite while fishing. Shortly thereafter he was also diagnosed with prostate cancer. Because he believes his illnesses were solved by alternative types of medical treatment, he is actively involved in the investigation of such treatments. Working with Senator Tom Harkin of Iowa, he was largely responsible for the establishment of The Office of Alternative Medicine at the National Institutes of Health with the mandate to "investigate and validate" alternative treatments for disease. He served as a member of the advisory board to that Office.

Working with Senator Tom Daschle of South Dakota, he helped to write and has actively worked for passage of The Access to Medical Treatment Act, which would make it possible for alternative types of treatment to be tried under carefully controlled circumstances.

He is founder and President of The National Foundation for Alternative Medicine, formed to investigate patient records at clinics world wide, and where effectiveness can be confirmed make such information available to the public.

Biography: Lori Bielinski, LMP

Lori joined the Office of the Insurance Commissioner in December of 1996 in the Health Policy Division, working with health care provider issues, reproductive health, complementary and alternative health care integration, tribal health, community outreach development, and public safety and emergency transport coverage issues.

Since at the OIC Lori has conducted a "first-ever" survey on reproductive health benefits. Recently, Lori has been funded by two grants to re-survey all Washington insurers on their coverage of comprehensive women's health care benefits, and is scheduled for release in February 2000.

Lori is the primary policy analyst at the OIC on integrated health care insurance issues and has managed a workgroup of over 50 people discussing the insurance coverage issues facing CAM providers and health insurance companies. Lori has coordinated a writing committee to capture the three-year process in another "first-ever" report of its kind.

Prior to working at the OIC Lori was a licensed massage therapist in private practice in Seattle, Washington for six years. With her background in lobbying Lori became active in the American Massage Therapy Association. She held both state and national positions with the AMTA, developing licensing laws throughout the country for massage therapy and other CAM professions.

Candace Campbell
Executive Director

Ms. Campbell has been executive director of the APMA since 1994. She has been responsible for developing and implementing APMA's federal lobbying agenda; coordinating a grassroots coalition of 65 allied health organizations; establishing APMA's Legal & Education Foundation; and researching and co-authoring the *National Plan to Advance the Integration of Health Care*. She has been a speaker at dozens of industry conferences.

Prior to joining APMA, she was president of Campbell & Company, a public relations firm that handled public policy issues ranging from the Dietary Supplement Health and Education Act to Native American rights and religious freedom. As a freelance writer for many years, Ms. Campbell wrote speeches for members of Congress and CEOs of corporations. Her articles have appeared in numerous newspapers and magazines, including *The New York Times*, *The Washington Post*, *The Washington Times*, *Washingtonian*, *Baltimore Magazine* and *Self*. From 1977 to 1981, she served as assistant press secretary and then press secretary to U.S. Senator Harrison A. Williams (D-NJ). Her tenure there encompassed the Abscam investigation and trial of the senator.

EDUCATIONAL BACKGROUND:

Richard E. Collins is a Nebraska native, graduating from the University of Nebraska College of Medicine in 1968. He completed his internship at Immanuel Medical Center in Omaha. Following this, he received a Master of Science in Biomedical Engineering from Drexel University in Philadelphia, Pennsylvania in 1971; served in the U.S. Navy and was a physician to the United States Congress from 1972-73; completed Graduate School for Internal Medicine in Rochester, Minnesota, at the Mayo Clinic in 1976; and his Cardiology Fellowship at Mayo Clinic in 1978. He is a fellow in the American College of Chest Physicians and the American College of Cardiology, maintains membership in several professional organizations, and serves on the Speakers Bureau of many pharmaceutical companies.

CURRENT AND PAST POSITIONS HELD:

Dr. Collins was instrumental in the formation of the Alegent Health Heart Institute and served as the Medical Director from 1993 to 1997. In addition, he continues to serve as the Medical Director of the Dr. Ornish Heart Disease Reversal & Prevention Program at Alegent Health. The Alegent Health Heart Institute was the site of the first demonstration project for this California-based program. His strong commitment to lifestyle modification as a means to reverse and/or prevent heart disease and other diseases is evident in his work. His interest is in integrated medicine promoting healthy lifestyle modifications, including the areas of diet, exercise and stress management. Dr. Collins is involved with outreach services for the Winnebago Indian Reservation in Winnebago, NE, providing prevention and nutrition education, along with health care.

ACHIEVEMENTS:

Dr. Collins has devoted a tremendous amount of time to the creation of culinary dishes using only ingredients known to promote good health. He is nationally recognized as "The Cooking Cardiologist". His creativity in the kitchen has resulted in delicious, heart-healthy dishes which have established him as a popular speaker for national meetings and conventions for prevention and nutrition. This interest has resulted in the production of his own cooking video and cookbook. His outgoing, innovative personality coupled with his enthusiasm and knowledge of lifestyle modification techniques keeps his schedule heavily booked for presentations to all age groups.

PERSONAL INFORMATION:

Dr. Collins is a firm believer in "looking on the light side" of life and has conducted many programs on humor and how it can positively affect the heart. As one of the most recognizable physicians in the metropolitan Omaha area, Dr. Collins tends to lead by example in all that he does. Not only is he an outstanding physician, but his service to the community extends far beyond the daily care of his patients.

Dr. Collins and his wife, Donna, are parents to three daughters; Heather, Kelly and Robyn.

Patricia D. Culliton M.A., L. Ac. is Director of the Complementary and Alternative Medicine Division at Hennepin County Medical Center in Minneapolis, MN and the Director of Alternative Medicine for the Center for Addiction and Alternative Medicine Research, an NIH, National Center for Complementary and Alternative Medicine funded program. She has a Master of Arts degree in Rehabilitation and is a Nationally Board Certified Acupuncturist. Ms. Culliton has been developing and implementing acupuncture research since 1981. She has developed an integrative service model that includes a staff of 18 non-physician CAM providers that render patient care, education and research. She has published several articles and book chapters about the use of acupuncture and other modalities for the treatment of addictions and pain. Ms. Culliton is a founding board member of the National Acupuncture Detoxification Association and the Society for Acupuncture Research. She is a part of several NIH funded research grants, helped develop a Post-Doctoral Fellowship program in Alternative Medicine and consults with agencies regarding Complementary and Alternative Medicine both nationally and internationally.

James N. Dillard, M.D., D.C., C.Ac., F.A.A.P.M.&R.
Medical Director, Oxford Complementary and Alternative Medicine
Attending Physician, The New York-Presbyterian Hospitals
Faculty, Columbia University College of Physicians and Surgeons
Alternative Medicine Expert and Columnist, OnHealth.com

Dr. Dillard is the founding Medical Director for Oxford Health Plans Alternative Medicine program, and the chairman of the Oxford Chiropractic Advisory Board. He is a board certified medical doctor, doctor of chiropractic and a certified medical acupuncturist. Dr. Dillard is an Assistant Clinical Professor at Columbia University College of Physicians and Surgeons, and on the medical staff at the New York-Presbyterian Hospitals Columbia Medical Center. He is the Director of Complementary Medicine Services at University Pain Center in Manhattan. He also serves as Clinical Advisor to the Rosenthal Center for Complementary and Alternative Medicine, an NIH - NCCAM granted research and education center at Columbia University College of Physicians and Surgeons under the direction of Fredi Kronenberg, Ph.D.

Dr. Dillard conducted research in spinal biomechanics with Gunnar Andersson, M.D., Ph.D., at Rush Presbyterian-St. Luke's Medical Center in Chicago while earning his medical degree at Rush Medical College. His research was published in the journal SPINE. He was elected to the medical honor society, Alpha Omega Alpha, and graduated in 1990. Dr. Dillard also did cancer and transplantation immunology research at the University of California, Los Angeles, while earning his Doctor of Chiropractic degree from Cleveland Chiropractic College and attending California Acupuncture College.

Dr. Dillard is the author of Alternative Medicine for Dummies, published by IDG Books Worldwide. He is the Alternative Health content expert and columnist for the #1 health web site in the world, OnHealth.com. He is currently under contract with Bantam/Random House to write a comprehensive guide on how to integrate the best of conventional and alternative medicine for chronic pain. Dr. Dillard has been featured in such publications as Newsweek, People, Town and Country, Outside, Mademoiselle, Shape, Woman's World, McCall's, Elle, Women's Sports and Fitness, Parenting and many others. He has appeared on the Oprah Winfrey Show, Good Morning America, The View, The Today Show, National Public Radio, The CBS Evening News, Donny and Marie, Good Day New York, and many other broadcasts.

Denise Drayton
Biography

Denise had been addicted to drugs for 20 years. After turning her life around she began her recovery process 10 years ago. Ms. Drayton has been working in the field of HIV/AIDS for the last 9 years: first a client and graduate of the ARRIVE training program, as a peer educator and outreach worker with ARRIVE and later as a pre and post test counselor at Cumberland Hospital. It was while at Cumberland that she began working with substance-users that were also HIV positive. Since then her career has been dedicated to the substance user and HIV community. She has served Exponents Inc. as a Board Member. Later as an employee of Exponents, she has held the positions of Coordinator of Outreach, lead developer and Assistant Director of the PWA/Leadership Training Institute and Coordinator of the Exponents Educational Services Section an AIDS Institute Regional Training Center. Currently Denise Drayton is the Assistant Director of Education. She is also a member of the board for AIDS Medicine and Miracles.

Robert M. Duggan, M.A., M.Ac.(UK), Dipl.Ac.(NCCA)

A practitioner of acupuncture for almost 30 years, Robert Duggan is President and co-founder of the Traditional Acupuncture Institute in Columbia, Maryland. He studied acupuncture with Professor J. R. Worsley in England from 1972 – 1974. He received his Master's Degree in Education from New York University in 1970 and holds degrees in Philosophy, Theology, Human Relations, and Community Organization. Mr. Duggan co-directs the Johns Hopkins University Medical School *Building Bridges* Program in Complementary Medicine. He participated in the White House Panel on Complementary Medicine during the healthcare debate in 1993. He participated in the NIH Office of Alternative Medicine strategic planning conference, also known as the Chantilly Report. He served as a Commissioner on the National Accreditation Commission for Schools and Colleges of Acupuncture, and as Chair of the Maryland State Board of Acupuncture. He is an active member of the National Alliance for Acupuncture and Oriental Medicine.

Tai Sophia Institute

Tai Sophia Institute is the new name for the expanded Traditional Acupuncture Institute which was founded in Columbia, Maryland 25 years ago, and was the first accredited school of its kind in the nation. Over 600 graduates of the Institute's three-year, fully accredited Master of Acupuncture Degree Program now constitute approximately 6% of the practicing acupuncturists in the country. Enrollment has doubled over the past five years. Today, it has over 200 graduate students, 58 staff, and 100 faculty members. In Fall 2001, the Institute is enlarging academic scope through the addition of two new Masters Degree Programs in Applied Healing Arts and Botanical Healing. The latter, under the direction of Simon Mills, will be the country's first Master's Program in Herbal Medicine.

There are currently over 25,000 annual patient visits to the school's acupuncture Clinics in Columbia, Baltimore, and Wheaton, Maryland. A Baltimore Community Health Initiative has, for five years, focused on people recovering from substance addiction and former inmates. This program currently treats over 1,000 annually at neighborhood clinics and detention facilities.

The Institute is now amidst transforming itself into a unique "University of the Healing Arts". Construction begins this month on a new 12-acre campus for integrated holistic health on Route 29, south of Columbia, Maryland. A first 45,000-square-foot building being designed for the Institute's programs has a projected occupancy of over 500 graduate students, faculty, and staff by Fall 2004. Expansion space is planned on the campus for the Institute's expansion, and a clinic and research facility, conference center, space for business start-ups, and other partnerships and collaborations in Complementary Medicine. The goal is to create integrated new models for training, research and practice, and demonstrate cost-effective strategies to deliver Complementary Medicine through mainstream healthcare providers.

Charlotte Eliopoulos RNC, MPH, PhD

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Charlotte Eliopoulos, is a specialist in holistic gerontologic and chronic care nursing who has dedicated over thirty years to the advancement of these specialties. Charlotte has been a strong voice for innovative long-term care, advocating improved status and salary of caregivers , expanded and innovative roles, and, when recognition of the specialty was barely achieved, subspecialization in gerontologic care . She has served in a variety of positions ranging from nursing assistant to director of nursing, and pioneered such roles as clinical specialist in gerontological nursing in the acute medical service of the Johns Hopkins Hospital and state specialist in gerontological nursing for the Maryland Department of Health. Currently, she serves as president of Health Education Network, providing consultation and educational programs throughout the country. To maintain her direct contact with consumers, she serves in a community caregiving ministry, a practice in which she is able to truly care for the mind, body, and spirit of individuals.

Throughout her career, Charlotte has been committed to educating caregivers in the growing body of gerontological and chronic care knowledge, evident through her prolific writing and workshop presentations. Her recent focus has been educating health care providers and consumers in the integration of conventional with alternative/complementary therapies for the care of chronic conditions. Her books include *Manual of Gerontologic Nursing 2nd ed, Health Assessment of the Older Adult, Gerontological Nursing (going into the 5th edition), Nursing Administration Manual for Long-Term Care Facilities*, and her latest, *Integrating Conventional and Alternative Therapies: Holistic Care of Chronic Conditions*; she also has written dozens of chapters and articles. She has been the Editor of the *Integrative Medicine Nursing Consult* and writes a regular column on "Complementary and Alternative Therapies in Long-Term Care Facilities" in NADONA's official publication *The Director*.

Charlotte holds a diploma in nursing from Sinai Hospital in Baltimore, a Baccalaureate from the Johns Hopkins University, a Masters in Public Health from the Johns Hopkins School of Hygiene and Public Health, and a Doctor of Naturopathy and Doctor of Philosophy in Natural Health from the Clayton College of Natural Health. She is certified in gerontological nursing by the American Nurses' Association and in nursing administration in long-term care by the National Association of Directors of Nursing Administration in Long-Term Care (NADONA). In 1998 she was presented with NADONA's Honorary Member of the Year. She is active in several professional associations and currently is the President-Elect of the American Holistic Nurses Association.

Charlotte supports the philosophy that holistic chronic care is an evolving specialty, and in a growing specialty, professionals must be committed to assuring new knowledge is translated into practical guidelines that every level of caregiver can understand and utilize. She also strongly believes the best care for individuals who have chronic conditions is that which integrates the best of conventional and complementary/alternative medicine.

Biosketch

Tiffany M. Field is director of the Touch Research Institutes at the University of Miami School of Medicine. She is recipient of the American Psychological Association Boyd McAndless Distinguished Young Scientist Award and has had a Research Scientist Award from the NIMH for her research career. She is the author of Infancy, Touch, Advances in Touch, the editor of a series of volumes of High-Risk Infants, and on Stress & Coping, and the author of over 350 journal papers.

History on Touch Research Institutes

Formally established in 1992 at the University of Miami School of Medicine, the Touch Research Institutes (TRI) are the first centers in the world devoted solely to the scientific study of touch, and its application in the fields of science and medicine. Under the direction of Tiffany Field, Ph.D., TRI's distinguished team of researchers, representing Harvard, Princeton, Duke, McGill, and Maryland explore the connection between touch therapy and the effective treatment of disease. Research efforts that began in 1982 and continue today show that touch therapy has numerous beneficial effects on human well-being including weight gain in premature infants, alleviating depressive symptoms, reducing stress hormones, alleviating pain and positively altering the immune system in children and adults with various medical conditions.

Biography of Michele D. Forzley, J.D.

Michele Forzley is an attorney and business consultant with 24 years of experience, who focuses her practice on new directions in health care, shaping health care policy and practice, alternative and complementary medicine, international health law and public health issues and health care business practices. She also is an international business transactions lawyer and serves as independent general counsel to her client companies and institutions.

Michele is Vice Chair of the American Bar Association International Health Law Committee and Chairs the Committee on Complementary and Alternative Medicine (CAM) Law, which she founded. Michele edits the American Bar Association International Health Law News. She was a member of the International Bar Association Medicine and Law Drafting Committee on Telemedicine which authored the International Telemedicine Treaty, presented to the World Health Organization. She has also served as a Jessup International Moot Court Practice Judge.

She began The Center for Complementary and Alternative Medicine Law and Business in 1999, whose mission is to be a source of guidance and information on the legal, ethical, regulatory and business issues confronting the complementary and alternative medicine community. The Center does this through its web site, special projects, speaking and consulting services. The community includes all persons, governmental agencies, providers, regulators, patients, practitioners, and organizations who are involved in complementary and alternative medicine.

Michele earned her J.D. from New England School of Law and her B.A. in Sociology and Economics from Simmons College, both in Boston. She has studied private international law at the Hague Academy of International Law at the International Court of Justice in the Netherlands, Mind-Body Medicine and Spirituality and Medicine at Harvard Medical School and Health and Human Rights at the Harvard School of Public Health. She has been an adjunct professor at the Lubin School of Business at Pace University in New York and an adjunct professor of international business transactions law at New England School of Law.

Michele speaks, writes and consults worldwide on topics related to the changes in health care. She serves on one of the special international boards of the St. Jude Children's Research Hospital and has served on the boards of the Lower East Side Service Center and the Arab American Family Support Center; both healthcare organizations located in New York City.

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Dr. Joyce Frye

Dr. Joyce Frye is an osteopathic physician and board certified obstetrician gynecologist. She serves as President-elect of the American Institute of Homeopathy, the nation's oldest medical professional organization founded in 1844 and is in her 3rd year as President of the National Center for Homeopathy, the nation's largest organization representing the public interest in homeopathy with approximately 6500 members. She has been in private in Philadelphia for over 17 years and utilizing homeopathy for ten years. Current practice is limited to office gynecology and homeopathy since a brain tumor in 1995. Dr. Frye was Chairman of the Department of Gynecology at Presbyterian Medical Center 1991-1998. She is a founder of the Jefferson Center for Integrative Medicine which opened in 1998 and continues to be a gynecology consultant there. She also completed a Master's degree in Business Administration at St. Joseph's University in 1998.

Alan R. Gaby, M.D. – Biographical Information

Dr. Gaby received his undergraduate degree from Yale University, his M.S. in biochemistry from Emory University, and his M.D. from the University of Maryland. He was in private practice for 15 years, specializing in nutritional medicine. He is past-president of the American Holistic Medical Association and served on the ad-hoc advisory panel of the National Institutes of Health Office of Alternative Medicine. He is the author *of The Patient's Book of Natural Healing* (Prima, 1999), *Preventing and Reversing Osteoporosis* (Prima, 1994), *and The Doctor's Guide to Vitamin B6* (Rodale Press, 1984), and numerous scientific papers in the field of nutritional medicine. He has been the contributing medical editor for the *Townsend Letter for Doctors* since 1985. Over the past 20 years, he has developed a computerized database of more than 25,000 individually chosen medical-journal articles related to the field of natural medicine. He is currently professor of nutrition and a member of the clinical faculty at Bastyr University in Kenmore, WA.

Milt Hammerly, MD -- Biographical Sketch

Milt grew up in Vancouver, BC and graduated there from Simon Fraser University in 1981 with a BSc in Kinesiology. He went on to graduate from the Medical College of Wisconsin in 1986 and completed Family Practice residency at Grant Medical Center in Columbus, Ohio and Board Certification the summer of 1989.

After residency Dr Hammerly settled down in Denver, CO where he has worked in various clinical and administrative capacities for a number of health care organizations. Other than the important roles of diet, exercise and stress reduction in disease prevention and health promotion (garnered from his undergraduate education), Dr Hammerly was skeptical about the use of CAM and did not incorporate these approaches into his practice nor recommend them to patients.

As a result of a ski-injury in college, Milt had undergone three knee surgeries but was still experiencing chronic pain, swelling and limitation of activities. When medications were not tolerated and the use of CAM (tried skeptically on the advice of a patient) provided dramatic relief Dr Hammerly's perspective on the use of CAM changed significantly. Until then any reports of favorable responses to the use of CAM by others were considered mere "anecdotes." His personal experience, on the other hand, was clearly a "case report." With this change in perspective he vigorously pursued finding data, studying, taking courses and self-experimentation with the use of CAM. Convinced of the data in support of using specific CAM interventions in specific clinical situations he gradually started to incorporate these approaches into his practice and to refer patients to qualified CAM practitioners.

In 1996 Milt opened an integrative medicine clinic in Littleton, CO with a team of over 30 CAM practitioners. As the director of this clinic he gained invaluable experience and insights on the value of collaboration and on the value of integrative health care, particularly in patients with chronic disease. In 1997 Dr Hammerly became Medical Director of CAM for Centura Health, the largest health care provider in Colorado (and part of CHI). In August of 1999 he accepted a position with CHI as their Director of Integrative Medicine. This role involves educating, consulting and developing a research program and implementation strategies for those CHI facilities interested in integrative health care.

Dr Hammerly maintains an active clinical practice. He is also a contributing editor for the AltMedDex and AltCareDex medical databases produced by Micromedex and is a volunteer physician for Colorado HealthSite (**www.coloradohealthnet.org**). He has spoken across the country to medical societies, hospital staffs, the VHA, hospital administrators and lay audiences on a wide array of topics related to integrative health care. He has testified for the Colorado state HEWI committee regarding legislation affecting physicians who practice integrative medicine. He recently authored a series of books for the general public on an integrative health care approach to fibromyalgia, menopause, diabetes and depression. The fibromyalgia book is currently available in bookstores and online. The remaining three books are scheduled for release in 2001. His web site is: **www.healingpartner.com**

Milt can be contacted by phone at 303-778-5818 or fax at 877-897-3993.

Exponents, Inc. 2000
White House Commission on Complementary
and Alternative Medicine Policy

Bio

Howard Josepher, CSW
Executive Director
Exponents Inc.

Howard Josepher, CSW, is the founder and Executive Director of Exponents, Inc., a non-profit agency offering harm reduction services, New York State licensed, medically supervised, drug treatment and HIV/AIDS prevention, education and care. Mr. Josepher has 33 years of experience in the substance use field and was an early participant and pioneer of the therapeutic community model.

Mr. Josepher is a NY State Certified Clinical Social Worker who has been active in drug policy reform for many years. In 1997, the National Association of Social Workers awarded Howard Josepher the Diego Lopez Memorial AIDS Service Award for outstanding service to people with AIDS. Recently, he was a presenter at the XIII International AIDS Conference in Durban, South Africa.

White House Commission Testimony

Tori Hudson, N.D.
Professor, National College of Naturopathic Medicine
Medical Director, A Woman's Time
Program Director, Institute of Women's Health and Integrative Medicine

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Biographical Sketch

Dr. Tori Hudson, Naturopathic Physician, graduated from the National College of Naturopathic Medicine in 1984. She has served the college in several capacities including: Medical Director, Associate Academic Dean and Interim Academic Dean. In addition, she has over 16 years of extensive clinical experience through being a clinical faculty member, and through her private practice. Currently, Dr. Hudson is a professor of Women's Health at the National College of Naturopathic Medicine and maintains a private practice at two locations: A Woman's Time and in the office of four Obstetricians/Gynecologists at Emanuel Legacy Hospital.

In October of 1999 the American Association of Naturopathic Physicians (AANP) awarded Dr. Hudson the prestigious honor of being named "Physician of the Year." In 1990 Dr. Hudson was also awarded by the AANP the President's award for her research in the field of women's health care. Her research has been in the areas of cervical dysplasia, menopause, genital warts, and breast cancer. She is active as a practitioner, educator, researcher and consultant. She serves on several editorial boards and advisory panels.

Dr. Hudson's work is accessible through her published studies in the Journal of Naturopathic Medicine, The Townsend Letter for Doctors, her textbook title Gynecology and Naturopathic Medicine, and her new book, Women's Encyclopedia of Natural Medicine. She is a contributor to Alternative Medicine the Definitive Guide, The Definitive Guide on Cancer, numerous Rodale Press books, natural health magazines and articles, and HealthNotes Online. Dr. Hudson was recently named as one of the "19 Healer's for the New Millenium" by Healthy Living magazine. She is a nationally recognized lecturer for both professionals and the general public.

Konrad Kail Biographical Sketch

Konrad Kail is a Naturopathic Physician (N.D.) and a Physicians Assistant (P.A.), which gives him both conventional and alternative medical licenses. He is a leader in natural health care, with over 25 years of experience. He has been practicing "integrated medicine" since 1983. He is a past president and serves on the advisory board to the American Association of Naturopathic Physicians (A.A.N.P.) and was named their 1997 Physician of the Year. He is a co-founder, director of research and serves on the board of trustees of the Southwest College of Naturopathic Medicine and Health Sciences. He is one of 18 advisors to the National Center for Complementary and Alternative Medicine at the National Institutes of Health appointed by the secretary of H.E.W. Dr. Kail recently completed a 5 year study on the Natural Elimination of Allergy Therapy (N.E.A.T.) which is pending publication and is an authority on electrodermal screening for diagnosis. He teaches a continuing medical education course on the N.E.A.T. therapy to doctors around the world. He is the author of fifty articles and books. He was the editor of the stress chapters in "Alternative Medicine, the Definitive Guide" and is co-author of "Allergy Free" both published by Alternative Medicine .Com Books. Dr. Kail is a much sought after speaker and has lectured nationally and internationally. Dr. Kail appears Tuesday and Thursday at 9:00 – 10:00 AM on Sonoran Living, where he does health segments called "Second Opinion" (KNXV Channel 15 ABC affiliate in Phoenix). Dr. Kail is owner/operator of Naturopathic Family Care, Inc. a multi-specialty Naturopathic group practice. He is a consultant to government agencies, the natural foods and insurance industries.

D.E. Kendall, O.M.D., Ph.D.
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D.E. Kendall is a Doctor of Oriental Medicine in private practice in California for the past twenty years, licensed by the State Medical Board as a primary health care provider for acupuncture and oriental medicine. He also worked two years at the UCLA School of Medicine, Internal Medicine Department, and participated in a acupuncture research effort at the UCLA School of Dentistry. His practice includes treatment of musculoskeletal and pain syndromes, certain affective behaviors, internal disorders, and immune dysfunction shown to be helped by Oriental medicine and acupuncture. He successfully applied electroacupuncture in the hospital setting to provide analgesia for foot surgery, oral surgery, liposuction surgery and the removal of a kidney stone. Dr. Kendall also devised safe and effective acupuncture protocols for the treatment of substance abuse and has actively promoted improved educational standards for Oriental medicine. He developed a 300 hour "acupuncture orthopedics" graduate training program that provides a modern understanding of Chinese orthopedics and has participated in teaching acupuncture students as well as other health care providers, including participants in the International Veterinarian Acupuncture Society (IVAS) certification program.

In addition to oriental medicine, Dr. Kendall has a background in physiology and engineering and has devoted considerable efforts in understanding the physiological basis of needling therapy (acupuncture). He devised the first physiological model that explains all the mechanisms of acupuncture that establishes a firm basis for its action (American Journal of Acupuncture 1989). This scientific acupuncture model is consistent with Western physiology and the original Chinese medical theories.

He has also devoted much time to understand the historic basis of Chinese medicine through translations of the ancient Chinese texts, including the *Yellow Emperor's Internal Classic (Huangdi Neijing)*. Dr. Kendall has written several articles on these topics and has authored a forthcoming book published by Oxford University Press, entitled: *"Dao of Chinese Medicine: Understanding an ancient healing art"* to be released in the spring of 2001.

Dr. Kendall is a board member of the National Guild of Acupuncture and Oriental Medicine (NGAOM) responsible for education and research. The NGAOM is a professional guild for practitioners of acupuncture and Oriental medicine organized under the auspices of the Office and Professional Employees International Union (OPEIU) of the AFL-CIO. Past professional participation included: member of the Board of Directors of the American Association of Acupuncture and Oriental Medicine (1983-1986) and was its director of research for 4 years; first state president of the California Acupuncture Alliance; former director on the National Board of Acupuncture Orthopedics; and served on the State of California 1991 and 1992 "Blue Ribbon" panels on scope of practice for acupuncture and Oriental medicine.

Whccamp (NCCAM)

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ent: Wednesday, November 29, 2000 10:33 AM
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Subject: bio of Paul Kurtz

PAUL KURTZ

Paul Kurtz is Professor Emeritus of Philosophy at the State University of New York at Buffalo. He received his BA from NYU and MA and Ph.D from Columbia University. He is Chairman of the Committee for the Scientific Investigation of Claims of the Paranormal (CSICOP), which publishes the Skeptical Inquirer magazine. CSICOP is committed to enhancing the public

understanding ofscience.. It has called for the careful testing of paranormal claims and believes that the public has not heard dissenting scientific appraisals of them.

Paul Kurtz is also publisher of The Scientific Review of Alternative Medicine(SRAM), a journal sponsored by the Council for Scientific Medicine, a coalition of scientists and physicians. SRAM does not belief that adequate ›ouble blind clinical tests of CAM therapies have been done and it autions ;he medical community and public about their possible misuses

He is President of Prometheus Books, which has published a series of books on health care, . paranormal issues, including alternative medicine.
Kurtz is the author of 600 articles and reviews and 35 books, including The New Skepticism (1992) and Skepticism and Humanism: the New paradigm(2000).
He is a Fellow of the American Association for the Advancement of Science.

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Dr. Meeker is Executive Director of Research for the Palmer Center for Chiropractic Research at Palmer College of Chiropractic in Davenport, Iowa; and Palmer College of Chiropractic-West in San Jose, California. He is also the Principal Investigator of the Consortial Center for Chiropractic Research (CCCR), a collaboration of eleven institutions established by a grant from the National Center for Complementary and Alternative Medicine. He has also been appointed to serve on the Advisory Council of the National Center for Complementary and Alternative Medicine. Dr. Meeker has been a Project Director for the "National Conference to Establish the Chiropractic Research Agenda" for the last five years, which is supported by a contract from the U.S. Health Resources and Services Administration. Graduating from Palmer College of Chiropractic-West in 1982, he received his Master of Public Health degree from San Jose State University in 1988. From 1989-1995, Dr. Meeker was President of the Consortium for Chiropractic Research, a non-profit organization facilitating collaborative research in chiropractic institutions in North America. He was appointed to the Governing Council of the American Public Health Association in 1996, and received the Distinguished Service Award from the newly established Chiropractic Health Section there in 1998. Other offices held by Dr. Meeker include terms on the Boards of the American Back Society, the Silicon Valley Ergonomics Institute, and the American Spinal Research Foundation. Dr. Meeker is the Editor of the Journal of the Neuromusculoskeletal System, the official scientific publication of the American Chiropractic Association. In addition, he is on the editorial boards of the Journal of Manipulative and Physiological Therapeutics, the Journal of Chiropractic Technique, the Back Letter, and Advances in Chiropractic.

Richard B. Miles / 29 Silverwood Drive / Lafayette, CA 94549 (925) 962-0282

Brief Resume

After a 16 year career in the development and marketing of published and audio-visual educational materials, became a student of cultural change, social trends, and what is now referred to as the paradigm shift. In 1971 founded Crossroads Communications, an event management organization devoted to the exploration of emerging perspectives. In that capacity, managed:

First National Symposium of acupuncture for physicians (Stanford, June, 1972)
Twelve professional seminars on acupuncture (Stanford, USC, UOP Dental, Univ. of Oregon, Ariz. Medical Assn., etc.)
New Dimensions of Healing (5 events, SF Bay Area, LA, NY, Chicago)
Professional seminar series on biofeedback (4 events)
Frontiers of the Mind (2 events, Santa Barbara, Chicago)
Close and Free, Issues of Intimacy and Individuality (5 events)
Designed and participated in "Magical Child Seminars" with Joseph Chilton Pearce

- Education Coordinator and producer of "Nurturing the Child of the Future," a UN year-of-the child seminar for the Mental Health Assn. of Santa Clara County, 1977
- Chairman, 10th anniversary Council Grove Conference, an annual gathering of mental health professionals sponsored by the Research Dep't. of the Menninger Foundation, 1978
- **Adjunct faculty, Health Science Dep't., San Jose State University, 1978-80**
  Designed and taught an innovative course, "Principles of Holistic Health" in an inter-disciplinary program offered to all departments of the university.
- **Assoc. Dean, Graduate School of Consciousness Studies, designer and director of the graduate program in holistic health education, John F. Kennedy University, Orinda, CA, 1979-83**
  Created the curriculum for and launched a 72 unit graduate program in holistic health counseling. Coordinated seminar style classes led by faculty teams. Taught classes on changing world views.
- **Curriculum Development Coordinator, Faculty Development Consultant, St. Mary's College Certificate Program in Health and Wellness, Mpls, MN, 1983-84**
  Worked with faculty and staff to design the framework for, and the class sequence of a 36 unit certificate program in wellness education.
- **Adjunct Faculty, Dep't. of Public Admin., Calif. State Univ., Hayward, 1998-9**
  Taught graduate level classes on formation of health policy, social and political aspects of health care organization, and the impact of changing world views on health care issues.

- President, Health Frontiers, a program development and business consulting group
- Consultant to innovative health care practitioners and programs, including:
  Emmett E. Miller, M.D., Source Cassettes, Menlo Park
  Fritz Smith, M.D., Zero Balancing Association, Aptos
  Claremont Behavioral Services, Orinda
  Wellness Guide Project, UC Berkeley School of Public Health
  International Bioethics Institute, Tiburon Health Medicine Forum, Walnut Creek
  Mayacamas Healing Network, Calistoga Institute of Noetic Sciences, Sausalito
  Meridian Institute, Monterey Integrative Cntr for Culture & Healing, St. Luke's Hosp, SF

Boards

University of the Pacific, Grad. Program in Learning Disabilities, 1975-78
San Andreas Health Council, Palo Alto 1978-79
Bay Area Wellness Network 1980-81, Berkeley Holistic Health Center 1980-82
Samaritan Counseling Center, Palo Alto 1991-93, Health in Common current

Education

B.S., Business Administration, Drake University, Des Moines

"Ad hoc graduate studies" interacting for more than 25 years with many of the leaders of the "new health" movement as organizer and master of ceremonies of 25 seminars and conferences on innovative health care, psychology, and human development.

Publications

Changing Perspectives in American Health Care, A report for The Institute of Noetic Sciences, December,-1998

Organizing Collaborative Practices, Alternative Health Practitioner, Spring, 1998

Evolving Views of Health and Illness, Institute of Noetic Sciences "Connections," Jan. 1998

Forging a New Trail: Emerging Trends for Marriage and Family Therapists, The California Therapist, February, 1997

Medical Care at a Crossroads, At Work Newsletter, November/December, 1996

The Paying Customer? Commentary on service in health care Vision/Action Newsletter, 1995

Health Benefits from Organizational Development Interventions, Vision/Action, 1989

Healing From the Inside Out, in "The Ultimate Guide to Health and Fitness," Vortex Publ. 1988

Holistic Health and Orthodox Medicine, in "Women's Health Care: A Guide to Alternatives, Reston/Prentice-Hall, 1984

The Rituals of Childbirth, in "Mind,Body, and Health: Toward an Integral Medicine," Human Sciences Press, 1984

Dialysis Plus Dollars Equals Dilemma, The Association for Humanistic Psychology Newsletter, 1983

A Health Modality Matrix, in "The Future of Pharmaceuticals," Wiley Medical Press, 1981

The Holistic View, in "The New Healers," And/Or Press, 1980

Freedom From Chronic Disease, with Arthur L. Kaslow, M.D., J.P. Tarcher, LA, 1979

Humanistic Medicine and Holistic Health, in "The Holistic Health Handbook," And/Or Press, 1978

Mort Rosenthal

Biography

Mort Rosenthal is Chairman and Founder of Wellspace, Inc. Wellspace is the largest provider or complementary and alternative health services in the US. Currently, Wellspace operates clinics in the Boston area, and expects to open clinics and build other models of affiliation nationally within the next several years. Rosenthal, as well as several venture capital firms, have been the financial backers of Wellspace.

Prior to Wellspace, Rosenthal founded and was Chairman and CEO of Corporate Software Inc. from 1982 to 1997. The company went public in 1987 and changed its name to Stream in 1994. Corporate Software/Stream was the largest software distributor, largest software support organization, and largest physical manufacturer of software. It had revenue of $1.8 billion, 9000 employees, and operations in 18 countries. In the early 1980's, Corporate Software pioneered a more efficient PC software distribution channel in the corporate market, creating a distinctive brand, a high quality service offering, and an unparalleled information resource. Rosenthal has earned a track record for starting, managing and growing a successful and consistently innovative and profitable business in an emerging high growth (highly competitive) marketplace.

Rosenthal has been a member of the Board of Directors of many technology firms, as well as several community and educational institutions. He invests privately, where appropriate.

He has been a frequent speaker at many business, technology and healthcare venues

Rosenthal earned an MBA in 1979 from Columbia Business School and a BA in 1975 in psychology and biology from Yale University.

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Robert H. Schneider, M.D.
Biographical Sketch

Professor Robert H. Schneider, M.D., is a physician, scientist, educator, and internationally-renowned leader in the field of natural medicine. He is Dean of the College of Maharishi Vedic Medicine and Director of the Center for Natural Medicine and Prevention at Maharishi University of Management, which is one of eleven CAM centers funded by the National Institutes of Health-National Center for Complementary and Alternative Medicine.

Over the past twelve years, Dr. Schneider has been the Principal Investigator of a series of grants from the National Institutes of Health and private foundations totaling $18 million. The overall objectives of these randomized controlled clinical trials have been to conduct research and demonstration projects on Vedic Medicine, including the Transcendental Meditation program, herbal preparations and other traditional natural medicine modalities in the treatment and prevention of hypertension, cardiovascular disease, cancer and aging. These awards include a recent $8 million grant from the NIH-National Center for Complementary and Alternative Medicine to establish the first center of research excellence specializing in natural medicine for the elderly and high risk minorities. The medical research program he directs has been termed the largest systematic evaluation of prevention-oriented, natural medicine supported by the federal government and national foundations.

Dr. Schneider is board-certified in public health and general preventive medicine and is a specialist in clinical hypertension. He completed a fellowship in hypertension and his residency training in internal medicine at the University of Michigan Medical School and received his M.D. from the University of Medicine and Dentistry of New Jersey. He has authored or co-authored over 100 scientific papers on the prevention and treatment of cardiovascular disease and other chronic disorders. These have been published in conventional medical texts, CAM textbooks, and leading medical journals such as the American Heart Association's journals-*Hypertension* and *Stroke, American Journal of Cardiology, Journal of Managed Care, Annals of the New York Academy of Sciences, Psychosomatic Medicine, Journal of the National Medical Association,* and *International Journal of Neuroscience.* In addition, he has been invited to lecture on prevention and treatment of chronic disease with natural medicine at major medical institutions, professional conferences and specialty societies throughout Europe, Asia, the Middle East, and the United States.

Dr. Schneider and colleagues' research findings on Vedic medicine have been featured in over 1,000 television, radio, magazine and newspaper reports in recent years. This media coverage includes CNN Headline News, The Discovery Channel, CNN Healthwatch, ABC's 20/20, ABC's Dateline, CNN Health Special, ABC National Radio Network, UPI National Radio Voice of America, Drkoop.com, WebMD, *The New York Times, USA Today, Wall Street Journal, Washington Post, Los Angeles Times, Chicago Tribune, San Francisco Chronicle, Boston Globe, London Daily Telegraph, Paris Match, Jerusalem Post, American Medical News, Medical Tribune, Prevention Magazine, New Scientist, American Health, Self, Let's Live, Insight, Health, Longevity , Yoga Journal , Associated Press, Reuters* and *French News Agency.*

Dr. Schneider has served as a consultant to the U.S. Congress' Prevention Coalition and to members of the British Parliament - House of Lords.

MAHARISHI UNIVERSITY OF MANAGEMENT
Office of Public Affairs, Fairfield, Iowa 52557 • Tel. 515-472-1134

For Immediate Release
September 30, 1999

Contact: John Revolinski
Ph. 515-472-1134

—PRESS RELEASE—

NIH Awards $8 Million Grant for First Natural Medicine Research Center for Minorities

Center to Be Inaugurated at Maharishi University of Management on October 11

FAIRFIELD, IOWA—The National Institutes of Health (N.I.H.) announced today that a grant of nearly $8 million has been awarded to Maharishi University of Management to establish the first research center specializing in natural preventive medicine for minorities in the U.S.

The new research institute, called the Center for Natural Medicine and Prevention, will be inaugurated on October 11 at the University's College of Maharishi Vedic Medicine in Fairfield. It is one of nine NIH-supported centers in the country for studying natural medicine, and the only one with specialization in minority health.

The new Center is being funded by the NIH National Center for Complementary and Alternative Medicine (NCCAM). It will study the effectiveness of alternative medical approaches for the treatment and prevention of cardiovascular disease in African Americans and other nigh-risk groups.

"The Center is the culmination of more than ten years of NIH- and private foundation-sponsored projects," said Robert Schneider, M.D., principal investigator and Dean of the College of Maharishi Vedic Medicine. "It is the result of national mandates which called for innovative research on the treatment and prevention of heart disease in at-risk minorities."

Previous Grants Total $10.5 Million

In the past decade, Dr. Schneider and his national team of collaborators have received prior grants totaling over $10.5 million for research on prevention-oriented natural medicine. Studies published in the American Heart Association's journal *Hypertension* have shown that high blood pressure—which afflicts over 40 million Americans—can be effectively treated using the Transcendental Meditation program, a well-known stress-reduction technique.

Other findings, published in periodicals such as the *American Journal of Cardiology*, *Psychosomatic Medicine*, *American Journal of Managed Care*, and *Ethnicity and Disease* have indicated that the Transcendental Meditation program can reduce heart disease, decrease stress hormones, promote longevity and reduce health care utilization.

—MORE—

BIOGRAPHY

J. DONALD SCHUMACHER, PSY.D.
PRESIDENT AND CHIEF EXECUTIVE OFFICER
THE CENTER FOR HOSPICE & PALLIATIVE CARE

Dr. Schumacher graduated from the Massachusetts School of Professional Psychology in June of 1986. From 1980-89 he was the President & CEO of Hospice West in Waltham, Massachusetts. His doctoral dissertation was on the Psychological Care of the Terminally Ill Patient. Prior to attending M.S.P.P., Dr. Schumacher graduated from SUNY Buffalo with his Masters degree in Counseling Psychology. From 1978-89 he was the CEO of Hospice West in Waltham, Mass. He has lectured nationally on the psychological care of the terminally ill patient and the patient with AIDS.

Dr. Schumacher has been the President and Chief Executive Officer of The Center for Hospice & Palliative Care since June of 1989. He is presently a member of the NHPCO Board of Directors and is the chair of the Children's Hospice International Task Force on developing Medicaid 1115 Waivers for pediatric Hospice care. He is a member of the NHPCO Legislative sub-committee of the Medicare Benefits Implementation Task Force and is also active in the National Hospice Workgroup. Dr. Schumacher also serves as chair of the NHPCO Nursing Home Task Force of which he has been a member since 1995 and is co-convener of the Last Acts Task Force on Institutional Innovation. He is currently the Director of Public Policy for Partnership For Caring.

Other affiliations include board membership on the AIDS Community Services Board, the Peter C. Cornell Trust, The Gilda's Club Steering Committee of Buffalo and Bishop Timon Board of Directors.

Dr. Schumacher is licensed as a clinical psychologist in both Massachusetts and New York State.

Anna Lisa Silberman

Anna Silberman is the President and CEO of Lifestyle Advantage, a joint venture of Highmark Blue Cross Blue Shield and the Preventive Medicine Research Institute. The goal of Lifestyle Advantage is to increase national access to the Dean Ornish Program for Reversing Heart Disease and other lifestyle improvement interventions. Her prior position was Vice President of HealthPLACE and Executive Director of the Health Education Center for Highmark Blue Cross Blue Shield.

Ms. Silberman serves on the Pennsylvania Coalition to Prevent Teenage Pregnancy Board, the Allegheny County Health Department Chronic Disease Council, Shadyside Hospital Advisory Committee for the Center for Complementary Medicine, and is a member of the Pennsylvania Public Health Association, Society for Public Health Education, Inc., and the American College of Healthcare Executives.

Ms. Silberman earned a Master's Degree in Public Health from the University of Pittsburgh.

Alan I. Trachtenberg, M.D., M.P.H. is Medical Director for CSAT's Office of Pharmacologic and Alternative Therapies (OPAT). This office is SAMHSA's focal point for pharmacologic therapies such as methadone, LAAM and buprenorphine, as well as alternative therapies such as acupuncture, in substance abuse and mental health. Dr. Trachtenberg came to CSAT from the National Institute on Drug Abuse (NIDA) where he served as a Medical Officer from 1991 to 1998. During that period, he also spent from 1994 to 1995 on a special detail, directing the NIH Office of Alternative Medicine (OAM). Prior to his return to federal service in 1991, he was Medical Director for a large network of methadone clinics in the San Francisco area, where he implemented one of the first federally funded demonstrations of acupuncture to be conducted within a narcotic treatment (methadone) program. Previous to that, he had served as Chief of Epidemiologic Research and Statistics for The California Department of Health Services' Office of AIDS. Alan has also served in the Indian Health Service, in Oklahoma and at Pine Ridge, SD.

A Board-Certified specialist in General Preventive Medicine, Public Health and Medical Toxicology, as well as a Fellow of the American Academy of Family Physicians, Alan received his Medical Degree from Tufts University and his Masters in Public Health from UC Berkeley. Dr. Trachtenberg has been involved in research on Traditional Chinese Medicine (TCM) for many years and chaired the planning committee for the recent, landmark, NIH Consensus Development Conference on Acupuncture. In the 1980's, while on the faculty of the American College of Traditional Chinese Medicine (ACTCM) in San Francisco, he taught what was probably the first course in research methods ever offered at an acupuncture college in the US. In the mid-nineties, Alan co-founded the Alternative and Complementary Health Practices (ACHP) Special Primary Interest Group (SPIG) of the American Public Health Association (APHA). He is also a member of APHA's Science Board, which evaluates the scientific merit of positions and policies that may be recommended for adoption by APHA.

Alan has appointments as an Adjunct Associate Professor at both the Uniformed Services University of the Health Sciences (USUHS) and the George Washington University Medical Center, where he teaches about drug abuse treatment as well as alternative and complementary health practices. Alan was also recently certified as a professional herbalist by the American Herbalist Guild (AHG).

Brief Biographical Sketch

Thomas Trompeter, MPA is the Executive Director of Community Health Centers of King County, a private non-profit corporation providing primary health care services for underserved residents of King County outside the City of Seattle and home of the King County Natural Medicine Clinic.

Prior to joining CHCKC, Mr. Trompeter was the Executive Director of the Northwest Regional Primary Care Association. He has worked with non-profit providers of primary care to underserved people for over 20 years.

Mr. Trompeter received his Masters Degree in Public Administration with and emphasis in health services and quantitative methods from the University of Washington.

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VII

Divider Title: _____

White House Commission on Complementary and Alternative Medicine Policy

Meeting on the Access and Delivery of Complementary and Alternative Medicine Services

COMMISSION DISCUSSION: "TOP OF MIND" THOUGHTS

If you wish, please submit any "top of mind" concepts, ideas, suggestions or thoughts that capture significant issues from this meeting. We will compile any documents received into a single file to be shared with all Commissioners as we begin to formulate the report draft. Please submit these sheets to Michele Chang before you leave the meeting, or fax them to us at 301-480-1691.

SUBMITTED BY COMMISSIONER: _____

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VIII

Divider Title: _____

White House Commission on Complementary and Alternative Medicine Policy

Meeting on the Access and Delivery of Complementary and Alternative Medicine Services

PUBLIC COMMENT ROSTER

DAY ONE – MONDAY, DECEMBER 4, 2000

1:35 p.m. Public Comment (Open Session, as pre-registered)

1. Francine Butler, Association for Applied Psychophysiology & Biofeedback
2. Nancy Dolores Kolenda, Center for Frontier Sciences
3. Diana Chambers, Friends of Health
4. Rustum Roy, University of Arizona-PIM

♦ **Panel Discussion**

5. David Murray Blalwas, Maryland Acupunture Society
6. Kathleen Golden, Acupuncture Society of New York
7. Natalia Egorov, California Oriental Medical Association
8. David Edgar Molony, American Association of Oriental Medicine

♦ **Panel Discussion**

9. Elaine Marie Wallzer, Henry M. Jackson Foundation
10. Bhavna P Bhut, OJAS Cancer Care Institute
11. Neeta Kunai Suryavanshi, Aspen Systems
12. Salvatore A. D'Onofrio, Natural Health Practitioners Board

♦ **Panel Discussion**

DAY TWO – TUESDAY, DECEMBER 5, 2000

1:30 p.m. Public Comment (Open Session– as pre-registered)

1. Bruce Nordstrom, American Chiropractic Association
2. Neal D. Barnard, Physicians Committee for Responsible Medicine
3. Doreen Chen, Chinese Medicine Council, AAOM
4. Gary Sandman, Integrative Medicine, LLC

♦ **Panel Discussion**

5. Danny Freund, Pennsylvania State University
6. Melinna Giannini, Alternative Link
7. Jane Hersey, Feingold Association
8. Boyd Landry, The Coalition for Natural Health

♦ **Panel Discussion**

9. Lawrence Auburn Plumlee, National Coalition for the Chemically Injured
10. Michael John Rohrbacher, Certification Board for Music Therapists, Inc.
11. Andrew L. Rubman, American Association of Naturopathic Physicians
12. Marshall H. Sager, American Academy of Medical Acupuncture

♦ **Panel Discussion**

1:35 p.m. Each speaker has 3 minutes to provide oral testimony, followed by BRIEF questions from Commissions. In the interest of time, please ask questions only, and refrain from making statements.

Francine Butler, Association for Applied Psychophysiology & Biofeedback

The Association for Applied Psychophysiology and Biofeedback represents practitioners involved with all aspects of biofeedback--the oldest and most well established of the mind/body applications on complementary medicine. Along with the Biofeedback Certification Institute of America, the AAPB offers basic education programs regarding the use of this modality for its members, has worked with the BCIA to create a certification for practitioners and created a Guideline for Practicing Standards for users. This model could be applied to other associations to develop educational programs and teaching methods for practitioners of alternative and complementary applications. We have also produced and put for others as a model, a book on one Clinical Efficacy of Biofeedback with the data to support the research.

Nancy Dolores Kolenda, Center for Frontier Sciences

It is important that the major medical schools and research centers throughout the United States have access to funding to set-up models to study various CAM therapies such as herbal medicine, acupuncture, and mind/body medicine. The NIH National Center on Complementary and Alternative Medicine and the firms that relate to these various CAM therapies should make these funding opportunities accessible to these institutions. This will expand the current research status on CAM therapies and these therapies will be adequately addressed and gain the needed respect of the medical community while improving the quality of life for the general public. With the present economic status at the major medical schools, such funding opportunities will be welcomed.

Diana Chambers, Friends of Health

"w hole Person Healing

Obesity, DM, Drug + Alcohol Abuse } most frequently occurring disease

HPT

Rustum Roy, University of Arizona-PIM

✍: Whole Person Healing ~~Success~~ Program

David Murray Blalwas, Maryland Acupuncture Society

Range of medical professionals providing Acupuncture and CAM Services. Training and certification needed by professionals to do so. Outcomes of consumer research on satisfaction with Acupuncture care. State by state reports on access to Acu. and Cam Services.

✍: Study Available
- mid Outcome Research Studies

Kathleen Golden, Acupuncture Society of New York

Information on prejudicial policies held by private and public companies and organizations regarding who can deliver Acupuncture services to the public.

✍: LAc vs MD. Dc.; Reimbursement to MD not LAc
Fair + equitable Acupuncture

Natalia Egorov, California Oriental Medical Association

CAM or ICAM (integrated, Compl. Alt. Med), is largely still an underground affair in most states. WHCCAMP will need further assistance in accessing the very practitioners and clients/patients for whom your group exists. As you know, it is the front-line 'process-owners' who often hold the keys to innovations and solutions. I have networked enough to be able to assist in bringing the best of the best of ICAM practitioners forward, those who are 'scientist/mystics', visionaries, innovators, if you will; within a safe environment of scientific inquiry, at least in the state of California. California has often led in social innovation. ICAM integration is no different. I will be discussing the elements at work in this state, and be able to postulate about most of your queries above from the happenings that I know of, or am formulating/doing in California at this time, mostly from the viewpoint of Oriental Medicine, but also from the viewpoint of energy workers; some of who are also successful, licensed healthcare practitioners in conventional medicine. Since it would take more than 3 minutes, I'll be preparing a written statement.

✍: Concern ~ loss of system delivery if integration occurs between systems.

David Edgar Molony, American Association of Oriental Medicine

In cases where national entry level requirements have already been developed, integration should involve those already a the level of training and certification before new providers are enabled. If there is no standardized process, or if cross profession use of modalities is indicated, levels of education on that specific modality should be developed with the input of those already using that modality involved in a clear way. Research on CAM modalities should focus on comparison to conventional modalities and CAM's ability to enhance effectiveness or minimize side effects of Conventional modalities. This can be easily performed by using regular patients in regular treatment and adding CAM treatment modalities to regular treatment to see cost effectiveness with regards to speedy recovery and lost productivity as well as reduced costs from reducing the continued use of Conventional modalities. CAM providers need to have availability of Conventional screening parameters and base lines to show effectiveness and to rule out advanced disorders.

Chiro - Harmonious model of TCM/Ac/Traditional Medicine
Suggest to State/Private health plans

Elaine Marie Wallzer, Henry M. Jackson Foundation

Bhavna P Bhut, OJAS Cancer Care Institute

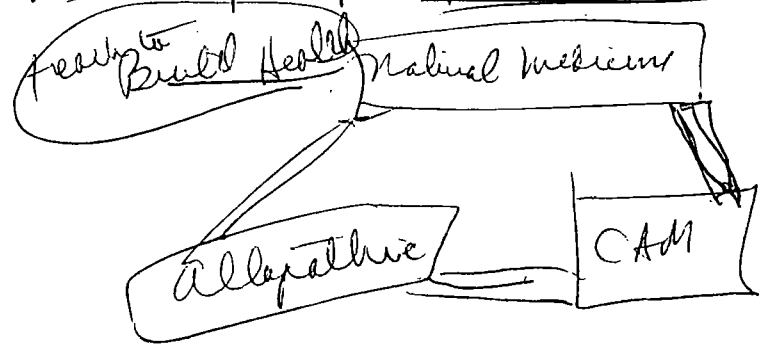
Neeta Kunai Suryavanshi, Aspen Systems

There should be a uniform standard of education, training, licensure and certification that should be applied to all CAM practitioners. They should be trained and educated in the medical schools in the various safe and effective CAM practices and interventions. MD's who have no training what so ever in CAM and are practicing it only because it is gaining popularity should not be allowed to practice CAM as they are doing more harm than good to the patients. Complementary Medicine should be clearly distinguished from Alternative practices. Integrated medicine which combines the best of traditional and Complementary medicine is the best approach.

Salvatore A. D'Onofrio, Natural Health Practitioners Board

Legal differences between natural health practices and the practice of medicine. Certification versus licensure.

✍: don't include natural health principles - spiritual, emotional (Minnesota)



DAY TWO: TUESDAY, DECEMBER 5, 2000

1:30 p.m. START

Bruce Nordstrom, American Chiropractic Association

✍:

Neal D. Barnard, Physicians Committee for Responsible Medicine

I would like to address (1) the need to prioritize nutritional treatments, particularly those using dietary interventions, as opposed to simply supplements, (2) the need to encourage nutritional instruction in medical schools, (3) the need to examine nutrition's role in disease prevention for the population at large, and (4) the need to examine federal policy conflicts that may interfere with the acceptance of nutritional interventions, e.g., promotion of meat and dairy products by USDA while the roles of these foods in disease is investigated by DHHS.

Doreen Chen, Chinese Medicine Council, AAOM

Gary Sandman, Integrative Medicine, LLC

I would like to address the commission with following proposal. My company and work over the last 30 years has been directed to develop a network of integrative health practitioners who meet the requirements of being credential by a legitimate certified school of higher learning and hold a license to practice If applicable) who would have to register with documented proof of their education and license and certification. Through the use of the internet and 800 phone lines the public would have access to these practitioners. (We developed a pilot program in the Washington DC area for the last three years.) The network would provide communication and access to the public as well as among and between the different types of Integrative Practitioners. Through the use of the internet we would also be able to rum outcomes studies through east practitioners office with the patients - using privacy rules and secure sites, we would work with willing patients through email to track their progress and health treatments and cost. This outcomes data would be analyzed by an academic team, published and transmitted to all members and be available to the public so that the best practices can be used to increase health and well being. We are also developing integrative treatment protocols specifically for chronic illnesses that can be applied throughout the network. I would like to explore how we can work together with this commission to establish this program. Thank you for your efforts and collaboration.

Danny Freund, Pennsylvania State University

As a PennState Honor's student in 'Science Technology & Society' and a cancer survivor, I am currently doing research to understand how college students perceive and use Alternative Medicine. I am interested to see how familiar college students are with CAM, and to see if person's knowledge of CAM relates to their use. I am also interested to see if students from traditional science backgrounds differ in their beliefs, use and knowledge of CAM. I suspect that students of traditional science backgrounds will have a more negative attitude towards CAM. I will be discussing my work and the need to integrate Alternative Medicine courses at the undergraduate level in light of finds from three studies. Furnham A, Yardley L, Fahmy S, Jamie A. Health beliefs and preference for medical treatment: a comparison between medical and social science students. Complement Ther Med. 1999. Jun; 7(2):101-9. Gaedeke RM, Tootelian DH, Holst C. Alternative therapies: familiarity, use and information needs. Mark Health Serv 1999 Summer, 19(2): 29-31. Yardley L. Frunham A. Attitudes of medical and nonmedical students toward orthodox and complementary therapies: is scientific evidence taken into account? The Journal of Alternative and Complementary Medicine 5,3 (1999) 293-295.

Melinna Giannini, Alternative Link

Poll CAM schools to identify available treatments by diagnosis and provider type. Use procedure coding to define providers by core training. Use state laws to define parameters of service by state. Use queries in existing software to compare CAM data to conventional data by diagnosis. Use RVUs to compare cost of CAM treatments to conventional medicine by diagnosis.

Jane Hersey, Feingold Association

Proven treatments for many learning, behavior and health problems are already available. Their effectiveness has been documented both in scientific studies and in decades of practical use. A simple elimination diet is one of the oldest and most conservative medical treatments, yet it is considered an "alternative." What's more, doctors are being prevented - through intimidation - from recommending this safe option.

Boyd Landry, The Coalition for Natural Health

Lawrence Auburn Plumlee, National Coalition for the Chemically Injured

The National Coalition for the Chemically Injured is a coalition of support groups coast to coast for persons with chronic multiple chemical sensitivities. The chemical industry has sponsored studies with psychiatrists to try to establish that these sensitivities are due to psychological factors, not the sequellae of chemical injury. It falls upon the government to fund definitive studies to explore the role of chemical injury in the etiology of chemical sensitivities.

Michael John Rohrbacher, Certification Board for Music Therapists, Inc.

Statistical overview of the music therapy profession, including scope of practice. Description of national credentialing programs offered by the Certification Board for Music Therapists (CBMT), including (1) national examination (including eligibility), and (2) continuing education. Emphasis on accountability and Code of Professional Practice. Description of model use of "MT-BC" by the state of Wisconsin in identifying qualified music therapists.

Andrew L. Rubman, American Association of Naturopathic Physicians

CAM practices and interventions need to be overseen by individual formally trained in this disciplines. CAM is an unfortunate pejorative misnomer for traditional medicines. The philosophy of wellness augmentation as contrasted by disease management and symptomatic suppression is not taught to medical doctors. Uniform standards of education, training, and licensure and practitioners are extremely important to ensure public safety. Current commission composition does not allow for objective, balanced oversight of this field. It is incumbent upon Dr. Gordon and The President to appoint at least one physician formally trained in medical school in not only the practice but also the philosophy of tradition medicine (CAM sic.). The only discipline, which provides both formal allopathic and formal traditional medical training, is naturopathic medicine. It is only by providing a strong effective voice for the naturopathic profession in this Commission, that safe access to this area of medicine and reasonable performance guidelines can be responsibly provided to the American public. At issue is not only access and educational issues, but preservation of public safety as well.

Marshall H. Sager, American Academy of Medical Acupuncture

Acupuncture treatment when delivered by a trained physician provides the patient with "the best of both worlds" i.e. both Eastern and Western paradigms. Incorporating acupuncture training into the Western medical School curriculum will not only increase the delivery of CAM therapies but should enhance its access. Reimbursement decisions should include consideration of the provider's education, and the moral, ethical, and legal responsibilities of his or her profession.

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[AAMA LETTERHEAD]

MEMORANDUM

TO: **Members of The White House Commission On Complementary and Alternative Medicine Policy**

FR: **Marshall H. Sager, D.O.**
President-Elect
The American Academy Of Medical Acupuncture

DA: **November 28, 2000**

RE: **December 5-6 Commission Meeting on Guidance for Access to, Delivery of, and Reimbursement for Complementary and Alternative Medicine Practices and Interventions.**

INTRODUCTION

The ancient medical modality of acupuncture is rapidly evolving as an effective complimentary paradigm within the framework of modern American medicine. Since President Nixon's trip to China in 1972, and the New York Times' James Reston's dramatic appendectomy during that trip, interest in, and the popularity of, acupuncture has surged in America. This popular pressure has led to scientific investigation of acupuncture's physiologic impact by the World Health Organization and, most recently, by the National Institutes of Health (NIH). Studies by these august bodies have concentrated on pain management and various disease entities and health problems as well as the integration of acupuncture into contemporary medical practice. The results of these studies have been positive and enlightening, lending credence to the efficacy of acupuncture - a medical paradigm which has persisted for more than 5,000 years.

Medical acupuncture, as distinguished from acupuncture, is the clinical discipline of acupuncture as practiced by a physician who is also trained and licensed in western bio-medicine. With its foundation in ancient Chinese medical theory and practice, medical acupuncture has become a therapeutic partner with conventional western bio-pharmacology. A physician who practices medical acupuncture offers a uniquely comprehensive approach to patient health care – an approach that combines western and eastern medical modalities. In other words --- the best of both worlds.

Physicians who practice medical acupuncture treat as wide a spectrum of medical challenges as do their western bio-medically-oriented counterparts. The distinction lies in basic philosophy. While western physicians treat problems people have, the medical acupuncture physician treats people with problems. With medical acupuncture, the concentration is on the well-being and health of the whole person. The goal is to restore the individual to a state of balance and harmony within him/herself and with his/her environment. This is in contrast to the traditional western medical approach which concentrates on ameliorating or combating a particular problem or symptom. As the medical acupuncture physician is well versed in both western and eastern paradigms, he/she can combine acupuncture effectively with conventional medical or surgical interventions.

The American Academy of Medical Acupuncture (AAMA) has experienced an approximately 20 percent annual membership increase over the last 5 years. Its current membership is 2,000 physicians. As the only medical specialty society for physicians practicing acupuncture in North America, the AAMA is a leader in establishing and maintaining the highest standards of training and continuing education in practice of medical acupuncture. The AAMA is committed to the pursuit of excellence in this field of medicine and will continue to maintain this ideal as its highest priority.

Just as there are many sub-specialties within western medicine, so there are multiple disciplines within the practice of medical acupuncture and all of them are represented in the AAMA's membership. The training and practice requirements for membership in the AAMA are based on international standards and serve as a

model for state licensure of medical acupuncture physicians, hospital practice privileges, liability coverage and third party reimbursement.

DEFINITION OF MEDICAL ACUPUNCTURE AND PHYSICIAN RIGHTS

Acupuncture practice by physicians falls within the scope of the practice of medicine. Medical acupuncture specifically represents the use of acupuncture by fully trained and licensed physicians. By effectively combining the practices of western and eastern medicine, the medical acupuncturist fills a unique and critical role in patient care. Once again, we reiterate – the best of both worlds.

The AAMA adamantly believes that appropriately trained medical acupuncture physicians must be permitted to use his/her knowledge and skill to benefit his/her patients. Healing is both an art and a science. The ability to help and to heal is the ultimate privilege. This ability must not be abridged or curtailed in any way. Understanding the depth of commitment of physician acupuncturists and regulating their practice rights must come from one's peers. Therefore, the AAMA contends that, as is the case with any other medical specialty, regulation of physicians practicing acupuncture must come only from medical boards.

Incredulously, the medical acupuncturists' private practice rights are currently threatened by the restructuring of health care delivery and reimbursement. The AAMA seeks protection of the physician acupuncturists' rights, appropriate endorsement by the conventional medical establishment and recognition by health care providers of medical acupuncture physicians whose practice may be uniquely different from that of their other medical colleagues as well as non-physician acupuncture practitioners.

ACUPUNCTURE QUALIFICATIONS FOR PHYSICIANS

The AAMA requires all members to be graduates of accredited American medical schools with more that 4,000 hours of allopathic education and licensed to practice medicine in their State. In addition, the AAMA requires 200 hours of formal, approved acupuncture instruction, consisting of 120 hours of didactic education and 80 hours of clinical training followed by two years of clinical acupuncture practice. Satisfaction of each and every one of these requirements entitles a physician acupuncturist to Full Practice Membership in the AAMA. The AAMA also requires each member physician to fulfill 50 hours of approved continuing education in acupuncture every three years.

These requirements are consistent with the world-wide standards established by the World Health Organization and the World Federation of Acupuncture/Moxibustion Societies.

After completing comprehensive training, medical acupuncture physicians are eligible to sit for an exhaustive examination which could lead to board certification through the American Board of Medical Acupuncture. This examination is the most comprehensive measure of expertise in the multiple disciplines of acupuncture in the world

COMPLEMENTARY AND ALTERNATIVE MEDICINE ACCESS, DELIVERY AND REIMBURSEMENT

It is of little value to have the potential for receiving the best medical care in the world if access to that care it is routinely blocked. This is precisely the case with delivery of medical acupuncture services throughout America. And this problem is critically and sadly magnified for the elderly -- those who would most benefit from easy access to medical acupuncture.

Reimbursement for medical acupuncture services is sparse, at best in 21st century America. Essentially, these medical services are limited to those patients who can afford to pay out of pocket. While physicians are routinely reimbursed by third party payers for conventional Western medical paradigm related services such as Evaluation and Management (E&M), rehabilitation, inoculations and the like, payment for and access to the ancient, well-respected and effective medical practice and intervention of medical acupuncture is generally precluded. This is illogical and disturbing, especially when we consider caring for our elderly – those who could benefit significantly from easy access to medical acupuncture therapy. Let us not forget that the elderly suffer from chronic and painful problems which are often uncontrolled by bio-pharmaceuticals. Let us also not forget that our elderly are most likely to suffer from drug interactions and adverse side effects. And finally, let us not forget that medical acupuncture is side-effect free, painless and effective. Those of us who care respectfully request --- no, we demand that this inequity be remedied.

Unfortunately, there is no "quick fix' to this problem. It must begin with today's medical students and extend to continuing medical education programs throughout the nation. Medical students and physicians must be educated about the use and effectiveness of all complimentary medical modalities, especially medical acupuncture. And they must understand that, when administered by a licensed physician, medical acupuncture is an ideal compliment to traditional western drug and surgical interventions. They must understand its benefits and applications so as to be able to inform their patients of the conventional, complimentary and alternative medical options and choices available to them. And they must understand that medical acupuncture is not a threat to their practice, it is an enhancement to their success.

In the present medical reimbursement climate, knowledgeable physicians who prescribe complimentary and alternative medical interventions must constantly weigh the insurance coverage considerations against the out-of-pocket burden both for themselves and their patients. Being able to assess every patient from both Western and Eastern vantage points represents a remarkable advantage for the patient. Again, we repeat, the best of both worlds. Insuring that physician acupuncturists are appropriately compensated for their expertise and time insures the integrity of the practice of medical acupuncture and the safety of the patients. The best and the brightest will not be able to afford the extraordinary amount of time and emotional commitment to learning this complex paradigm if they will not be appropriately compensated at the end of their efforts.

This fact of non-reimbursement for physician acupuncturist is causing a strain on our healthcare system. The fact that most health care plans do not reimburse for physician acupuncturists has forced patients from their primary medical care providers and out of the healthcare system. This tends to fractionalize health care - a less than desired condition. Furthermore, a disparity in health care delivery that borders on discriminatory is created with the poor patient unable to participate because of limited out-of- pocket resources.

Finally, we must look at hospital care in America. Earlier I mentioned famed columnist James Reston. In China, he benefited from acupuncture analgesia and anesthesia. Yet in America there is a virtual dearth of medical acupuncture in the hospital setting. This must be changed. Hospitalized patients can benefit enormously from medical acupuncture to alleviate pain and expedite recovery. Medical acupuncture saves money. Patients recover faster. Post hospitalization office visits are reduced. Everyone benefits.

In fact, that's the main point of my presentation. Medical acupuncture creates win-win scenarios. Patients benefit by a speedy recovery and bio-pharmaceutical reduction. Surgeons benefit because their patients heal faster. Hospitals benefit because of shorter hospital stays. The public benefits because of reduced health care costs. A win-win all around.

Thank you for your time and consideration.

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U

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Summary of Major Themes from Town Hall Meeting: Seattle, October 30-31, 2000

- Tie into the goals of Healthy People 2010, the Federal blueprint for public health.

- Facilitate collaboration...
  (1) between conventional and CAM practitioners;

  (2) among local, regional, state, and Federal government agencies (including regulators, licensing boards, public health officials, and community-based primary care facilities); and

  (3) with 3rd party payers.

- Identify obstacles slowing the incorporation of evidence-based CAM practices into mainstream practice. Address, through collaboration, lack of familiarity with CAM research and researchers, suspicion of CAM therapies, and mistrust of CAM practitioners and researchers. This is often difficult and a challenge for both communities.

- Strengthen accountability and develop uniform, high quality standards; consistent licensing procedures; and practice guidelines as the basis for the inclusion of CAM practitioners in Federal, state, and regional/local health programs; to ensure uniformity of services for reimbursement; and to allow patients freedom of choice.

- Develop public or private quality assurance programs to increase provider and public trust in CAM products.

- Develop an herbal pharmacopoeia with standardization and regulation of manufacture, similar to the homeopathic pharmacopoeia.

- Support with local, state, and Federal funds primary health care clinics that can serve as incubators for cross training and integrating multiple-practice approaches, and for stimulating other collaborative and relationship-building activities. Integrate CAM into community health center networks nationally.

- Increase Federal agency support for local community demonstration projects to integrate CAM into conventional health services.

- Eliminate arbitrary exclusions, avoid mandates, and focus benefits on scientific outcomes in state health programs.

- Reduce the disparity in funding for research on conventional medical modalities and on CAM practices and products; increase funding to CAM professional schools for research and research training. Fund planning grants to CAM academic centers to develop research agendas, etc. Issue an RFA to support research infrastructure at CAM

institutions. Establish collaborative relationships with universities and hospitals that have needed facilities and expertise.

- Increase funding for education and training at CAM institutions and at traditional universities, including schools of medicine, nursing, dentistry, pharmacy, public health, and veterinary science. Train CAM professionals in public health.

- Develop methodologies to study emerging unconventional healing practices. Find methodologies that accommodate the cultural context and patient-centered, unique questions posed by some CAM therapies. When placebo-controlled trials are not feasible or appropriate, employ practice-based outcomes research, best case series, clinical audits, cohort analysis, pattern recognition, statistical evaluation, multi-varied or cluster analysis, and other known or new methods. Start with practical health services trials as a basis for further study.

- Include CAM professionals on research advisory councils, regulatory boards, review committees, and policy groups.

- Educate IRBs to provide more informed oversight of CAM clinical research.

- Examine regulations that lead to the removal of licenses of CAM practitioners and intimidate collaborating, allopathic physicians.

- Study wellness, the effect of social context on health, quality of life measures, and cost effectiveness of CAM.

- Increase research support to provide valid chiropractic clinical outcomes data. Support researchers and infrastructure at colleges of chiropractic. Integrate chiropractic research and education programs in conventional higher education environments.

- Allow for continuum of care as part of collaboration between allopathic and CAM care.

- Increase research on CAM as an alternative to conventional approaches that are not successful or create adverse reaction risk, especially for chronic conditions.

- Be more proactive to ensure that CAM research findings reach a broader audience.

- Support National Library of Medicine indexing of CAM journals.

- Determine the distinctions between incorporation of CAM procedures into conventional medical practice and integration of CAM providers into patient care pathways.

- Design services for reaching and covering the underserved; evaluate utilization by the underserved.

- Expand Federal laws to include loan repayment and scholarships for some CAM professions to serve in underserved areas.
- Include CAM in Medicare, Medicaid, and other Federal and state health-related program coverage.
- Improve collaboration among payers, the research and regulatory communities, and the professions.
- Fund research on insurance company CAM databases and how CAM affects health care costs.
- Evaluate insurance data from the Washington state experience.
- Examine the effect of insurance coding and "medical necessity" as limitations on CAM.
- Investigate reimbursement for herbal practice in states with practice standards.
- Work toward insurance coverage in private, Federal, and state plans to provide access to licensed CAM providers and to cover (approved) substances prescribed and certified as part of treatment.
- Conduct regional conferences on CAM integration.
- Strengthen Federal role as facilitator, partner, and referee.

Prepared by GPollen (11/28/00)

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X

Divider Title: _____

White House Commission on Complementary and Alternative Medicine Policy

Proposed Meeting Schedule*

DATE	SITE	TYPE	TOPIC
September 8, 2000	San Francisco, CA	Town Hall (1)	West Coast/Region IX
October 5-6, 2000	**Washington, D.C.**	**WHC (2)**	**RESEARCH Part I**
October 30-31, 2000	Seattle, WA	Town Hall (2)	Pacific Northwest/Region X
December 4-5, 2000	**Washington, D.C.**	**WHC (3)**	**ACCESS & DELIVERY Part I**
January 22-23**, 2001	New York, NY	Town Hall (3)	North/Region II
February 20-21, 2001	**Washington, D.C.**	**WHC (4)**	**EDUCATION/TRAINING**
March 5-6, 2001	**Washington, D.C.**	**WHC (5)**	**INFO DISSEMINATION**
March 16, 2001	Minneapolis, MN	Town Hall (4)	Mid-West/Region VII
March 26, 2001	Albuquerque, NM	Town Hall (5)	SouthWest/Region VI
April 9-10, 2001	**Washington, D.C.**	**WHC (6)**	**RESEARCH Part II**
May 14-15, 2001	**Washington, D.C.**	**WHC (7)**	**ACCESS & DELIVERY (REIMBURSEMENT) Part II**
June 22, 2001	Atlanta, GA	Town Hall (6)	South/Region IV
July 2-3, 2001	**Washington, D.C.**	**WHC (8)**	**REVIEW INTERIM REPORT DRAFT**
September 13-14, 2001	**Washington, D.C.**	**WHC (9)**	**WELLNESS**
November 5-6, 2001	**Washington, D.C.**	**WHC (10)**	**REVIEW FINAL REPORT**
December 6-7, 2001	**Washington, D.C.**	**WHC (11)**	**FINAL FULL MEETING**
March 2002	**Washington, D.C.**	**WHC (12)**	**CLOSING EVENT**

* This information, including dates and locations of Town Hall Meetings, may change based on recommendations om the Commission; ** January 22 will be primarily media activities; January 23 is reserved for the hearing

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White House Commission on Complementary and Alternative Medicine Policy

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e-mail whccamp@od.nih.gov Website www.whccamp.hhs.gov

Commissioners' Biographical Sketches

Dr. James S. Gordon, of Washington, DC, who will serve as Chair of the Commission, is currently the Director of the Center for Mind-Body Medicine. Previously, he chaired the Program Advisory Council at the Office of Alternative Medicine of the National Institutes of Health. In addition to maintaining a private practice in Psychiatry and Medicine, Dr. Gordon has been a Clinical Professor at the Georgetown University School of Medicine in the Departments of Psychiatry and Family Medicine since 1980. He is a member of the National Institute of Health's Cancer Advisory Panel and was the Director of a Special Study of Alternative Services for the President's Commission on Mental Health. He has written extensively on the subjects of psychiatry and alternative and holistic care, and serves on the Editorial Boards of Alternative andComplementary Therapies and Alternative Therapies in Health and Medicine. He received his A.B. from Harvard College and his M.D. from Harvard Medical School.

Dr. George M. Bernier, Jr., of Galveston, TX, is a hematologist/oncologist and is currently the Vice President for Education at the University of Texas Medical Branch. Previously, he was Vice President for Academic Affairs, Dean of Medicine, and a Professor of Medicine at the University of Texas. Dr. Bernier has held academic appointments at the University of Pittsburgh, Dartmouth-Hitchcock Medical Center in Hanover, New Hampshire, and at Case Western Reserve University in Cleveland, Ohio. He has published numerous articles and abstracts, and several books. He received a B.A. degree from Boston College and a M.D. degree from Harvard University.

Dr. David E. Bresler, of Los Angeles, California, is one of the first contemporary American scientists to study and research acupuncture, guided imagery, and other mind/body approaches. As a professor in the UCLA Departments of Anesthesiology, Gnathology/Occlusion and Psychology, he applied his findings to treating clinical problems that did not respond well to conventional care, beginning with chronic pain. As the Founder and Executive Director of the UCLA Pain Control Unit, he and his team created the first multi-disciplinary, university-based chronic pain program in America. Dr. Bresler has authored or co-authored numerous publications, as well as twenty books and workbooks. Currently, Dr. Bresler serves as Associate Clinical Professor of Anesthesiology at the UCLA School of Medicine, Executive Director of the Bresler Center, Clinical Consultant to the UCLA Pain Medicine Center, Dean of Mind/Body/Spirit of the University of Integrated Studies, and Co-Director of the Academy for Guided Imagery. Dr. Bresler received his B.A. from Brandeis University, his M.A. from Bryn Mawr College, and his Ph.D. from UCLA. He received his Certificate in Acupuncture from the Institute for Taoist Studies.

Mr. Thomas Chappell, of Kennebunk, ME, is the co-founder and CEO of Tom's of Maine, which he co-founded with his wife Kate in 1970. It is a company that produces innovative, natural personal products and natural wellness products in a caring and creative work environment. Mr. Chappell is founder and CEO of the Saltwater Institute, a learning institute of leaders seeking to integrate their values into their personal and professional lives. He is active in many philanthropic organizations, among them an Advisory Council member for the Center for Study of Values in Public Life at Harvard Divinity School, Harvard Divinity School Dean's Council, and a Board Member of the Nature Conservancy of Maine. He has written two books, The Soul of a Business and Managing Upside Down. Mr. Chappell received his B.A. from Trinity College and his Master's in Theology from the Harvard Divinity School.

Dr. Effie Poy Yew Chow, of San Francisco, CA, is the founder of the East West Academy of Healing Arts in 1973 and, more recently, The EWAHA Qigong Institute, the American Qigong Association, and the World Qigong Federation. She is the recipient of over twenty awards including "The Humanitarian of the Year 1999" and the "Visionary of the Decade 2000" awards. She has been the only Qigong Grandmaster and acupuncturist involved in the development of national health policies within DHHS. She was also involved in the first Ad Hoc Advisory Panel of the Office of Alternative Medicine at NIH. She has made over two hundred and fifty media appearances and interviews in the area of complementary and alternative medicine. Dr. Chow received her training in Traditional Chinese Medicine and Qigong in China, Hong Kong, Taiwan, Canada, and the United States. She is a registered public health and psychiatric nurse and has received a Master's degree and a Ph.D.

Mr. George Thomas DeVries, III, of Rancho Santa Fe, CA, is Chairman, President, CEO and co-founder of American Specialty Health and its subsidiaries, American Specialty Health Plans, American Specialty Health Networks, and American Specialty Health & Wellness. In his position, he manages complementary and alternative health care benefits, networks and services for over 60 health plans covering over 25 million Americans. American Specialty Health Plans is a licensed specialty health plan covering over 3.7 million Californians for chiropractic and acupuncture. American Specialty Health Networks is a national health services organization serving over 21 million Americans and offering a provider network of over 19,000 chiropractors, acupuncturists, massage therapists, dieticians, naturopaths, and fitness clubs. American Specialty Health & Wellness is an alternative healthcare consumer products company offering e-commerce and mail order. Mr. DeVries has published a number of articles and has lectured on alternative health care in managed care and third-party reimbursement. He received a B.A. from the University of California at San Diego.

Dr. William R. Fair, M.D., of Longboat Key, FL, was, until recently, the Florence and Theodore Baumritter/Enid Ancell Chair of Urology, and was Chief of the Urology Service at Memorial Sloan-Kettering Cancer Center in New York City. Currently, he is Emeritus Professor of Urology at the Joan and Sanford I. Weill Medical College of Cornell University and Member Emeritus at Memorial Sloan-Kettering. Dr. Fair serves on the Cancer Advisory Panel for the National Center for Complementary and Alternative Medicine. He is the Editor-in-Chief of Molecular Urology and the Associate Editor of Alternative Therapies in Health and Medicine, and on the editorial boards of other highly respected journals. He has published extensively in the areas of urology and oncology. He chairs the Committee on Complementary and Alternative Medicine of the American Urological Association, and is Chairman of the Clinical Advisory Board of Haelth, LLC. Dr. Fair received his B.S. from the Philadelphia College of Pharmacy and Science and his M.D. from Jefferson Medical College.

Dr. Joseph J. Fins, of New York, NY, is an internist and Director of Medical Ethics at New York Weill Cornell Medical Center of New York - Presbyterian Hospital, Associate Professor of Medicine and

Medicine in Psychiatry at the Joan and Sanford I. Weill Medical College of Cornell University, Associate Professor in the Program in Clinical Epidemiology and Health Services Research at Weill Cornell Graduate School of Medical Sciences, and Associate for Medicine at The Hastings Center. He lectures extensively and has written widely in the field of Medical Ethics. Dr. Fins received his B.A. from Wesleyan University and his M.D. from Cornell University Medical College.

Dr. Veronica Gutierrez, of Lake Stevens, Washington, practices with Gutierrez Family Chiropractic. She is a professional member of the World Chiropractic Alliance, serving on the Board of Directors. She serves as Chair of the Council on Women's Health and Director of Programs in Public Policy. Dr. Gutierrez has been very active in the chiropractic community, serving on many boards and commissions. She has received numerous awards in her profession, including awards from the Chiropractic Society of Washington, the Straight Chiropractic Academic Standards Association, and the International Chiropractic Association. Dr. Gutierrez received her Doctor of Chiropractic from Palmer College of Chiropractic and did post-graduate work at Cleveland College of Chiropractic.

Sister Charlotte Rose Kerr, R.S.M., of Baltimore, MD, is a Registered Nurse, a Practitioner of Traditional Acupuncture and, since 1977 a Senior Faculty Member at the Traditional Acupuncture Institute. Previously, she was an Assistant Professor of Nursing at the University of Maryland School of Nursing. Sister Kerr has been a member of the Advisory Council of the National Institutes of Health (NIH) Alternative Medicine Program. She has spent several summers in Europe, studying such subjects as Theology and Healing. In her work, Sister Kerr emphasizes the integration of Western traditional medicine and complementary healing methods. Sister Kerr received her B.S.N. from the University of Maryland School of Nursing. She received her Master's Degree in Public Health from the University of North Carolina and another Master's Degree in acupuncture from the College of Traditional Chinese Medicine, U.K.

Ms. Linnea Larson, of Oak Park, Illinois, is Associate Director of West Suburban Health Care (WSHC), Center for Integrative Medicine in Oak Park. Previously, she was the Behavioral Science Coordinator at WSHC Family Practice Residency Program. She was a clinical social worker at St. John's Hospital in Springfield, Illinois, where she provided inpatient and home hospice services and was also associated with the St. John's Center for Mind-Body Medicine. She also has worked as a family therapist and as a lecturer at the University of Illinois at Springfield. Ms. Larson received a B.A. from Knox College and a M.S.W. from the University of Illinois at Urbana-Champaign.

Dr. Tieraona Low Dog, of Corrales, New Mexico, currently serves as the Medical Director for the Tree House Center of Integrative Medicine in Albuquerque. With more than twenty years in the field of botanical medicine, she was recently elected to serve as Chairperson for the Dietary Supplements and Botanicals Expert Panel for the United States Pharmacopoeia. Dr. Low Dog received her medical degree from the University of New Mexico School of Medicine. She is part of the core faculty for Columbia University's Botanical Medicine Course for Physicians. Dr. Low Dog is currently working with Beth Israel on the development of a continuing medical education program on herbal medicine for physicians. She frequently lectures on the subject of herbal medicine. In 1998, she received the International Martina de la Cruz award for her work with indigenous remedies.

Dr. Wayne B. Jonas, of Alexandria, VA, is currently a member of the Department of Family Medicine of the Uniformed Services University of the Health Sciences F. Edward Hebert School of Medicine. Previously, Dr. Jonas served as the Director of the Office of Alternative Medicine for the National Center for Complementary and Alternative Medicine at the National Institutes of Health. Prior to that, he served

as the Director of the World Health Organization Collaborating Center for Traditional Medicine. He has authored and co-authored numerous publications on alternative and homeopathic treatment and care. Some of his current research includes projects in environmental toxicology, neurotoxicology, stroke, and biofield healing. Dr. Jonas received a B.A. from Davidson College and a M.D. from Bowman Gray School of Medicine.

Dr. Dean Ornish, of Sausalito, CA, is one of the founders, and the president and director of the non-profit Preventive Medicine Research Institute. He is Clinical Professor of Medicine at the University of California, San Francisco, and a founder of the Osher Center for Integrative Medicine there. He was the first to prove that heart disease is reversible by changing diet and lifestyle. He has published many books and academic papers and has received numerous awards in recognition of his work. Dr. Ornish received a B.A. from the University of Texas and completed his medical training at the Baylor College of Medicine in Houston, Harvard Medical School, and the Massachusetts General hospital. He was a clinical fellow in medicine at the Harvard Medical School. Dr. Ornish was recognized by Life magazine as "one of the 50 most influential members of his generation."

Dr. Conchita M. Paz, of Las Cruces, NM, has maintained a private practice, in which she specializes in family medicine, for ten years. Currently, she serves as a part-time faculty member at the University of New Mexico School of Medicine and at the Southern New Mexico Family Practice Residency Program. She was Chairperson of the Family Practice Department and serves on a number of committees at Memorial Medical Center. Dr. Paz received her B.S. and M.D. degrees from the University of New Mexico.

Mr. Buford L. Rolin, of Atmore, AL, has been the Health Administrator for the Poarch Band of Creek Indians since 1984. He is a member of the State of Alabama Public Health Advisory Board and a member of the Board of Directors of the Creek Indian Heritage Memorial Association. Mr. Rolin is currently the Chairman of the Creek Indian Arts Council. He is the former Chairman of the National Indian Health Board, and he still serves as a member of the Executive Committee and as a Member-At-Large. He has received several awards from the National Indian Health Board, and he has also received a Lifetime Achievement Award from the Poarch Band of Creek Indians. Mr. Rolin attended the Health Services Administrators Development Program at the School of Community and Allied Health of the University of Alabama and Pensacola Junior College.

Ms. Julia Scott, of Washington, DC, is President of the National Black Women's Health Project (NBWHP), a national membership organization that focuses on wellness, self-help, and health advocacy. Previously, she was Director of the Public Policy and Education Office of NBWHP. Ms. Scott was Special Assistant to the President and Coordinator of the Adolescent Pregnancy Child Watch at the Children's Defense Fund. She has directed and administered to several foundations and community health agencies and has written numerous articles on African American Women's health. Ms. Scott was educated in nursing at the Waterbury Hospital School of Nursing.

Dr. Xiao Ming Tian, of Bethesda, Maryland, is Director of the Academy of Acupuncture and Chinese Medicine and Wildwood Acupuncture Center. Dr. Tian is currently conducting a National Institute of Health (NIH) supported clinical trial with Georgetown University Medical School to treat fibromyalgia patients using acupuncture. He has completed many research projects on the use of Chinese herbal medicine and dietary supplements to treat and prevent arthritis, sports injuries, and fibromyalgia, in collaboration with NIH and the U.S. Department of Agriculture Nutrition Center. In 1991, Dr. Tian was the first person to be appointed a Clinical Consultant of Acupuncture to the NIH medical staff. He is an Adjunct Assistant Professor of Preventive Medicine at the United States Uniformed Health Service. Dr. Tian is the President of the American Association of Chinese Medicine. He is also the Honorary Director

of the China Association of Traditional Chinese Medicine and Vice President of The International Academy of Medical Qigong, both in Beijing, China. He currently serves as an advisor to World Health Organization and Pan-American Health Organization on traditional medicine. Dr. Tian received his Medical Degree from Beijing Medical University and was a Ph.D. Research Fellow at NIH.

Dr. Donald W. Warren, of Clinton, Arkansas, currently practices general dentistry, which includes dental cranial osteopathy, an alternative and complementary approach to health; temporomandibular joint dysfunction treatment, an alternative treatment for head, neck and facial pain and orthodontics/orthopedics. Since 1989, Dr. Warren has presented seminars on dental cranial osteopathy, temporomandibular joint dysfunction treatment, contact reflex analysis and designed clinical nutrition, and correct dental occlusion. Since 1999, these seminars have been accredited by the Academy of General Dentistry. He also instructed a hands-on clinic at the Texas College of Osteopathic Medicine, hosted by the Sutherland Cranial Teaching Foundation. Dr. Warren has taught in the United States, the United Kingdom, and Australia. Dr. Warren received a B.A. from Hendrix College and a D.D.S. from the University of Tennessee College of Dentistry. Since then, he has continued to study in his fields of expertise and is a diplomat of the American Board of Head, Neck and Facial Pain.

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