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Meeting Summary of ~~the~~ December 4-5, 2000



MEETING SUMMARY

The following is an overview of the presentations and major issues discussed during the recent meeting of the White House Commission on Complementary and Alternative Medicine Policy, held at the Hubert H. Humphrey Building in Washington D.C., December 4-5, 2000.

Session I: Overview

Commission chairman, Jim Gordon, M.D., began the meeting by saying that recent surveys (Eisenberg, 1998, Paramore, 1997) have established that approximately 40 percent of Americans are using some form of complementary and alternative medicine (CAM). He said, however, that this overall percentage of usage is based on phone surveys of English-speaking people. For many non-English-speaking populations, therefore, CAM may be, in fact, their source of primary care. Dr Gordon said, "one of the charges of the Commission is to address the needs of those people and to understand the importance of the contributions that those people make to our health care system, as well as the needs that they have from our health care system." He also noted that comparisons between recent surveys and earlier surveys (Eisenberg, 1993; Eisenberg, 1998) have shown a dramatic rise in the use of certain forms of CAM, particularly megavitamin, herbal treatments, and homeopathic remedies. Furthermore, recent studies show that although most people do not turn their back on CAM (Astin, 1998) but tend to use CAM to supplement their conventional treatments. He added that studies show CAM useage to be high among those facing chronic and life-threatening conditions (Eisenberg

et al, 1998), that interest in and referrals to CAM by conventional physicians is relatively high (Astin et al, 1998; Bermen et al, 1995, 1998), and that the majority of medical schools in the U.S. are now offering at least elective courses in CAM therapies.

Dr. Gordon then went on to briefly summarize the problems that the commission was going to be addressing at this meeting, including the need for more data on effectiveness and cost effectiveness and the need for more research on the issue of integration. He said one of the “central purposes” of the meeting is for the Commissioners to hear testimony about some models of integration.

Panel Discussion:

Following Dr. Gordon’s overview, Commissioners discussed whether the rise in use of certain CAM therapies was related to increase marketing of those therapies. Commissioner Jonas suggested that Commissioners may want to examine a book on the social dynamics of CAM use, which had just been released. Commissioners also discussed whether increased utilization of CAM therapies was linked with decreased access to health insurance. The consensus was that decreased access to health insurance did lead to increased use of CAM but was not the only explanation. Chairman Gordon said that in the homeless population, even though there was access to medical services through emergency rooms, CAM was appealing because homeless people do not feel particularly “cared for” when they go to hospitals.

Session II: Clinical and Cost Effectiveness of Selected CAM Services

Chiropractic:

William Meeker, D.C., MPH, testified that numerous studies have demonstrated the effectiveness of chiropractic manipulation, and it has been rated as an effective treatment for back pain by the United States Government, by the UK, Denmark, New Zealand, Australia, and Sweden, and others. In terms of cost effectiveness, he said studies suggest that the cost of chiropractic and conventional medical care is similar, although chiropractic patients tend to be much more satisfied with their care compared to patients receiving conventional care. He urged the Commission to examine three major reports on the cost-effectiveness of chiropractic as part of their deliberations.

Naturopathic Medicine:

Konrad Kail, N.D., P.A., testified that there are a number of studies demonstrating the effectiveness of individual naturopathic modalities. However, naturopathic medicine tends to combine many modalities in the treatment of a single condition. There have been few, if any, studies that have look at outcomes in naturopathic medicine in general. There is also only a short history of limited third-party reimbursement to look at utilization and cost effectiveness of naturopathic approaches. However, potential cost savings of naturopathic medicine include better education of patients about how to stay healthy and the greater knowledge and the home use of nutritional, botanical, and homeopathic medicines, both of which reduce costly visits to the physician. Dr. Kail urged the Commission to recommend greater funding for the

NCCAM, and said it is extremely important for the Commission to recommend inclusionary language for CAM in entitlement acts, such as Medicare, Medicaid, Indian Health Service, and CHAMPUS for the military.

Acupuncture:

Patricia Culliton, LAc, testified that despite acupuncture's 4,000-year history, to date there have not been a great deal of studies done on the effectiveness of acupuncture for specific conditions. Therefore, she said, the acupuncture data, like the naturopathic data, is still in its infancy. She noted that in a recent NIH Consensus Conference on acupuncture, which was held in 1997, only two areas of utilization for acupuncture were considered to have definitive data, while several other areas had positive trends. Therefore, she "strongly" recommend further research expenditures on the clinical efficacy of acupuncture in conditions such as musculoskeletal pain and analgesia, breech aversion, nausea and vomiting, dysmenorrhea (menstrual pain), and bladder disorders. There have been no major cost effectiveness studies on acupuncture. However, several clinical studies have made cost-analysis and discovered that people in the experimental group that received acupuncture had significant financial savings compared to the control group. She urged the Commission to recommend large clinical effectiveness study and cost effectiveness studies of acupuncture for specific conditions as well as the development of CME courses and CEU courses for physicians in acupuncture and for CAM modalities and approaches in general. She also urged the Commission to consider a school loan forgiveness program for those people going to acupuncture schools, if they commit themselves to work in public health agencies after graduation.

Homeopathy:

Joyce Frye, DO, MBA, FACOG, said there are an estimated 2,500 medical practitioners using homeopathy in the U.S.. Research on both clinical efficacy and cost effectiveness of homeopathy has suffered from limitations that are common to all of the CAM practices. The most useful summary of clinical efficacy, she said, is provided by the meta-analysis of 89 placebo-controlled trials published by Linde (Linde et al, 1997), which indicated that patients using homeopathy were 2.5 times more likely to have a therapeutic effect compared to placebo in a variety of conditions. The most complete data on cost effectiveness, she said, comes from the French Government Social Security statistics, which demonstrated significantly reduced costs using homeopathic versus conventional medical care. She said that these data are particularly compelling in view of France's ranking as the "number one" health care system in the world in terms of performance, in comparison to the United States, which is ranked 37th. She added that France also ranks third in life expectancy compared to 24th for the U.S.

Massage:

Tiffany Field, Ph.D., of the Touch Research Institute (TRI), testified that massage therapy, along with acupuncture, is one of the oldest therapies, dating back to Hippocrates in 400 B.C. She said that most of the research on the effectiveness of massage has been conducted at TRI during the last decade. TRI studies have demonstrated that massage can reduce prematurity and low birth rates associated with pregnancy, stress, and anxiety; can enhance the growth of preterm babies; can affect the outcomes of a number of psychiatric disorders; and can impact on immune problems, including asthma, diabetes, dermatitis, HIV, and cancer. The only study

on the cost effectiveness of massage was in pre-term infants and was able to demonstrate a hospital cost savings of \$10,000 per pre-mature baby (Field et al, 1986). Multiplied by the 470,000 pre-term babies born in the U.S. each year, it equals a cost-savings of \$4.7 billion per year, according to Dr. Field.

Panel Discussion:

Commissioners asked the panel to comment on: 1) their profession's attempts to teach self-management techniques patients, 2) where they thought cost-effectiveness studies should be directed, 3) what are the barriers to delivery of their therapies, 4) how their approaches to disease prevention might be broken down into reimbursable segments of time and services, and 5) what are the education priorities. Although all said teaching patients self-care is integral to their approaches. Dr. Meeker said he was not in favor of teaching self-manipulation to patients, however, because of the degree of skill needed to avoid self-injury. In regard to cost-effectiveness studies, Dr. Kail said that naturopathic studies must look at the whole system of care, because naturopathic physicians rarely deliver a single modality for condition. In regard to barriers, Dr. Fields said that in the field of massage, the traditional training of doctors not to touch patients is a major barrier. She said underlying mechanism studies to persuade the physicians that massage approaches work are necessary. In regard to reimbursement, Dr. Kail said there are new reimbursement codes for time spent in discussion and patient education that are being underutilized by the insurance industry. He said that inclusionary language in Medicare and Medicaid is the fastest way to get those codes better utilized. In terms of education, Ms. Culliton said that education resources should be directed to

training medical students and physicians in the effectiveness and cost benefits of CAM approaches as opposed to delivering the modalities themselves. Dr. Meeker said he agreed with Ms. Culliton. He added that there is an even greater need to train all health professionals, not just medical doctors, but CAM professionals as well, in how to interrelate to each other.

(Session II Continued)

Herbal Medicine:

Dennis Awang, Ph.D., SCIC, said herbal medicine's potential contribution to health care appears to be fundamentally related to the ability of the consumer to have access to safe and efficacious products. However, knowledge of the nature of active principles and the mechanisms of action of herbals remedies is severely limited. He recommended the institution of a system, such as that proposed by the World Health Organization (1978), to establish guidelines for the assessment of herbal medicines and to ensure proper identity and quality of both raw materials and finished products. Since most of the adverse reactions attributed to herbal remedies have been due to substitution, adulteration, misidentification, or linguistic confusion, he said it is not wise to leave the establishment of the identity and quality of these materials to manufacturers.

Christopher Hobbs, an herbalist and a licensed acupuncturist, said that he has received funding from a pharmaceutical company to sift through the literature on a hundred herbs in great detail. He and his colleagues have researched 26 international electronic databases

and accessed a great deal of foreign material. Unfortunately, very few herb studies to date that have met high scientific standards. He recommended that well-trained herbalists be involved in studying the safety and efficacy of herbs on a scientific basis because many scientists have the view that herbs do not work until it is proven that they do work, which is the antithesis of how an herbalist would view them. He added, that although herbs can have side effects, generally speaking, herbs are far safer than drugs.

Nutritional Supplements:

Alan Gaby, M.D., provided examples of the superior cost effectiveness of nutritional supplementation versus conventional therapy for 10 common, but costly ailments. He added that he has seen many patients spend thousands of dollars on care that didn't work, when, in fact, all they were suffering from was a food allergy. Therefore, he recommended the better teaching of nutritional information in medical schools. If implemented, he said, the cost of care will undoubtedly come down by billions of dollars.

Patsy Brannon, Ph.D., R.D., a registered dietitian, testified that the recent Institute of Medicine report on the role of nutrition and malnutrition in maintaining health in the nation's elderly (Institute of Medicine, 1999) defines two tiers of nutritional services that impact the consideration of CAM. The first is basic or general nutrition education or advice that can be provided by a variety of health care professionals. The second tier is medical nutrition therapy, which involves nutritional assessment, evaluation of nutritional needs, intervention, counseling, enteral and parenteral nutrition, and other modalities, as

well as follow-up care. This type of therapy is generally provided by registered dietitians in a health care team of physicians, nurses, pharmacists, physical therapists, and psychologists. Beyond these two tiers, however, the vast majority of consumers get their nutritional information through the mass media. She said that nutrition therapy is “strongly supported” by observational studies, consensus documents, systematic reviews, and extensive clinical trials for a number of conditions. Furthermore, several recent reports have examined the cost effectiveness of nutritional therapy and have found potential savings ranging from the millions to billions of dollars for the health care system. She said there are a number of barriers to nutrition therapy, including the lack of recognition of nutritional therapy by Medicare and Medicaid and private practice health plans. She recommended the passage of legislation currently in Congress, H.R. 1187 and S. 660, to provide outpatient medical care coverage for medical nutrition therapy for diabetes and kidney disease. She also recommended the consideration of expanded Medicare and Medicaid coverage as recommended by the Institute of Medicine report for the other chronic diseases for which nutritional therapy has been documented effective.

Integration Overview:

Harley Goldberg, D.O., Medical Director for CAM for Kaiser Permanente in Northern California, said his job is provide information on CAM practices to Kaiser's physicians, members, and health care providers, to coordinate a research program, and to evaluate education and training needs for providers. It is also his responsibility to identify the appropriate access and delivery systems. He said that a recent Kaiser-funded survey

(Gordon et al, 1998), which found a very strong interest about CAM amongst Kaiser's members, patients, and physicians and clinicians, formed the basis of Kaiser's CAM strategy. Based on the survey, areas of modalities and conditions were identified in which to conduct systematic reviews. The systematic reviews, in turn, drive the activities of Kaiser's Education Committee, informs Kaiser's research agenda, and the consideration which CAM services to deliver. To be considered an appropriate for a specific condition, there must be reasonable evidence of safety and effectiveness. He, therefore, asked the Commission to recommend funding of organized systematic reviews in a coordinated fashion on specific CAM methods and by clinical conditions. He further suggested the need to increase research on clinical implementation of specific CAM treatments for specific conditions involving CAM practitioners and experienced researchers.

Panel Discussion

Commissioners asked Dr. Goldberg: 1) which CAM services Kaiser is currently providing, 2) who fills the role of the gatekeeper for these services, 3) what the process is for generating consensus, and 4) to explain Kaiser's system for CAM education. Dr. Goldberg replied that Kaiser is integrating acupuncture as one component of its chronic pain delivery system and provides manual therapies through Kaiser's Physical Therapy Departments. He said that the role of gatekeeper depends on whether a service requires physician referral and whether a service is available on self or patient referral. Treatments for a specific clinical condition require a primary care physician referral, although

referrals can come from any specialist or any provider in the system. He said consensus was generated by the survey he mentioned, but members were not involved in reviewing the evidence. He added that Kaiser uses many different formats for imparting information on CAM, including in written summaries of the research, full practice guideline including the bibliographies and evidence tables, summaries of clinical information, and video conference presentations.

The Commissioners also asked panel members to make recommendations for improvements in labeling regulations for herbal and dietary supplements, and on licensing and credentialing. Mr. Hobbs recommended a “traditional medicines” category that would take into account the historical and traditional use of an herb and to better educate consumers how to use them. Dr. Gaby suggested that manufacturers be allowed to put the information on the known effects of nutritional supplements on the label so that it would greatly enhance both the effectiveness and the safety. Dr. Awang noted, however, that much of the information currently put on labels is unreliable. He said that the most useful information that can be put on labels is warnings against possible adverse effects or toxicity, and recommendations as to use. On the other hand, he agreed with Dr. Gaby that limiting claims about efficacy is problematic because many people are buying herbs and nutritional supplements for treating specific conditions and they need accurate information on efficacy. For example, he noted that Saw Palmetto is often labeled as promoting prostate health rather than as a treatment for symptoms of benign prostatic hyperplasia, which is what most people buy it for. Dr. Brannon agreed with Dr. Awang that there needs to be

added focus on potential adverse effects and not focus on those that do not have adverse effects. Finally, Dr. Goldberg said because it is such a long process to conduct randomized clinical trials on herbs for specific condition, to get relatively good answer questions more quickly, one can use epidemiologic data and other types of studies in the meantime.

Session III: Use of CAM for Selected Health Conditions

Substance Abuse/HIV-AIDS

Howard Josepher, Executive Director of Exponents, Inc., a not-for-profit drug treatment program in New York City, testified that because of AIDS, Exponents created an alternative approach to engaging and working with drug addicts, called ARRIVE.

ARRIVE does not require abstinence for participation, but instead focuses on risk reduction for sex, drug use, and opportunistic infections and promotes proper nutrition through counseling and vitamin supplementation. ARRIVE also promotes stress reduction through a variety of CAM approaches including acupuncture, aromatherapy, music therapy, and meditation.

Denise Drayton, a graduate of the ARRIVE training program, and currently a staff member at Exponents, testified that she was first introduced to CAM during detoxification for heroin addiction. Her treatment including conventional treatment methods along with acupuncture for stress and pain management, which she continued using on an outpatient basis. She said the ARRIVE program also taught her visualization and deep breathing meditation and she has been drug-free for 10 years as a result. She said that in her

community, however, CAM therapies are not readily available and even when it is, there a natural distrust of anything that is not traditional (i.e., conventional).

Cancer

Barrie Cassileth, Ph.D., Chief of Integrative Medical Services at Memorial Sloan Kettering Cancer Center in New York City, did not testify by submitted written testimony to the Commission, in which she described Sloan Kettering's CAM integration program and preliminary data on how its CAM services compare with conventional services. She said the CAM integration is extremely important to the treatment of cancer patients, because cancer is "a massive biological event and its treatments are often extremely difficult." She said that it is absolutely essential the CAM therapist work along side of oncologists at every stage of treatment and rehabilitation to ensure that therapies and their administration are consistent with patients' physiologic status and that patients receive only care that benefits them.

Jeanne Andrews, a cancer patient, testified that 21 months ago she was diagnosed with Stage IV colon cancer, after which she underwent colon resection and six months of chemotherapy. She was first introduced to CAM when a friend recommended that she see massage therapist. After her oncologist gave her the book, Comprehensive Health Care, she read it and contacted its author, Dr. Jim Gordon [Commission Chairman] and began attending programs at Dr. Gordon's center. There, she learned deep meditation, visualization, and a number of other forms of relaxation and also began undergoing acupuncture and intensive medical Qigong at another center. She said she is currently

cancer-free and that she believes CAM treatments played a major role in her recovery. She said, however, there were a number of obstacles to her gaining access to CAM, including lack of insurance coverage and no central location for gaining credible information on CAM.

Heart Disease

Richard Collins, M.D., a cardiologist and Director of the Heart Disease Reversal and Prevention Program in Omaha, Nebraska, testified that traditional approach to cardiovascular disease management in this country is not cost-effective because there is a 30 to 50 percent restenosis rate after angioplasty or stent placement, and after typically bypass operations only last 7 years before costly recurrent admissions for heart failure occur. On the other hand, he said, the Dr. Dean Ornish program for heart disease reversal and prevention strikes at the very root cause of the disease process, by stabilizing plaques, reducing angina and costly readmissions to the hospital, and improving quality of life and well-being. He said several studies have documented and reconfirmed the programs effectiveness with multi-year follow-ups (Ornish et al, 1983; 1998). He said the Mutual of Omaha demonstration project has documented a cost savings \$29,000 per patient. Similar finding also have recently been found by Highmark, Blue Cross/Blue Shield of Pennsylvania, which has embraced the Ornish program. For the insurees in Pittsburgh, a cost savings has been noted of more than \$17,000 per person, improvement in SF well-being scores, outcomes, and reduction of angina. He, therefore, recommended that lifestyle behavior should be listed as a prudent, first-choice medicine for people with heart disease and said that the Commission also should “embrace” the Ornish program by providing access to it for all populations.

Walter Czapliwicz, a 45-year-old participant in Dean Ornish's program for reversing heart disease, testified that he came to the program after having had three heart attacks

and bypass surgery. The bypass worked for about two years, but then he started having chest pains again. However, within 10 days of starting the program, he said, he said his chest pain had diminished greatly and was completely gone after six weeks. He hasn't had any chest pain since then and has lost 64 pounds. In addition, his resting blood pressure has dropped from 160/80 to 128/72, his cholesterol is down from 196 to 114, and his triglycerides are down from 311 to 116. He said he truly believes this program saved his life.

Hospice Care

J. Donald Schumacher, Psy.D., of the Center for Hospice and Palliative Care, testified that in many ways hospice care is the epitome of high-quality CAM. Many of the nurses in his program are trained in therapeutic touch, and oftentimes engage in stress reduction using guided meditation and visualization. His program also employs homeopathy, chiropractic care, and acupuncture, the latter of which helps patients significantly reduce their dependence on narcotics and other debilitating medications. Unfortunately, one-third of the patients that receive hospice care die within seven days. As a result, most hospice care today is brink-of-death care, rather than true hospice care. He said that patients facing end-of-life problems need to be able to get access to hospice care sooner in order to be able to experience its full benefit.

Panel Discussion

The Commissioners asked Dr. Schumacher: 1) why referrals to hospice care have declined so dramatically in recent years, 2) what the hospice movement is doing increase access to hospice care for hospitalized patients, and 3) if hospice care could be delivered at home to save costs. Dr. Schumacher answered that cost is the major reason referrals to hospice have declined dramatically in recent years. "Our median length of stay has gone from about 29 days down to 14 days, and that is absolutely wrong for patients who need this care," he explained. He said that the hospice movement, with funds from the Robert Wood Johnson Foundation, has begun an innovative pilot project, called the Center to Advance Palliative Care, to help increase hospitalized patients' access to hospice care. He said that 80% of hospice care is provided at home. He emphasized, however, that there is a major distinction between hospice care and home health, particularly in regard to prescription benefits. For hospice patients, prescription drugs are paid for, for home health care patients, they are not. He said the largest obstacle to providing hospice in this country is the six-month criteria for Medicare coverage (i.e., the person has to have six months or less to live). He said he believes the Federal Government needs to develop demonstration projects around the country that will allow hospice programs to provide care without a reimbursement cap and without a criteria or prognostic cap.

The Commissioners asked Mr. Czaplewicz and Dr. Collins to make recommendations on how best to educate people of the benefit of lifestyle changes on the prevention and treatment of heart disease. Mr. Czaplewicz said that developing effective programs to educate people about what they are doing to their bodies through their diet is key. Dr.

Collins added that it is extremely difficult to get people to listen to lifestyle advice until they are faced with the reality of increased risk. He said, however, that the new emerging technology, such as electron beam CT scanner that can detect plaque in peoples' arteries and veins and determine total plaque load may change that. He cautioned, however, that lifestyle changes can only affect heart disease if an artery has not been touched. "There is evidence that once an artery is touched, either through a stent or angioplasty, lifestyle cannot control it," he explained

Commissioners asked Mr. Josepher to elaborate on the ARRIVE program's efforts to reach out into the jails and prisons, and how such efforts may help prevent recidivism as well as prevent increasing illness from HIV, and if good studies existed that indicate there is a positive value of using CAM approached to help manage individuals in drug withdrawal. Mr. Josepher answered that ARRIVE does a substantial amount of outreach in the institutions in New York, primarily by engaging prisoners before they are released. Therefore, a whole new area that is being developed in addiction work with the criminal justice population is transitional planning, where the idea is to engage people in the institution and inform them of the various kinds of services that are available out in the communities. He added that most of the innovation and inroads that are currently occurring in addiction treatment are because of HIV and AIDS. In regard to research, Mr. Josepher said a Dr. Mike Smith from New York City, who developed auricular acupuncture has a substantial documentation on its effectiveness for managing drug withdrawal. However, he noted, that in the substance abuse field evidence of effectiveness

often does not mean very much because it is a field that still prefers to treat drug use primarily through incarceration.

Commissioners asked Ms. Drayton if there was a single, key ingredient that helped her the most and to suggest ways that the Public Health Service and other agencies can get the message out to the African-American community that CAM is not necessarily second-rate medicine

Ms. Drayton answered her first contact with ARRIVE gave her a newfound sense of self-worth and spirituality, which then led her to the use of acupuncture. She said that the most influential way to deliver health messages in her community is through peer education. "If it is coming from someone who has experienced it and has a working knowledge of it through first-hand experience, they tend to believe it," she explained. Mr. Josepher added that although race is sometimes a barrier, if teachers had information and have conviction, they can transcend those barriers.

Commissioners asked Ms. Andrews to describe all of the CAM treatments that were not paid for by her insurance in her effort to try to create integrative cancer care for herself. Ms. Andrews replied that she has done Reiki, massage therapy, support groups, Chinese herbs, various vitamin supplements, acupuncture, and art therapy. The only one that was covered by insurance has been acupuncture when it is administered by a medical doctor. She added that prayer has been a very important part of her healing. She said that if one does not have hope or faith, it is extremely hard to beat something like cancer.

Session IV: Issues in Integrating CAM in Service Delivery

Richard B. Miles of Health Frontiers testified that 30 years ago he began organizing and managing major conferences on CAM, including the first national symposium on acupuncture at Stanford in 1972. He said the prevailing attitude of our conventional medical system has been that when an individual presents with a disease, they are essentially ill and need to be made well with interventions. There is an emerging perspective, however, that people are essentially well and need to be made ill. If one can get the factors that are contributing to this illness out of the way, the system will heal itself. He said that he is currently working with organizations and programs that are trying to develop this particular kind of concept. Mr. Miles said that doctors should be better listeners and to help people reestablish connections with nature and allow the diseases of this culture to heal themselves rather than try to fix them.

Berkeley Bedell, former congressman from Iowa and current president of the National Foundation for Alternative Medicine, testified that he believes the Commission has a genuine opportunity to make a difference. He said that 3 years ago, he and his wife formed the National Foundation for Alternative Medicine to conduct CAM field trials that NIH was unwilling to conduct itself. He said the Foundation currently is focused on cancer treatments and is sending teams led by a medical doctor to visit alternative cancer clinics and go over their patient records. He said the foundation is finding clinics in Europe

administering low-cost, non-toxic cancer treatments with success that would not be expected at major cancer clinics here in the United States. He, therefore, pleaded with the Commission to recommend passage of The Access to Medical Treatment Act, which would make it possible for these non-toxic treatments to be tried under strictly controlled circumstances. He also said the Commission should recommend that any medical treatment that has been in use in another country, where there is no evidence of it posing a danger to the patient, to be allowed here in the United States.

Paul Kurtz, Ph.D., a representative of The Committee for the Scientific Investigation of Claims of the Paranormal, said he was troubled by the lack of skepticism in the Commission's deliberations. He said that he and his colleagues are committed to scientific medicine because it has been the most effective way of curing disease and promoting human health. He said he was also troubled by the Commission's having categorized too many things as alternative, when some clearly are not. For example, he said that lifestyle management in cardiology should not be labeled as alternative medicine. As commissioners on a Presidential Commission, he said there is obligation to see that CAM methods are carefully judged by double-blind tests, that they are backed up by coherent theories, that there are studies of mechanisms to explain why they work. He emphasized that CAM research needs to be conducted by neutral observers who are objective and impartial, neither strong negative skeptics, nor strong proponents, but people who are committed to scientific research.

Panel Discussion:

Several Commissioners disagreed with Dr. Kurtz's assessment that most conventional medicine treatments have been scientifically proven to be effective while most CAM therapies have not. It was pointed out that most prescription drugs have not been shown to be more effective than placebos. Dr. Kurtz replied that even conventional medicine should be continually questioned. He said he is not defending conventional medicine, per se, but the system of scientific inquiry used to test it.

Commissioners asked Mr. Miles whether he viewed CAM as being able to co-exist with western medicine or something that should be integrated into it. Mr. Miles answered that the groups he has worked with achieved their best results when there was collaboration between conventional and CAM practitioners. He said, however, that one of the main determinants of collaboration is the reimbursement system. The movement toward medical savings accounts appears to be a step in that direction, particularly, for separating routine preventive care from more catastrophic "insurance" care. He cautioned, however, that unless we change the mindset that people can do whatever they want to their bodies and the insurance system will bail them out, we will be facing an uphill battle.

Commissioners then asked Mr. Bedell to elaborate on his proposal to allow acceptance of use of therapies that have been shown to be relatively safe in other countries. He replied that because there are not good treatments for most degenerative diseases, people with such

conditions should have the right to try potentially beneficial treatments developed in other countries with out fear of government interference. He said there is a need to “open up” the present regulatory system so that these new treatments can be at least tried. He said, however, that it would be a very different situation if there is any evidence that a treatment is toxic. Mr. Kurtz argued that “determining toxicity” is a difficult problem. There was not agreement among panel members regarding who should be responsible for determining toxicity—with Mr. Bedell saying that he didn't trust the FDA to do it because it is too closely aligned with the pharmacetical companies—however, there was general agreement that the Federal Government should play some role in the process.

Session V: Meeting Public Needs/Systems of Delivery

Private Practice Integration:

Robert Atkins, M.D., a private practice physician, said he began practicing a “different kind” of medicine in the early 1960s in order to get better outcomes as well as to disprove prevailing medical notions about diet and illness. After many years of practicing medicine differently, he said he and his colleagues believed they had succeeded in achieving better outcomes in many areas than when they were practicing strictly conventional medicine. In the early 1970s, he wrote a book about his experiences. He said the term “complementary medicine” aptly applies to practicing physicians and, in fact, should be the future of mainstream medicine. He said complementary medicine should not be viewed as adding complementary therapies to mainstream medicine, but an entire system of patient care, a different system, a system which is based on a “working knowledge” of all of the healing

arts. He said that complementary medicine offers the Federal government an opportunity to solve its most pressing health problem: controlling spiraling health care costs.

Nursing Integration of CAM:

Charlotte Eliopoulos, a representative of the American Holistic Nurses Association (HNA), said the nursing profession has a long history of providing holistic care. For a number of reasons-- including their large relative numbers, the diverse clinical setting in which they practice, and their multi-disciplinary education--she said nurses must have a significant role in this integration of CAM into the health care system at large. She said there is a need for nurses to increase their knowledge about CAM through continuing education for the existing work force, as well as the integration of this within the undergraduate nursing programs.

Stand-Alone CAM Center:

Mort Rosenthal, chairman and founder of Well Space, a for-profit CAM clinic, said that Well Space has been open in Cambridge Massachusetts for 27 months. It has 21 treatment rooms, 70 practitioners, and offers massage, acupuncture, Chinese herbs, chiropractic, naturopathic medicine, and nutritional classes. To date, the clinic has served approximately 10,000 patients and will take in approximately \$2 million year, a very small amount of which is profit. He said 45 percent of the Well Space visits are related to stress or the need for relaxation. The rest of the condition range from headaches, back and neck pain, sleep disorders to fibromyalgia, fatigue, and cancer. He emphasized that Well Space

is complementary, not integrated, and that Well Space's patients, for the most part, are not interested in integrative care. He said that in more than 40,000 visits, no patient has asked to have information sent back to their conventional physician. He added, however, that Well Space has an excellent relationship with local physicians, whom often give them informal referrals, as opposed to a traditional referral. He said that in a recent six-month pilot study, among 2,000 people who essentially offered free CAM care without referral, 70 people took advantage of the program and 50 of those, or 71%, continued their care even though they now had to pay out of pocket. From a policy perspective, he said he believes that the delivery system for CAM will continue to be largely stand-alone. He suggested that any policies that are made should not be biased in favor of full integration.

Panel Discussion:

Commissioners asked Dr. Atkins to describe some of the obstacles he faced in setting up and implementing his practice. He answered that there were many areas that they believed their methods were getting good results, but that the insurance companies would not reimburse for them. For example, he said, he and his colleagues often use a high resolution microscope for diagnosing the presence of various bacteria, yeasts, and parasites, but that they could not get reimbursed for the use of this expensive equipment because there was not an insurance code for it. He added that very few of the cancer treatments he and his colleagues use as alternatives to chemotherapy and radiation are eligible for insurance reimbursement. Furthermore, he said that he and his colleagues use a number of treatments that have been approved in Europe but that have not been approved here in the U.S. for

various conditions that are not being reimbursed. The solution to all of these obstacles is to fund the kind of research that will allow everyone to see the two systems of medicine—conventional and CAM—compared side by side with a matched group of subjects to determine which gets better results and at lower costs.

The Commissioners asked Mr. Rosenthal: 1) what Well Space was doing to increase access for low-income people; 2) if it has an approach for improving the dissemination prevention materials; 3) why more people didn't take advantage of its pilot program; 4) why Well Space chose to be complementary rather than integrative; and 4) to make recommendations for research. Mr. Rosenthal said Well Space does provide discounts to needy patients but that its prices are fairly inexpensive already. In terms of prevention information, he said that there are great deal of preventive CAM and non-CAM treatments that are not reimbursed, so reimbursement of these approaches certainly would enhance their access and delivery. Although the pilot program was not a great success, it was still worth trying. He said that education is key because the people who know about CAM seem willing to pay for it and those who don't know much about it are not willing to pay for it. In terms of Well Space's model, he said there were three basic reasons that Well Space chose to be complementary rather than integrative: 1) concerns that physicians would be reluctant to treat CAM practitioners as equals; 2) there are several other clinics who have physicians in their models and they have not done too well; and 3) in order to be profitable, Well Space did not want to spend too many resources dealing with issues of reimbursement and the other problems inherent in a traditional health care system. In terms of research,

he said that Well Space has more than 40,000 computerized records that should be useful for research purposes.

The Commissioners asked Dr. Eliopoulos to elaborate on the role nurses could play in helping to integrate complementary alternatives into mainstream. Dr. Eliopoulos answered that nurses can play a crucial role in educating physicians about complementary medicine. She added that perhaps one of the reasons that patient seen in a complementary medicine clinic did not want their records sent back to their physicians was because they did not want to be admonished by their doctors. She said that this is where nurses can play a vital role, because nurses are in private practices doctors as well as in hospitals and can help educated doctors about which CAM treatments may be effective and which have not been shown to be effective.

(Session V Continued)

Community Based Center:

Tom Trompeter, M.P.A., Executive Director of Community Health Centers (CHC) of King County, Washington, said that his organization is a private non-profit, tax-exempt organization, with six medical and four dental clinics in suburban Seattle. Each year, the CHC provide about 90,000 visits for people who are mostly poor and uninsured. Those patients who do have insurance are generally insured either by Medicaid or by the Washington Basic Health Plan, which is a sliding-scale, managed-care product designed for

people with incomes significantly below poverty level. In 1995, CHC competed for and won a grant to establish an integrative medicine clinic. During that process, CHC developed a partnership with Bastyr University. The grant required the CHC to provide conventional primary care, along some elements of CAM. An evaluation component also was required. He said the process for determining which products and practices to make available for which conditions is based on soliciting input from the clinical and administrative leadership from both Bastyr and CHC. Through this process, four CAM disciplines were identified, including naturopathic medicine, acupuncture, chiropractic, and therapeutic massage. The decision was made to offer naturopathy and acupuncture on site, and to offer chiropractic and massage via referral. Just recently, however, he said that CHC hired a licensed massage practitioner to provide on-site therapeutic massage.

Hospital-Based Center:

Sylver Quevedo, M.D., Director of the Center for Integrative Medicine at the O'Connor Hospital in San Jose, California, testified that he believes integrative medicine is THE MEDICINE of the future. Any hospital not considering an integrative approach will be seen as obsolete within 10 years from now, he asserted. On the other hand, programs that take a proactive and serious look at integration will have a competitive advantage. Indeed, integrative medicine offers advantages over the narrow biomedical model of care because it takes seriously the notion that culturally appropriate care in our increasingly pluralistic society is a necessity rather than an afterthought. He said that although there was initially resistance from the hospital medical staff, which was due primarily to unfamiliarity with

CAM, once the dialogue began, such resistance largely disappeared. Now, the hospital medical staff are asking the Center to organize a department of integrative medicine to bring these therapies into the in-patient setting.

Integrated Academic Centers:

Woodson Merrell, M.D., Executive Director of the Beth Israel Medical Center's Continuing Center for Health and Healing in New York City, said that his Center, which just opened in June 2000, comprises 16 clinicians, nine physicians, and seven allied health and CAM providers covering most aspects of integrative medicine in a hospital-based practice. He said several years ago Beth Israel Hospital quickly understood that integration is the future of medicine and put together a team of people to set up an integrative medical center that would be academically based and combine the best of the traditional healing practices with the best of conventional western bioscience. The Center includes all aspects of research, education, and clinical care and provides patients access to most CAM treatment modalities and approaches. Because Beth Israel Medical Center is a teaching hospital, it is very focused on integrating CAM into all aspects of training and has the nation's first required residency rotation in integrative medicine. It has just received funding to set up a two-year fellowship in integrative medicine. The Clinic is primarily fee-for-service, but there are a number of programs for uninsured and underinsured patients, including a program called Helping Hands Fund, which has raised approximately \$50,000 to date to provide free care for the uninsured. He said it is "critically important" that most licensed fields of CAM be incorporated in these integrated centers and be allowed to be primary

care providers, and, by doing so, it actually allows for many of these patients to come back into the traditional medical care model.

Panel Discussion:

The Commissioners asked Dr. Quevedo to elaborate on the “culturally appropriate” medical care offered in his clinic and how CAM practitioners are interacting with conventional physicians in the hospital setting. He answered that one of the most important issues to address with patients is language and belief systems. He said that all of us operate in a given belief system, and that belief matters, particularly in mind-body connections. In terms of CAM practitioner interactions with hospital staff, he said that the Center’s agreement with the medical executive body is to limit the scope of CAM practice and credentialing to the out-patient setting until enough experience was gained. To date, therefore, the Center has declined the opportunity to provide CAM in the in-patient setting, a decision that has been greeted with disappointment among the staff in the hospital who would like to give their patients access to these treatments. However, he said the Center staff is just beginning the process of helping the hospital to develop a CAM integration and credentialing strategy.

The Commissioners asked the panel about funding strategies that would facilitate integration and whether they believed they were at an economic disadvantage compared to other CAM stand-alone models. Dr. Merrell said he thinks it is very difficult for these types of centers to exist without private funding and government grants, because it is very

difficult to make money for the first three years of operation. He added that his Center is lucky because Beth Israel made the development of integrative medicine an integral part of its mission statement. By doing this, the Center gained access to the hospital's donor lists and the development office resources. Dr. Quevedo said that being associated with a hospital increases the value of what his Center is doing because it increases their visibility but is also adds additional burdens because of the heavy overhead and administrative costs inherent to being part of a hospital system. He said that for many reasons, however, his group decided against developing a proprietary model for its center. Mr. Trumpeter said having both conventional and CAM modalities under one roof has been a big boost for his program. He added that his group developed a rather elaborate protocol for informing patients of their options and their choices and ways of making sure that people knew what they wanted. However, he said they gave it up because people absolutely knew what they wanted to choose. Dr. Merrell added that the quality of the practitioners is key to success.

(Session V Continued-Reimbursement)

Oxford Health Plan:

James Dillard, M.D., said that in the mid-1990s, he was asked by Oxford Health Plans to help build a comprehensive CAM program inside the insurance company. To date the program has credentialed almost 3000 CAM providers in six areas. Although the program has, in many ways, been successful, the company had some financial challenges at the end of 1997, which has led to an incomplete experiment in building a CAM program. Oxford has had very remarkable financial turnaround recently. However, the widespread

financial problems that have occurred throughout the managed care industry, making it a challenge to build these kinds of programs within a managed care environment. In terms of integration, he said there are a number of barriers, including resistance on the part of the physicians, resistance on the part of the CAM practitioners, and resistance on the part of patients. He said that many patients simply do not want their primary care physician to know that they are seeing a CAM practitioner and, thus, often are resistant to having their records shared by both their conventional and CAM physicians. Overall, he said, it is appropriate to create access to the therapies that are considered to be safe. However, reimbursement should only be embraced those therapies that have strong evidence supporting their effectiveness.

Highmark Blue-Cross/Blue-Shield:

Anna Silberman, a representative of High Mark Blue Cross/Blue Shield in Pittsburgh, Pennsylvania, said that in 1997, Highmark became the first insurance company in the country to both provide and pay for the Dean Ornish program. Highmark did this because if heart disease is managed with only surgery without also addressing the root causes, bypasses need to be redone in 7 to 10 years and angioplasties within six months. The Ornish program, which has four components and is delivered by a team of physicians, exercise physiologists, registered dietitians, yoga instructors, behavioral health clinicians, and other professionals, both alternative and conventional. She said Highmark's senior management supported the Ornish program because of the science behind it, and, to date, patients have experienced 57% less angina; 50% less depression; improved cholesterol (an

average of 22 points); and a 10% reduction in body. Most importantly, there has not been a single heart attack or death since 1997, when the program was implemented. There has been only one bypass surgery, one stroke, and four angioplasties among these 400-plus very high risk patients. Moreover, there has been a cost saving of \$17,000 per patient, which translates into a little over \$8 million in savings for the entire group of patients. As a result, Highmark has started a new company, called Lifestyle Advantage, to significantly influence the way heart disease is managed and financed in this country. She asked the Commission to: 1) continue to support scientific investigations into CAM treatments to help separate what is effective from what is not; 2) promote proven CAM interventions to the public; and 3) influence health plans to reimburse for evidence-based CAM interventions.

Washington State Office of Insurance:

Lori L. Bielinski, Senior health policy analyst for the Washington State Office of the Insurance Commissioner, gave the Commission background about how the Washington State law is being implemented. It allows consumers a choice of the provider who will treat the condition in which they are seeking care. There are currently several different coverage models of CAM services used in Washington State, including: 1) a dollar-cap model, 2) a condition-based model, 3) a gatekeeper model, 4) an open-access model, 5) a self-referral and preventive care model, and 6) a discount networks model. She explained the advantages of disadvantages of each of these models.

Panel Discussion:

The Commissioners asked Dr. Dilliard to explain: 1) the method of access to Oxford's CAM benefits program, 2) whether there has been a difference between when services that are covered as a benefit versus those that are discounted, and 3) how Oxford sets limits on access. Dr. Dilliard said that Oxford began by paying for chiropractic with referral from a primary care physician and mandated that patients could make up to eight visits before the chiropractors had to file a care plan. To date, three states have a standard benefit for chiropractic, which is managed the same as any other benefit. In Connecticut there is also a mandated naturopathic service, which Oxford treats exactly the same way as it does chiropractors. Finally, acupuncture was put into a rider, which was sold to about 60 large groups and was delivered in the same way and managed the same way as the chiropractic was in terms of an eight-visit limit. He said that recent surveys have shown that the most popular parts of the program have been chiropractic, nutrition, massage, and acupuncture, in that order. He added that there is discounted network program for chiropractic, in which patients can go to a chiropractor without a physician referral and simply pay the Oxford rate. The vast majority of utilization has been through the benefit with the primary care physician referral. He added that the direct access riders have been very popular products as well. He said, however, that Oxford has not had the resources to capture all of the data on CAM utilization rates that is available. In regard to limiting access, he said Oxford adopted mandated benefits that were fully in compliance with the Insurance Equality Act in New York State. If patients feel they have been wrongfully denied access, he said there is a peer-based appeals process. He added that Oxford is

generally considered to be the most generous payer in the Mid-Atlantic, so consequently there hasn't been much of a problem in terms of limiting access.

Commissioners asked Ms. Silberman how Highmark chose to offer the Dean Ornish program and if it is planning to offer other CAM modalities in a similar way. She answered that choosing Dr. Ornish's program was simply a matter of her hearing Dr. Ornish speak at a conference, and presenting what she heard to Highmark's board of directors. They were very receptive to it, she said. In terms of expanding CAM offerings, she said that Highmark has a delivery system, called Health Place, with 17 centers delivering various CAM programs on a daily basis to about 40,000 people a month.

Commissioners asked Ms. Bielinski to help the Commission understand how the Department of Insurance in Washington looks at access. She answered that the State does not have a formula, statute, or a rule. However, there have been significant number of complaints filed by consumers about lack of access. In Washington State, CAM is not really differentiated with conventional medicine any more. The part where it gets to be confusing, she said, is when plans set an arbitrary limit. She, therefore, recommended that the Commission try to find out what are the most common guidelines for setting limits and apply them to CAM. Otherwise, she warned that the carriers could be allowed to sell what is essentially an illusory benefit.

(Session V Continued—CAM Systems of Medicine)

Ayurvedic Medicine:

Robert Schneider, M.D., of the Maharishi University in Fairfield, Iowa, submitted evidence on the effectiveness of Vedic medicine, which include meditation, herbal approaches, diet, purification therapies, behavioral approaches, and even the influences of architecture on the environment. He said the clinical syndromes that have shown to be most responsive to various approaches of Vedic medicine include cardiovascular disease and its risk factors, psychological disorders, cancer prevention and treatment in terms of quality of life improvements, chronic pain, age-related disorders, and many disorders commonly seen in primary care. In terms of cost effectiveness, several studies have reported 50 to 80 percent reductions in health care utilization and related health care costs, with meditation and other Vedic medicine approaches. This has been true for both in-patient and out-patient utilization. Patient satisfaction with Vedic medicine also is almost twice as high as is patient satisfaction with conventional medicine, he said. Based on these data, he asked that the Commission recommend that Vedic medicine services that are shown to be effective and cost-effective in published, peer-reviewed scientific research, be reimbursed by third-party payers, including government payers, such as Medicare and Medicaid, and private reimbursers. He also asked that certified practitioners be allowed to practice in their areas, following the Minnesota model. He said that over time, states should adopt a licensure procedure for natural medicine practitioners, including Vedic medicine practitioners, and licensure would be dependent on certification and completion of other state licensing requirements, such as an exam or experience requirements. He also asked

the Commission to recommend Federal grant to educational institutions of higher learning for the training of Vedic medicine practitioners.

Naturopathic Medicine:

Tori Hudson, N.D., of the National College of Naturopathic Medicine in Portland, Oregon, said that naturopathic doctors, or NDs, essentially are licensed primary care family physicians with a specialty in natural medicine. NDs utilize nutrition and lifestyle counseling prescribe nutritional supplements, plant extracts, and other natural therapeutic substances and techniques, as well as selected pharmaceuticals. She noted that women's health is an area in which an integrative medical framework could bring about a more reliable understanding of and treatments for a number of poorly understood and treated conditions, such as interstitial cystitis, vulvodynia, fibromyalgia, PMS, fibrocystic breasts, pelvic infections, menopause, endometriosis, and uterine fibroids. Her experience in Portland, Oregon, she said, is one of having a women's integrative clinic with ND, MD, DC, acupuncturists, massage therapists and counselor working together, referring back and forth, discussing the co-management of shared patients. Thus, she said her vision of integrative medicine is basically a cadre of health care disciplines and practitioners, each with their own scope of practice, each with their own tools of their trade, but also each with a common understanding, a common respect, and a shared commitment to coordinate care, cross-refer, and co-manage patients. The Federal government could go a long way towards providing a framework in which all of this can take place, she explained.

Traditional Chinese Medicine:

Robert Duggan, M.A., MAc, President of the Traditional Acupuncture Institute (TAI) in Columbia, Maryland, said that his school currently has 700 graduates across the country, many of whom are earning higher than average salaries. He emphasized that TAI students are trained not only in the modality of acupuncture but also in the art of healing, which is completely different than the reductionistic model of conventional medicine. In TAI's model, he said, the patient is the primary care provider. Only when the American health care system understands that by making the patient the primary health care provider, will it be able move the majority of the visits out of the sick care system into a wellness culture, he explained. Traditional acupuncturists who see themselves as educators of the empowerment of the patient, therefore, do better than those that are simply delivering a modality. He asked that the Commission consider changing a reimbursement model that favors the delivery of the modality over the healing art of the individual patient. He also suggested that all schools of medicine, complementary and mainstream, foster relationship-centered care. He suggested that a separate agency be established to deal with the issue of the quality of herbs and that a bill currently before congress that would forgive student loans to induce CAM practitioners work in impoverished areas should be fostered. Finally, he said there should be an initiative to foster CAM and wellness education from the first grade onward.

Panel Discussion:

The Commissioners asked Mr. Duggan to elaborate on his comments about the regulation

of herbal therapies as well as his proposal about educating people about wellness and lifestyle choices. Mr. Duggan replied that he believed it was wrong to turn plants into products. He said the policy issue for the Commission would to look at ways restore an awareness of plants as healing and then begin to define where is that line between what is food and what is medicine and must be professionalized. That is why he believes there needs to be a separate agency from the FDA to address the questions about herbs differently that it is currently being done. Mr. Duggan said that education about wellness and healing needs to start from the first grade, by teaching children an awareness of breathing, of drinking, of sleeping, of eating. He added that there need to be incentives for people to learn how to take care of themselves.

The Commissioners then asked the panel members to tell what their institutions are doing to reach out to the less advantaged in their communities. Dr. Hudson said that her clinic has three tiers of pricing to give people different cost options as well as some free clinics. In addition, she said that she practices one month a day at a rural clinic. Mr. Duggan said that TAI commits approximately \$200,000 a year to an inner-city clinic and that a several TAI graduates have established similar clinics. Dr. Shneider said that his institution is part of a federally funded center that has conducted a number of randomized trials of mind-body approaches in high risk African-Americans for the treatment and prevention of cardiovascular disease. Also, it has been very involved with the nation's historically black medical institutions in rolling out CAM approaches in lower socioeconomic and ethnic communities, particularly African-American communities. It also is planning initiatives in Native American and Hispanic communities and other ethnic communities.

Session VI: CAM Integration in Existing Delivery Systems

Alan Trachtenberg, M.D., medical director for the Office of Pharmacologic and Alternative Therapies at the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), said that a vital part of SAMHSA's mission is the full integration of CAM services with the rest of the public health and medical care system. He said the bulk of his activities at CSAT are currently involved with taking over from FDA in the regulation of opiate addiction treatment providers. For example, the kind of CAM clinic CSAT is now dealing with includes a group of Yale who recently published the results of randomized trial of ear acupuncture for cocaine addiction that achieved highly significant results. He said CSAT supports a variety of alternative practices that maybe included as elements of comprehensive treatment programs, including acupuncture, meditation, and culturally-specific healing practices, such as sweat lodge and traditional Hawaiian medicine. He said alternative therapies and traditional healing practices have been included in CSAT's programs, primarily as culturally relevant elements of a comprehensive treatment and outreach program. If an alternative therapy brings patients into the treatment setting and keeps them coming longer, then it has utility over and above whatever specific efficacy it may have. He said CSAT is presently requesting funds to assemble a consensus panel to make recommendations about how acupuncture should be incorporated into more existing drug treatment programs.

Milton Hammerly, M.D., of Catholic Health Initiatives (CHI), said that the system he represents encompasses more than 100 facilities in 22 states, employing more than 75,000 people. He said the incorporation of CAM services into this system has been an evolutionary process, beginning with a steering committee consisting of CAM proponents. Early on, there was a steering committee, but now there is a more heterogeneous cross-section of the organization involved, including skeptics. He said CHI now has unanimous organizational buy-in and support of the philosophy of integration. He said the essence of CHI's philosophy, which is to provide comprehensive mind-body spirit care which personalizes care and which has to be, of necessity, collaborative. He said, however, CHI faces a number of barriers in integration. The first is research. CHI has not been successful in accessing research funding, which seems to be mostly finding its way to academic centers, he said. In an effort to remedy this, CHI have approached pharmaceutical companies with synergistic combinations of supplements and pharmaceuticals which are, in fact, patentable, providing an incentive for them to want to pay for the research. Another barrier is the issue of reimbursement. He said, however, that reimbursement is only a barrier because the system is still trying to put the new clinical model of integrative health care in the old reimbursement model. He said clinicians can have far greater impact by working together as an orchestra than they can by practicing as individuals. He said that the Commission, by helping to break down the barriers to collaboration as well as the barriers to reimbursement in clinical areas, can actually help lead that orchestra.

Panel Discussion:

The Commissioners asked Dr. Trachtenberg if there was research looking at the effects of CAM on compulsive behaviors as well as to elaborate on his organizations efforts to reach the untreated populations and Native American populations. Dr. Trachtenberg said unfortunately there has been too much attention on withdrawal and not enough attention paid to compulsion to date. He added, however, that addiction treatment in this country, even in fairly conventional circles, has traditionally had a spiritual dimension. He said that the Commission could perhaps urge that more attention be given to the interface of the issues of spirit and the neurophysiology of craving and compulsion and reward. In terms of reaching out to those who currently want treatment but are not receiving it, Dr.

Trachtenberg said that our society is often too willing to blame people for their problem and put such a moralistic judgment on this particular category of illnesses [sustance abuse], that there is a significant barrier to treatment even when it is available. He said, therefore, that stigma, in addition to resources and the lack thereof, has much to do with that treatment gap. In terms of programs for Native Americans, Dr. Trachtenberg said those programs are part of community-based treatment programs that are serving specific Native American communities. The leaders from the communities themselves being served usually provide the culturally resonant aspects of the overall treatment program, such as sweat lodge or vision quest. He noted that such programs typically begin as grants to local groups and are used a method for the Federal Government to gain access to these groups.

Commissioners asked Dr. Hammerly if CHI has any ongoing data monitoring program

related to CAM interventions and to comment further on the environmental aspects and obstacles encountered in CHI's CAM program. He answered that CHI has a comprehensive care assessment tool, which has the SF-36 embedded in it. Unfortunately, with the lack of research funding, CHI has not actually started collecting data. In terms of addressing the hospital environment, he said that program looks at a number of factors in the hospital environment that can impact on patients' health, including the lighting, the food, the presence of plants. He said there is no organized initiative, but that several hospitals have Healing Environment Committees and are looking at models that are changing the environment to more holistic, and not as sterile a setting. In terms of obstacles, he said that to make integration work, there is a need to address the underlying philosophy of patient care. If the philosophy it is not coherent, there is organizational dissonance and nothing works. He added that the integration program needs to be very much tailored to the specific location and environment. The approach needs to be sensitive to consumer interests and readiness, the availability of services, physician readiness, and to politics.

Public Comments:

Francine Butler, Executive Director of the Association for Applied Psychophysiology and Biofeedback, said that biofeedback is one of the most well-established of the CAM therapies, and here is a large body of scientific work demonstrating its treatment efficacy without adverse side effects. She said largest problem with access and delivery of biofeedback is denial by third-party payers because biofeedback is still branded as experimental. Nancy Dolores Kolenda, Director of the Center for Frontier Sciences at Temple University, said that 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 and homeopathy and acupuncture. Because our nation's major medical schools are facing critical financial crises, they are now more open now than ever to incentives to advance the research in CAM. Diana Chambers, of Friends of Health, said "whole person healing" as best describe most CAM practices, which primarily focus on prevention, wellness, and health. She said that Friends of Health wants the Commission to focus carefully on issues of language and philosophy of CAM as well as access and delivery issues for the poor, both urban and rural. Rustrum Roy, a representative of the University of Arizona Program for Integrative Medicine, said there are three primary communities that need to have better access to knowledge about CAM: 1) the approximately one-half million practicing physicians, 2) academic research scientists, and 3) the general attentive public. He said there is a need for an emergency, crash education program for these groups. Bruce Nordstrom, on behalf of the American

Chiropractic Association, encouraged the Commission to focus on wellness and to recommend policies for reimbursing CAM providers for health promotion. He said a good example of how prevention is cost effective can be found in an HMO in Illinois called Alternative Medicine, Inc., (AMI), which utilizes doctors of chiropractic as traditional gatekeepers and has reduced the rate of hospitalization for its members by about 75 percent. Neal Barnard, President the Physician's Commission for Responsible Medicine, said that nutrition is the most fundamental medical treatment, and research proves that when patients change their diets, in combination with other lifestyle changes, they can reduce cholesterol levels, reverse heart disease, improve and sometimes even cure Type II diabetes, and hypertension. He recommended that the Commission promote initiatives to integrate nutrition into the core curricula at American medical schools, encourage the Public Health Service issue grants for research on the effects of vegetarian and vegan diets for a number of chronic illnesses, and encourage the Department of Agriculture review of federal policies that conflict with healthy nutritional goals. Doreen Chen, chair of the Chinese Medicine Advisory Council of the American Association of Oriental Medicine, said that integrative medicine is the future of medicine and asked that the services rendered by an Oriental Medicine physician be covered by any health insurance, both Federal or private. Gary Sandman, founder of a community-based alternative medicine referral service in the Washington, D.C., area, said CAM tends to teach empowerment, and individuals that are empowered tend to heal. He said there needs to be a 20-year plan to

integrate conventional medicine into patient-centered, whole-person health care. Danny Freund, a cancer survivor, said he has tried many CAM therapies in the course of his recovery and now teaches a course on CAM. He said there is a great deal of information on CAM but there is no central source on information to help people decide how to find and interpret it. Melinna Giannini, Director of Alternative Link, said that her company has developed about 4,000 codes that describe what is said, done, ordered, prescribed, or distributed by alternative care practitioners, and each one of these codes has a relative value unit attached to it so that a rate can be developed for each procedure. She asked that the Commission promote the incorporation of this code into Federally funded CAM research so that cost-effective CAM treatments can be identified as a solution to escalating health care expenses, especially where these procedures could have an impact on Medicare/Medicaid recipients. Jane Hersey, Director of the Feingold Association, said that a the Feingold Association show families how to reduce or eliminate many behavior, learning, and health problems in their children by eliminating synthetic dyes, artificial flavors, and certain preservatives from their diet. Despite the potential of this healthy option to help medical and social problems, and despite all of the supporting evidence, it is opposed, ignored, or misrepresented by Government agencies and professional organizations that should embrace it. She asked that the Commission urge the National Institutes of Health and the Department of Agriculture to conduct new research on the efficacy of the elimination diet. Boyd Landry, Executive Director of the Coalition for

Natural Health, said the Commission needs to seize the opportunity “to look outside the box,” rather than looking at ways to fit CAM inside the box. He said the Commission should focus on what consumers want, not what practitioners want. He, therefore, urged the Commission to seek out consumer input. Lawrence A. Plumlee, M.D., President of the National Coalition for the Chemically Injured, said there is a great need to conduct research on the role of toxic chemicals in syndromes, such as multiple chemical sensitivities, auto-immune diseases, fibromyalgia syndrome, and chronic fatigue syndrome. Currently, he said, patients with these conditions are subjected to dangerous and ineffective psychiatric drugs which prolong the illnesses, because the causes are not recognized and eliminated. There also is the need for research to investigate the role of nutritional supplements in enhancing improved metabolic function in these syndromes. Another area requiring scientific research and better medical education is the induction of mild immunodeficiency by some toxic chemicals with resultant super infections by viruses, bacteria, parasites, and fungi. Appropriate diagnosis and treatment of these infections will enable substantial gains in health. Michael John Rohrbacher, Director of music therapy at Shenandoah University in Winchester, Virginia, said that music therapy is the use of music in the accomplishment of therapeutic gains, the restoration, maintenance, and improvement of mental and physical health. He said there are over 3,700 individuals currently hold American Music Therapy Association membership, and nationwide, there are 69 undergraduate music therapy programs, 25 graduate programs, and 159 internship

sites approved by AMTA. Andrew Rubman, of the American Association of Naturopathic Physicians, said the present needs of our citizens and the enormous body of emerging medical information leaves us no choice but to produce a better model of health where no one approach to medical care is forced to stand in judgement of others. He said that incorporating naturopathic medicine as a guiding principle to help shape and implement the new medicine will allow our citizens to become better, more objective consumers, limiting high-priced procedures and pharmacy by increasing their wellness and thereby avoiding disease. Marshall Sager, President-elect of the American Academy of Medical Acupuncture, said that medical acupuncture, which is the practice of acupuncture by fully trained and licensed physicians, falls within the scope of the practice of medicine. The fact that most health care plans do not reimburse for physician acupuncturists services has forced patients from their primary medical care providers and out of the health care system. Medical students and physicians must be educated about the use and effectiveness of all complimentary medical modalities, especially medical acupuncture and must understand that medical acupuncture is not a threat to their practice. Diana Miller, an attorney, said she is committed to research, education, and designing laws that take away the legal barriers for consumers for access to alternative health and other kinds of health care that they deem necessary for their healing. She said the current system is disempowers consumers, and anything that disempowers consumer makes healthcare more expensive and impedes wellness. She said the exception is the State of Minnesota, which believes

consumers have the right to access any person or treatment they deem helpful to bringing them to full health. Courtney Banks, a former Hodgkin's Disease patient, said that CAM saved her life. After radiation therapy, she began exploring and using acupuncture, eating only organic fruits and vegetable and whole foods, and using homeopathy. She said she has never felt healthier, had more energy, and a more positive outlook. Richard Pavek, from the Biofield Research Institute, said that he was concerned that the movement toward integration would disenfranchise alternative practitioners who are not doctors. He said that every alternative practice, teaching, method, or philosophy was developed outside of conventional medicine. He recommend that alternative practitioners be enfranchised with as much legal right to practice as possible.

Session VII: Commissioners' Discussion:

Chairman Gordon began the discussion by saying it was very much an open discussion and he wanted to give everyone a chance to share their thoughts, observations, and concepts about the meeting and about future directions. Commissioner Chappell said he believed the Commission needed to affirm the equal importance of promoting wellness as well as healing and to see CAM as having two charges: equal rights and equal accountabilities. He said that if the Commission seeks to create equality, then integration can occur wherever it is natural.

Commissioner Bresler said that another recurring theme appears to be the need for early education the let people know two things: first, what are they doing that is deleterious to their health, and second, what they can do in order to enhance and improve their health. Commissioner Gutierrez said that it would be helpful for her to know what is the intent and purpose of each provider group. Commissioner Rolin emphasized that the Commission needs to focus on those that aren't being served, such as Indian tribes living on reservations, because she said those are areas where CAM can make vast improvements within the communities. Commissioner Kerr said that in the future she would like to hear from agencies and organizations that may be impacted by the Commission's recommendations, such as the Department of Agriculture or a Fortune 500 company or a pharmaceutical company or public health people. She said such agencies and companies are willing to help and want to be called to service. Commissioner Chow said that the Commission is talking about more than health care but also about lifestyles. She agreed that the conversation needs to be expanded and more skeptics included. She added that new paradigms and spiritual issues also needed to be considered. Commissioner Fins endorsed Commissioner Kerr's comments and added that he there needs to be a broad articulation of principles that will set the agenda for the next 20 years, in addition to concrete recommendations. He also said that the Commission needs a better sense of the sociology of CAM and to consider the mechanisms and agencies and collaborations that

will allow dialogue to continue when the Commission is no longer around. Commissioner Paz said that as culture here in the U.S. becomes more and more diverse it will be necessary to continually expand the list of potential CAM therapies. Commissioner Bernier said the time is ripe to take a major step in integrating CAM. Nevertheless, there remain a number of issues, including guaranteeing the safety and efficacy of treatments of all types. One of the problems, he said, is that the term "CAM" means so many different things, and many CAM disciplines are not necessarily eager to see themselves integrated with conventional medicine. Chairman Gordon suggested that the Commission should begin to dialogue more with the conventional medicine community, particularly the American Medical Association and the American Association of Medical Colleges. Commissioner Bernier agreed to help begin the dialogue with those groups. Commissioner Scott said she would like to see many more African-Americans both as panelists and speaking in the open debate, because she saw it as a real "gap." She also was concerned that CAM is often viewed as a second-class medicine for conditions affecting people who are not valued in the community. Commissioner DeVries encouraged the Commission to create recommendations that can be applied to multiple tracks, regardless of which way our country moves forward with its health care policy. Commissioner Low Dow said that there have to be social policies in place that allow for healthy communities and healthy families and healthy children. She said that as the Commission discusses various issues, she hoped it didn't lose track of the bigger issues. Commissioner Fair expressed concern that there was

a great need for education but that the Commission had heard nothing concrete about how to increase education. He said the Commission should stress the develop of plan for universal health education. By educating people universally, the personal, family and community improvements will follow, he said. Chairman Gordon reminded the Commission that the next two meetings were going to focus primarily on professional education and on public information, which includes education in the schools and in other places. Commissioner Jonas added that the most effective use of resources may be health care advertising, maybe even more than education. He added that the two types of activities that can lead to more specific items that deal with wellness are the area of health support and health promotion. He added that a focus on accountability was also necessary, including accountability of care and services on the part of the CAM providers. Commissioner Low Dog agreed, saying that she hopes the Commission looks at access as giving people the freedom to seek the practitioners they want as long as there is some type of accountability. Commissioner Chappell added that he would like to see a focus on bringing health promotion and health support to the public in an affordable way. He said his concern about the discussion on reimbursement is that it is not in the control of the consumers' hands. So affordability is the language to use as a goal to try to get that. Commissioner Tian said the Committee has to make sure that it adequately defines the CAM modalities what it is considering. It also needs to answers three important questions: where we are;

where we are going; and how to get there? He said that each professional group can help with these answers. He also suggested that the Commission invite the FDA as well as consumers, because when the Commission discusses herbal nutrition, for example, a lot of these are controlled by FDA policy. Commissioner DeVries said that one critical issue the Commission needs to remember is that the individual states, not the Federal government, regulates the individual licensures of providers. The Commission, therefore, can consider recommending licensing statutes for acupuncture, massage, and naturopathy. This would go along way toward helping these modalities gain access to reimbursement and create the ability to access benefits. Chairman Gordon then thanked everyone for coming and participating, whereupon the meeting was adjourned.

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