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001b. supporting docs	statement, June Brown (partial) (1 page)	01/09/1999	b(6)
001c. supporting docs	statement, Paul DeRitter (partial) (1 page)	01/14/1999	b(6)
001d. supporting docs	statement, Robert Strasburg (partial) (1 page)	01/11/1999	b(6)
001e. supporting docs	statement, Susan Evans (partial) (1 page)	01/10/1999	b(6)
002. resume	Sylvestre Quevedo (partial) (1 page)	nd	b(6)
003. testimony	Michael Rohrbacher (partial) (1 page)	12/05/2000	b(6)

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

OA/Box Number: 43238

FOLDER TITLE:
WHCCAM Meeting Testimony, December 4-5, 2000 [2]

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RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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Divider Title: Dooley

Commission on Complementary and Alternative Medicine
Meeting on the Access and Delivery of CAM, Washington D.C. December 4, 2000
Chairman James Gordon, M.D.

Topic: The Federation of State Medical Boards: Efforts to Suppress and Discipline CAM Physician's and, thus, the Public's Access to CAM

Bruce R. Dooley, M.D. [dooley@attglobal.net]

Summary: The Federation of State Medical Boards (FSMB): **(1)** Develops strategies to curtail the expansion of CAM, **(2)** Lobbies federal agencies, state medical boards and legislatures on the implementation of these strategies, and **(3)** Indirectly and powerfully influences the course and content of all new physician training in the United States via control of national testing.

The Federation of State Medical Boards (FSMB) is a private corporation that filed incorporation papers in 1912. This period of time is significant in medical history as it involved:
(1) David Rockefeller's entry into the embryonic pharmaceutical industry;
(2) The Carnegie sponsored **Flexner Report** which, while purportedly setting standards for medical schools, nevertheless successfully contributed to the eventual eradication of the training and practice of **Homeopathic Medicine** (a very worrisome competitive threat to Allopathic Medicine at the time).
(3) The disappearance of the **Quackery Committee** of the American Medical Association (AMA) which had been in existence from the founding of the AMA in the late 1880's.

Details of the history and other aspects of FSMB may be found at www.fsmb.org.

Since it's inception the FSMB has managed to inculcate itself with enormous influence into all the medical boards of the United States, the territories, and even some allied countries. Each state medical board has a member designated as the "*Delegate*" to the FSMB. Special Committees are organized to research and develop policy on particular areas of concern. The delegates are flown to FSMB's annual meetings, which are usually held at 5-star facilities, at the expense of FSMB. There at the Delegate Meeting they sit in assembly, review, modify and then vote on these policies. These approved policies are then distributed to the state medical boards where they are commonly adopted as medical board policy. It is quite common at Florida Medical Board general and committee meetings to hear reference to the "Federation". In particular, and with reference to CAM, the following example of the above policy-making is proffered.

SPECIAL COMMITTEE ON QUESTIONABLE AND DECEPTIVE HEALTH CARE PRACTICES

[A full copy of this report is available from their website *www.fsmb.org*]

Following the remarkable Harvard Eisenberg study of 1993*, the FSMB created the **Special Committee on Health Fraud**, later to be named the **Special Committee on Questionable and Deceptive Health Care Practices.**

*[**1990 Survey Harvard study by Dr. Eisenberg** - Summary of facts presented on this landmark report which sent shock waves through conventional medical and pharmaceutical establishment: - ***New England Journal of Medicine* (1993):** One-third of Americans were using alternative medicine. 425 million visits/annually to alternative care providers that exceeded the number of visits to primary care providers in same year. $13.7 BILLION dollars spent on this care, and **$10.3 billion was out-of-pocket**. 72% of these patients were not informing their conventional physicians that they were receiving alternative medical treatment/supplements. **1997 Repeat Survey** - Revealed a 40% increase in utilization of alternative medical therapies, exceeding primary care visits by 24% and **$27 billion spent out-of-pocket**. To place this in context only $9 billion was spent O-O-P that same year for all expenses related to hospitalization and equaled the O-O-P expenses for ALL physician's services in the U.S.]

The President of the FSMB, **James Winn, M.D.**, rejected 23 letters from **ACAM**, (American College for Advancement in Medicine) requesting participation as experts in the research and fact-finding sessions held in 1995 and 1996 prior to publication of the report. ACAM, a 25 year-old organization representing nearly one thousand CAM physicians, is without doubt the oldest, largest, and most accomplished body of physicians practicing in the field of CAM. It is understood that FSMB enlisted the services of the so-called "Quackbusters" Drs. Steven Barrett and John Renner as part of their panel of experts for this report. [As of June 2000, the FSMB held a traveling educational seminar with Dr. Renner as their expert speaker on the topic of the "Regulation of Integrative and Complementary Medicine".]

The report released by the Special Committee on Questionable and Deceptive Health Care Practices was widely distributed and **is essentially a blueprint for state medical boards to follow in their identification and disciplining of CAM physicians**. It is to be noted that the arrogant bias of this document is set forth from the onset in the section on definitions stating that the report will utilize the wording "*questionable medical practices*" to indicate Complementary and Alternative medical modalities.

The Federation was also instrumental in the redefinition of the word "**HARM**". The mandate of state medical boards is to protect the public from harm. As it became clear that the practices of CAM physicians were not producing any clear physical harm in the patient community, nor even patient complaints, the definition needed changing so that medical boards could evoke their mandate in CAM physician disciplinary actions. Therefore there were two new definitions added to the original intent:
(1) ECONOMIC HARM - which resulted in monetary loss but not present a health hazard, and (2) INDIRECT HARM - which may result from the delay of appropriate treatment. Two new clubs were thus added behind closed doors at a private corporation and passed on to U.S. medical boards which could be used to bludgeon CAM physicians.

At the Federation's last annual meeting in Dallas on February 2000, a seminar on "The Regulation of Integrative and Complementary Medicine" was delivered. One of the speakers was Larry Dixon, a senator from Alabama, Executive Director of Alabama's Board of Medical Examiners, past member of the FSMB board, and a member of FSMB's Executive Director's Advisory Committee. Mr. Dixon spoke the following words; *"About the chelationists...is there a Board present that has successfully prosecuted a chelationist, revoked a license and made it stick? We find that very difficult. We got the major chelationist in our state but only when he branched out into other forms of...quackery"*

The FSMB's report suggests state medical boards "***coordinate with and among***" and "***collaborate with***" insurance companies and at least 8 state and federal agencies (FDA, FTC, US Postal, HCFA, etc.) and other trade associations (AMA, Nat. Assoc. of Attorneys General, etc) to assist them "***in efforts to identify and eliminate questionable health care practices that are adverse to the public health, safety, and welfare***".

TESTING OF PHYSICIANS

Briefly, the FSMB is closely aligned with the National Board of Medical Examiners in the development, preparation and administration of the USMLE parts 1-3. The FSMB and NBME developed and began administering the FLEX exam in 1968. They co-jointly have established the new PLAS, Post-Licensure Assessment System. Located in Boulder, CO, this comprises the SPEX Program and the Assessment Center Program. A highly challenging computerized program, the SPEX can be used as yet another club by medical boards against physicians ascertained as operating outside of standard medical practices. In the words of the Federation the PLAS is *"an invaluable resource for evaluating a physician's competency to practice medicine."* In Florida, we have already witnessed a CAM physician from Boca Raton who is being forced to take the PLAS for a **records-keeping violation.** This 70-year-old internist, 35 years in practice without a malpractice claim, may decide to relinquish his license rather than go through the ordeal of study and preparation for this expensive test.

APPEALS TO U.S. MEDICAL BOARDS TO RESIST GOVERNMENTAL EFFORTS IN CAM LEGISLATION AND INITIATIVES

Finally, speakers for FSMB have made many calls at their meetings and in their publications for medical board representatives to actively resist state and national initiatives for Freedom of Medical Access bills. Additionally, they fear a unified national physician license. They actively lobby in Washington, D.C. and tell medical boards that they will show up at a recalcitrant state legislature's office to help lobby an initiative that either needs to be passed or stopped.

CONCLUDING THOUGHT: The anti-CAM activities and bias of the Federation of State Medical Boards, only a fraction of which have been detailed in this talk, I believe warrant further investigation by this Commission. Clearly, it is troublesome that a private corporation should wield such influence on the members of state medical boards and thus a physician's means of livelihood. Thank you.

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December 4, 2000

Testimony to: The White House Commission on Complementary and Alternative Medicine Policy. December 4-5, 2000 - Commission Meeting on the Access and Delivery of Complementary and Alternative Medicine Services; Topic: Insurance Parity in the field of Acupuncture and Oriental Medicine.

Good Afternoon Members of the Commission, thank you for your attention today. My name is Kathleen Golden; I am a licensed provider of acupuncture and Oriental medicine in New York State. I am the Chair Emeritus of The Acupuncture Society of New York, a professional organization representing the interests of the practitioners and patients of New York. I maintain a private acupuncture and Oriental medicine practice in New York City. I am on the faculty at The Tri-State College of Acupuncture (NY), and have taught for the other NY colleges of Acupuncture and Oriental medicine. I have a strong background in public health; I have supervised acupuncture services in addiction rehabilitation programs and have worked as a provider of acupuncture and Oriental medicine in an AIDS day treatment program for seven years.

The focus of the Commission today is Access and Delivery of Complementary and Alternative Medicine to the American public. I will offer information to the Commission on the issue of insurance parity as it relates to acupuncture and Oriental medicine public access and delivery in this country.

Acupuncture and Oriental medicine is a traditional medicine that has been safely, effectively and consistently practiced by and for human beings for thousands of years. The medicine seeks to preserve and maintain health; and when necessary, heal disease. Until thirty years ago Americans were, for the most part, unaware of the benefits of this medicine. In the current health care climate many Americans are aware of the benefits of acupuncture and Oriental medicine and seek to utilize the medicine for both health maintenance and treatment of pathology.

Acupuncture and Oriental medicine is a rich, complex form of health care. I feel strongly that Americans are obligated to preserve the integrity and wholeness of the medicine. It has been an unfortunate pattern in our country to dilute the traditions of culture to suit an impatient nation. I do not wish to see acupuncture and Oriental medicine diluted to serve

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existing hierarchies of health care in subsuming this medicine to augment the diminishing financial returns currently experienced or, to boost professional all controlling egos.

In this country the acupuncture and Oriental medicine profession has established national education standards. These standards generally require graduation from an accredited three year Masters program, passing a national board exam in acupuncture and/or Chinese herbs (administered by an impartial third party), and clean needle technique. Completion of these standards enables a provider to be licensed in their state. In many states, allied health care providers are able to practice acupuncture with a minimal amount of training. For example: in New York, doctors, dentists and osteopaths can take a three hundred hour training program in acupuncture and then become 'certified' to practice acupuncture. In many other states, this is also the case. An unfortunate consequence of this disparity in education is that the public consumer is generally unaware of the differences in education and quality of care possible. It is also true in many states, including New York, that insurance companies will only cover acupuncture administered by a 'certified' acupuncturist. That is to say, the western doctor with three hundred hours of training is eligible to bill an insurance company for acupuncture services while the 'licensed' acupuncturist is ineligible. This is where the issue of insurance parity comes in.

It is absolutely impossible to begin to comprehend the depth of the scope of acupuncture and Oriental medicine in a three hundred hour course. Yet, in many instances, a patient with limited financial resources has no option but to accept treatment from the less educated provider. This is due to archaic insurance company reimbursement policies. Parity is not mandate. Mandate forces an insurance company to cover acupuncture services. Parity insures that if an insurance company chooses to provide reimbursement coverage for acupuncture and Oriental medicine, that all providers legally eligible to provide that service under the laws of an individual state be included in the reimbursement of that service. It is also imperative that all providers be given fair and equitable financial remuneration for their services.

There are many patients in America who can benefit from acupuncture and Oriental medicine. It is important that this medicine be available to all who seek its benefits and that the patient seeking care under insurance coverage be in a position to chose who will provide that care. A patient should not be locked into settling for a provider with three

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hundred hours, or less, of training, when a provider with three years of training is a possibility. It is unacceptable that due to limited resources and/or limits in provider entrée that Americans be denied choice in deciding access and delivery as concerns acupuncture and Oriental medicine.

Currently in the USA there are thirty-nine states and D.C. that have statutes licensing acupuncture and Oriental medicine. Four of those states (Montana, Nevada, Washington, West Virginia) mandate insurance coverage for acupuncture and Oriental medicine and four have Parity (California, Florida, Maine, Oregon).

Recommendations to the Commission:

- Allocation of federal funds to assist in research efforts studying the efficacy of Acupuncture and Oriental medicine.
- States without statutes that allow the practice of acupuncture and Oriental medicine be supported in gaining licensing laws.
- States with statutes that allow for the practice of acupuncture and Oriental medicine be supported in establishing insurance Parity laws.
- Support for public access to acupuncture and Oriental medicine by a policy change that would lead to coverage of these services under Medicare and the Federal Employee Benefit Plan.
- A fair and equitable reimbursement fee schedule for licensed providers of acupuncture and Oriental medicine based on an assessment of services and time based care.

I have attached supporting documents that may help the Commission to delve further into this issue. I offer the support services of The Acupuncture Society of New York (ASNY) in assisting the Commission in furthering its recommendations to the President of the United States. If I can myself be of further assistance, I offer my services as well. Thank you for your time and attention to these important matters of health care in this great country.

Acupuncture and Oriental Medicine Alliance

Legislative Update

May 5, 2000

Jurisdictions With Acupuncture Laws

Alaska	Arizona	Arkansas
California (own exam)	Colorado	Connecticut
District of Columbia	Florida	Georgia New 2000
Hawaii	Idaho	Illinois
Indiana	Iowa	Louisiana (no exam)
Maine	Maryland	Massachusetts
Minnesota	Missouri	Montana
Nevada (own exam)	New Hampshire	New Jersey
New Mexico	New York	North Carolina
Ohio New 2000	Oregon	Pennsylvania
Rhode Island	South Carolina	Tennessee New 2000
Texas	Utah	Vermont
Virginia	Washington	West Virginia
	Wisconsin	

States That Allow Practice Through a Ruling by the Board of Medical Examiners

Kansas	Michigan

States in Which There is No Legislation or Rule

Alabama*	Delaware	Kentucky*
Mississippi	Nebraska*	North Dakota
Oklahoma*	South Dakota	Wyoming*

*A statute has been introduced

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Table 10 Insurance Requirements

State	Mandated Third Party Reimbursement	Mandated Workers Compensation Reimbursement	Mandated Professional Liability Insurance
Alaska	No	No	No (disclosure required)
Arizona	No	No	No
Arkansas	No	No	No
California	Parity	Yes	No
Colorado	No	No	50,000/50,000
Connecticut	No	No	No
DC	No	No	No
Florida	Parity	No	$30,000
Georgia	No	No	$100,000/300,000
Hawaii	No	No	No
Idaho	No	No	No
Illinois	No	No	No
Indiana	No	No	No
Iowa	No	No	No
Louisiana	No information	No information	No information
Maine	Parity	No	No
Maryland	No	No	No
Massachusetts	No	No	No
Minnesota	No	No	No
Missouri	No	No	No
Montana	Yes	Yes	No
Nevada	Yes	Yes	No
New Hampshire	No	No	No
New Jersey	No	No	No
New Mexico	No	No	No
New York	No	No	No
North Carolina	No	No	No
Ohio	No	No	No
Oregon	Parity	Yes	Yes
Pennsylvania	No	No	No
Rhode Island	No	No	No
South Carolina	No	No	No
Tennessee	No	No	No
Texas	No	No	No
Utah	No	No	No
Vermont	No	No	No
Virginia	No	No	No
Washington	Yes	No	No
West Virginia	Yes	Yes	$10,000/30,000
Wisconsin	No	No	No

Acupuncture and Oriental Medicine Laws, 2001 edition, by Barbara B. Mitchell, J.D., L.Ac., published by the National Acupuncture Foundation.

Acupuncture and Oriental Medicine Alliance

Cost Effectiveness of Acupuncture

Acupuncture Treatment Results in Avoidance of Surgery

29 patients with severe osteoarthritis of the knee, each awaiting arthroplasty surgery, were randomized to receive a course of acupuncture treatment or be placed on a waiting list to receive similar acupuncture treatment starting 9 weeks later. Of the 29 patients, 7 were able to cancel their scheduled surgeries.
Cost savings: $9000 per patient.

Christensen BV et al (1992) "Acupuncture treatment of severe knee osteoarthrosis: a long-term study", *Acta Anesthesiol Scand* 36:519-525.

Acupuncture Treatment Results in Decreased Days In Hospital Or Nursing Home

Half of 78 stroke patients receiving standard rehabilitative care were randomly chosen to receive adjunctive acupuncture treatment. Patients given acupuncture recovered faster and to a greater extent, spending 88 days/patient in hospital and nursing homes compared to 161 days/patient for standard care alone.
Cost savings: $26,000 per patient.

Johansson K et al (1994), "Can sensory stimulation improve the functional outcome in stroke patients?", *Neurology* 43:2189-2192.

Acupuncture Treatment Allows Low-Back Pain Patients To Return To Physical Labor

56 patients at a workers' compensation clinic were randomized to receive either physical therapy/ occupational therapy/exercise or the standard care plus acupuncture. Of the 29 treated with acupuncture, 18 returned to their original or equivalent jobs and 10 returned to lighter employment. Of the 27 who received only standard therapy, 4 returned to original or equivalent jobs and 14 to lighter employment.

Gunn CC et al (1980), "Dry needling of muscle motor points for chronic low-back pain", *Spine* 5:279-291

Acupuncture Treatment Results In Avoidance of Surgery, Fewer Hospital Visits And Greater Return to Employment

69 patients with severe angina pectoris received 12 acupuncture treatments in 4 weeks. Patients were also instructed to perform shiatsu 2x/day and received counseling in stress reduction, exercise and diet. Of the 49 patients who were candidates for coronary bypass or balloon angioplasty surgery, 30 had surgery postponed by the 2-year follow-up due to clinical improvement.
Cost savings: $13,000 per patient. Decrease in number of in-hospital days for all 69 patients: 79% first year post-treatment, 95% 2nd year post-treatment. Reduction in number of out-patient visits: 60% and 87% respectively. Estimated additional cost savings from increase in percent of patients able to work: 11% prior to treatment; 60% at 2 years post-treatment. Estimated savings in annual sick-pay: $18,000/patient.

Ballegaard S et al (1996) "Cost-benefit of combined use of acupuncture, shiatsu and lifestyle adjustment for treatment of patients with severe angina pectoris", *Acupunct Electro-Ther Res* 21:187-197.

Summarized by Richard Hammerschlag, Ph.D. For more detailed summaries see *Acupuncture Efficacy: A compendium of controlled clinical trials* by Stephen Birch and Richard Hammerschlag, NAAOM, 1996.

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ASNY Memorandum in Support

S.3635, Libous

At the turn of the decade, the Acupuncture Society of New York (ASNY) was founded by practitioners and patients, educators and students, following legislative action to make acupuncture more available to patients throughout New York State.

ASNY is advancing access to acupuncture in New York by helping patients find licensed or certified practitioners in their area. ASNY encourages acupuncturists to continue their education following licensure, and has provided advisory input as the managed care sector brings additional acupuncture coverage to New York's families.

As more of the public seek the benefits of acupuncture, and as the insurance industry responds to market interest, the Acupuncture Society of New York is meeting the step by step challenges of mainstreaming this effective approach to health care.

Introduction

Many patients are discovering their health insurance offers coverage for treatments by a certified acupuncturist, but omits coverage for treatments performed by a New York State licensed acupuncturist.

The result – New York patients who would benefit from the services of a licensed acupuncturist are denied reasonable access.

Assembly bill 6206 / Senate bill 3635 when enacted, would resolve this disparity. Insurers would of course retain the marketplace freedom to decide whether or not to include acupuncture in their coverage. This legislation is in no way, shape, or form construed as a mandate bill. This legislation simply provides for parity. Insurers remain free to respond to subscribers and the marketplace according to their best business judgement. For those insurers offering acupuncture coverage, such coverage would simply include treatment by a legally qualified provider, whether that be a New York State licensed acupuncturist or a certified acupuncturist

Background

The 1989 law defining the acupuncture profession in New York has enabled patients throughout New York State to seek the services of a legally qualified provider, either licensed, with three years of professional acupuncture study representing thousands of hours in class time and clinical training, or certified, applying to physicians and dentists with 300 hours of acupuncture training.

Since then, the public's effective use of acupuncture services continues to rise in New York, as direct experience and continued research demonstrate its benefits, and as increased numbers of legally qualified providers become available.

However, patients are often surprised to find their insurance offers coverage for treatments by a certified acupuncturist, but omits coverage for treatments performed by a New York State licensed acupuncturist, even though licensed acupuncturists have far more acupuncture training, and very often charge far less for the same service.

Since acupuncture can often resolve problems that have resisted treatment by other modalities, or resolve problems without recourse to far more expensive and dangerous treatments, it is vital that acupuncture reimbursements be available to patients who seek treatment by a legally qualified provider, licensed or certified.

Good for Patients, Good for Business

Insurance companies and managed care plans which currently offer coverage for acupuncture services find they have an enhanced product which satisfies both subscribers and the bottom line.

In Oregon, for example, legislation was enacted six years ago which required insurers in the state to offer coverage for acupuncture, and to pay licensed acupuncturists on an equal basis with physicians performing the same service. The increased availability of acupuncture proved to be a boon to the people of Oregon, who are now able to benefit from appropriate levels of treatment. The cost to insurers, as reflected in the charge for acupuncture riders to existing policies, has been minimal.

Some insurers and managed care plans in the New York area have included acupuncture coverage with little or no premium adjustment, reflecting conservative assessments that acupuncture will incur little short term cost and in the long run, has the potential to actually enhance insurance profits, as more expensive procedures are reduced and fewer patient work days are lost to absence due to prolonged illness.

An Ancient Healing Art Joins the Modern Health Care Family

Acupuncture is becoming widely embraced as an effective therapy for a variety of conditions for which it is also cost effective. Mainstream periodicals including *Life (The Healing Revolution), Time (The Frontiers of Medicine), US News (Acupuncture Goes Mainstream), Hudson Valley (Holistic Healing), Insight (Holistic medicine),* and *Arthritis Today (Acupuncture)* have run recent cover stories highlighting the benefits and increasing use of acupuncture.

Evidence is mounting that acupuncture is indeed an effective approach to healing. A few minutes on the Internet with *Medline,* the medical research database used by doctors around the world, a glance through *Acupuncture Efficacy,* or a reading of the *National Institutes of Health Consensus Report on Acupuncture* reveal hundreds of recent studies that demonstrate acupuncture's benefits.

Current investigations indicate that acupuncture is an extremely effective and safe therapy for chronic pain, disabling chronic pulmonary disorders, childhood asthma, circulatory problems, myofascial and musculoskeletal pain disorders, autologic immune disorders, and a host of other conditions which cause the loss of thousands of workdays in New York State and which cause tremendous suffering and expense.

Patients report acupuncture helped them when other possibilities were exhausted, speaking of relief from persistent symptoms, the ability to return to work, reduced dependence on medications with their troubling side effects, preclusion of surgical intervention, and the satisfaction of seeing results from just a few initial acupuncture treatments.

Building the Future

Acupuncturists are one of the fastest growing groups of the "ancillary health care professions." The ability of the profession to be of service and aid to the people of New York depends on building a strong and viable economic basis, so the expanding demand for acupuncture treatment can be met, and the best possible students can be attracted to study and practice in New York.

Several schools in New York State now offer acupuncture programs fulfilling educational requirements for licensure. Licensed acupuncture is fast becoming a mainstream option for students in New York seeking a career in a health care profession. New York State has issued over 850 acupuncture licenses thus far, and that number is likely to double in a few years.

Thanks to New York State legislative action in 1990, increasing numbers of patients throughout the state have joined patients around the nation in reaping the benefits of being treated by a licensed acupuncturist. A. 6206 and S. 3635, simply put, would offer patients increased access to the services of a licensed acupuncturist, while preserving the insurers' marketplace options, bringing New York closer to the promise and potential of acupuncture health care throughout the state.

For any questions regarding this bill or another matter, feel free to contact ASNY's Executive Director, Fred Cramer, at (914) 923 – 0632, (e-mail: ASNYmail@compuserve.com) or ASNY's representative, Tim Sheridan, at (518) 438 – 1455.

Acupuncture Society *of* New York

Acupuncture Insurance Parity Bill

As you may know, last year the Acupuncture Society of New York introduced an Insurance Parity bill, which is sponsored by Assemblyman Sam Hoyt (D-Buffalo) and Senator Thomas Libous (R-Binghamton) in the New York State Legislature. Passage of this bill would guarantee that any insurance company covering acupuncture services by any provider in New York, (M.D., Dentist, etc.) would also include coverage of such services by a New York State Licensed Acupuncturist. This bill is very important to the continued professional development of acupuncture in New York and ASNY is organizing its membership and working with other professional associations to garner support for the bill.

Currently in New York, insurers can, and often do, cover acupuncture only when performed by a medical doctor or dentist, severely limiting patients' access to acupuncture services.

The ASNY parity measure stands to benefit the entire acupuncture community – patients, licensed practitioners, suppliers and schools. The proposed legislation has garnered the committed support of regional and local acupuncture groups, sponsors in both houses and parties of the state legislature, and has received official support from the New York State Office of Professions, responsible for commenting on proposed legislation. Patients across the state are writing letters of support for the parity bill, and ASNY members have volunteered time and money toward the goal of seeing parity enacted into law.

Transcript of the ASNY Acupuncture Parity Bill

AN ACT to amend the insurance law in relation to reimbursement for services performed by a person certified or licensed to perform acupuncture.

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Subsection i of section 3216 of the insurance law is amended by adding a new paragraph 18 to read as follows:

IF A POLICY PROVIDES FOR REIMBURSEMENT FOR ACUPUNCTURE TREATMENT WHICH IS PERFORMED WITHIN THE LAWFUL SCOPE OF PRACTICE OF A PHYSICIAN OR DENTIST LICENSED TO PRACTICE IN THIS STATE AND CERTIFIED IN THE USE OF ACUPUNCTURE, AN INSURED SHALL ALSO BE ENTITLED TO REIMBURSEMENT FOR SUCH TREATMENT WHEN IT IS PERFORMED BY A PERSON LICENSED PUSUANT TO SECTION 8214 OF THE EDUCATION LAW.

Section 2. Subsection 1 of section 3221 of the insurance law is amended by adding a new paragraph 15 to read as follows:

EVERY INSURER DELIVERING A GROUP OR BLANKET POLICY OR ISSUING A GROUP OR BLANKET POLICY FOR DELIVERY IN THIS STATE WHICH PROVIDES COVERAGE FOR ACUPUNCTURE TREATMENT WHICH IS PERFORMED WITHIN THE LAWFUL SCOPE OF PRACTICE OF A PHYSICIAN OR DENTIST LICENSED TO PRACTICE IN THIS STATE AND CERTIFIED IN THE USE OF ACUPUNCTURE, SHALL ALSO PROVIDE COVERAGE FOR SUCH TREATMENT WHEN IT IS PERFORMED BY A PERSON LICENSED PURSUANT TO SECTION 8214 OF THE EDUCATION LAW.

Section 3. Subparagraph H of paragraph 4 of subsection f of section 4235 of the insurance law is relettered subparagraph I and a new subparagraph H is added to read as follows:

....ANY SERVICE WHICH IS WITHIN THE LAWFUL SCOPE OF PRACTICE OF A PHYSICIAN OR DENTIST LICENSED TO PRACTICE IN THIS STATE AND CERTIFIED IN THE USE OF ACUPUNCTURE, A SUBSCRIBER SHALL ALSO BE ENTITLED TO REIMBURSEMENT FOR SUCH SERVICE WHEN IT IS PERFORMED BY A PERSON LICENSED PURSUANT TO SECTION 8214 OF THE EDUCATION LAW.

Section 4. Subparagraphs J and K of paragraph 1 of subsection b of section 4301 of the insurance law are relettered subparagraphs K and L and a new subparagraph J is added to read as follows:

....ACUPUNCTURE TREATMENTS PROVIDED THROUGH PERSONS LICENSED PURSUANT TO SECTION 8214 OF THE EDUCATION LAW PROVIDED REIMBURSEMENT IS ALSO MADE FOR ACUPUNCTURE TREATMENTS PROVIDED THROUGH A PHYSICIAN OR DENTIST LICENSED TO PRACTICE IN THIS STATE AND CERTIFIED IN THE USE OF ACUPUNCTURE.

This act shall take effect immediately.

Acupuncture Society of New York
1858 Pleasantville Road - # 112 Briarcliff, NY 10510-1038
Phone / FAX: 914-923-0632 E-Mail: ASNYmail@compuserve.com

Statement on Acupuncture Insurance Parity before the New York State Assembly Committee on Higher Education, Hearing on Acupuncture, May 24, 2000

Good afternoon, Mr. Chairman, and members of the New York State Assembly Committee on Higher Education. Thank you for the opportunity to speak at these proceedings.

My name is Fred Cramer, and I serve as Executive Director for the Acupuncture Society of New York. I am speaking today on the subject of acupuncture insurance parity, sometimes called acupuncture insurance inclusion.

In my capacity as the Acupuncture Society's executive director, it is my privilege to take phone calls from the public, helping with a variety of general questions.

Several times each week, patients and their family members express surprise, frustration, even indignation, that their health insurance plans have chosen to cover acupuncture treatments, but only if patients obtain those treatments from a medical doctor.

Typical expressions of callers include:

"You mean I have to drive a full hour each way to go to a certified acupuncturist, when I have a licensed acupuncturist blocks away from where I live?"

"Is my health plan telling me I have to go to a certified M.D. with a lot less training in acupuncture, but they won't reimburse me if I want to be treated by a fully trained, licensed acupuncturist?"

The answer to both of these questions is unfortunately, yes - most insurers that choose to cover acupuncture, will only cover acupuncture when performed by an M.D. who is also a certified acupuncturist.

People who have never had acupuncture treatments before often ask whether acupuncturists pass any kind of qualifying exam. I am able to answer yes in the case of licensed acupuncturists, who must pass a national third party administered qualifying examination before New York State will grant a license. But I cannot answer yes in the case of certified acupuncture, which has no such requirement of its candidates. Such callers are amazed that their insurance plans want them to be treated by a practitioner who has not passed such a qualifying exam, especially after abbreviated training.

This disparity in coverage also impacts hospital patients. Callers have asked if they can have an acupuncturist with them in the hospital during labor, post-operatively, or during a painful treatment regime. A very few hospitals in New York State are beginning to include acupuncture services in their offering to patients. Other hospitals may be interested, but do not want the clerical and billing headache of a two tier coverage system.

The insurance disparity between certified and licensed acupuncture in New York deserves to be remedied, for the following reasons:

1. The current situation is, on its face, simply wrong.

2. Patients feel they have to see a certified acupuncturist, with far less training and capability, when they should have a right to choose any willing provider who is legally credentialed by the state of New York.

3. The full range of acupuncture, applied by fully trained licensed practitioners, can help reduce lost work time, and in some cases effectively preclude the need for more expensive drug regimes and other medical interventions. Employers and insurance companies would, in the long term, save money.

4. In the category of workers compensation, patients feel compelled to follow the insurers' directives with regard to treatment and recuperation.

5. Patients should not have to travel unnecessarily, in order to see a certified practitioner, when a licensed acupuncturist might be in a more convenient location.

Most of New York's Blue Cross companies have begun covering licensed acupuncture by directly reimbursing the patient. Their experience has been notable for how easily licensed acupuncture services were incorporated into coverage.

Insurance parity has worked well elsewhere in the country, with no red flags resulting.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. supporting docs	statement, Sheila Underhill (partial) (1 page)	01/08/1999	b(6)

COLLECTION:
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OA/Box Number: 43238

FOLDER TITLE:
WHCCAM Meeting Testimony, December 4-5, 2000 [2]

2011-0568-S
kc886

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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1035

Statement of Support for S.3635 and A.6206

This is a statement of support for the Acupuncture Insurance Parity bill, introduced in the NYS Senate and Assembly by Senator Thomas Libous (R-Binghamton) and Assemblyman Sam Hoyt (D-Buffalo), which would provide greater patient access to NYS licensed acupuncture services.

I began having acupuncture treatments by Dan Zal last September for chronic fatigue, flu-like symptoms, and recurrent sinus infections caused by an underlying systemic yeast infection. At the time, I was very sick and struggling to get to work since I had a relatively new job and very little sick time available to take off. I was seriously considering the possibility of needing to go on disability as it was getting more and more difficult to function.

I credit Dan's treatments for getting me back on track and able to function. Due to the acupuncture and some herbal preparations Dan prescribed, I was able to get rid of the sinus infection I had (I had been on antibiotics for 1 month without results, which of course exacerbated the yeast problem) – and have not had any sinus infections since. I also got rid of the flu-like symptoms within a month, and have had a steady increase in my energy level since beginning treatment.

At this point, I have been having weekly acupuncture treatments for over three months, all at my own expense, since this is not covered under my insurance. However, I don't have much choice, since nothing else I had tried previously helped my condition. I truly believe that acupuncture is the best treatment for many conditions and that treatment by licensed acupuncturists should be reimbursed by insurance.

I do not think it is necessary for the practitioner to be an MD, and in fact, given the lower training requirements for MDs, I would prefer to be treated by someone with the license and degree in acupuncture. In fact, I was treated previously for shoulder pain by an MD who practiced acupuncture, but I believe Dan is more equipped to deal with the more complicated problem I currently have.

I encourage the support for the successful passage of this legislation. Please feel free to contact me regarding your views on this bill, or with your questions.

Sheila Underhill Sheila Underhill Jan. 8, 1999

Phone: (b)(6) Address: (b)(6) Clifton Park, NY 12065

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. supporting docs	statement, June Brown (partial) (1 page)	01/09/1999	b(6)

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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[0016]

1026

To Whom it May Concern:

I am pleased to make a statement regarding the benefits I have enjoyed following acupuncture treatment. For many months I had had pain in my right hand and wrist. After the initial treatment I felt immediate relief, and the follow-up treatments aided in my recovery. I cannot speak too highly of the acupuncture practitioner, Mr Graham Marks, who treated me. He was thorough and highly professional in his approach, and also very understanding regarding my particular problem.

The community in which I live is rural, and many miles from the nearest doctor who performs acupuncture. Especially in the winter months it is very difficult to travel any distance to get help of this nature.

I would encourage successful passage of "The Acupuncture Insurance Parity Bill" (S.3635 and A.6206). It is so important that patients of licensed practitioners in the State of New York receive parity for acupuncture insurance coverage.

June E. Brown
(b)(6)
Alfred, New York 14802

Telephone: (b)(6)

June E. Brown

January 9, 1999

FREDONIA

1049

School of Music

1004 Mason Hall
716-673-3161

September 21, 1998

To Whom it may concern,

I am a faculty member at the State University College of New York at Fredonia teaching in the School of Music. I am entering my twenty sixth year of college teaching and am fifty-six years old. At this age, I have certain problems with my body which make singing and conducting difficult. After numerous appointments over the years with massage therapists and chiropractors, I began treatments this summer (1998) with a licensed acupuncturist. I assumed at the outset that my treatments which gave me immediate relief would be covered under my New York Empire Plan. Not so!

I understand there is a Parity Insurance Bill coming before the New York State Legislature which is being brought forth to correct this problem. I also understand that insurance is currently covering acupuncture when a licensed MD performs the treatment, but not when the treatment is performed by a licensed acupuncturist. This seems extremely strange to me since I had such a positive result. It has also come to my attention that other states offer coverage in both cases. Why not follow suit here when the entire situation makes GOOD sense? Why not provide coverage so the relief from pain which these licensed acupuncturists provide may be available to those who might not otherwise be able to afford such treatment and relief?

I urge you to act now to bring us up to date with many places elsewhere in the country and in the world.

Best regards,

David F. Evans

David F. Evans, Chair
Voice Faculty
SUNY at Fredonia
School of Music

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001c. supporting docs	statement, Paul DeRitter (partial) (1 page)	01/14/1999	b(6)

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[601c]

1036

To Whom It May Concern:

I would like to urge your support of the "Acupuncture Parity Bill" ("S.3635" and "A.6206") which would mandate that if an insurance company reimburses for acupuncture they must reimburse for all practioners licensed by the State of New York - not just doctors.

At present, my acupuncture treatments are postponing inevitable hip replacement surgery. Pain from osteoarthritis has lessen with the treatments without the side effects of the 16 daily Ibuprofen which I had been taking for the pain. It would seem to be cost-effective for an insurance company to pay for my acupuncture treatments at $45. each rather than the cost of a hip replacement.

Living in a rural community, I am a few hours away from the nearest medical doctor who practices acupuncture. The trip to a N.Y.S. licensed acupuncturist is 45 minutes.

In my reading I have not found evidence that acupuncture is more effective when performed by a medical doctor.

Thank you for your attention to this matter.

Signed,

Paul De Ritter

(b)(6)

Olean, New York 14760

(b)(6)

1/14/99

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001d. supporting docs	statement, Robert Strasburg (partial) (1 page)	01/11/1999	b(6)

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[0016]

Robert C. Strasburg II

(b)(6)

Cohocton, New York 14826

1037

(b)(6)

January 11, 1999

The Acupuncture Society of New York
1858 Pleasantville Road - Suite 112
Briarcliff, New York 10510-1038

Re: S.3635 and A.6206

Dear Society Members,

I am writing to give my personal story how acupuncture has benefited me and how I feel we need the passage of the above named bill. I have suffered with Ulcerative Colitus and have found great relief from visits to a National Board Certified Acupuncturist, Graham Marks.

I have gone from the condition controlling my day and leaving me at the mercy of unpredictable bowel movements to a much greater sense of predictability and control. The condition was greatly impairing my ability to make an income and provide for my family. The condition continues to improve with each visit to the Acupuncturist.

I live in the southern Tier of New York and the drive to reach a Medical Doctor that performs Acupuncture would be prohibitive in time and cost.

You have my permission to pass this letter along to the involved Senator and Assemblyman proposing the passage of the above legislation with my strong request to pass the bill.

Sincerely,

Robert C. Strasburg II

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001e. supporting docs	statement, Susan Evans (partial) (1 page)	01/10/1999	b(6)

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[001e]

1038

January 10, 1999

To Whom It May Concern:

I am writing this letter in support of increasing insurance coverage for acupuncture services set forth in the proposed "Acupuncture Insurance Parity Bill."

Over the past several years I have received numerous acupuncture treatments for various conditions when traditional western medicine failed to provide relief. I went with an attitude of skepticism but quickly became a believer. My first treatments were for migraine headaches. I have not had one now in 3 years. My second series of treatments were for tendonitis after cortisone failed. Another success. My third treatments were for incredible nausea and vomiting associated with first trimester pregnancy. I had instant and safe results. I have had other successes but time does not allow for them.

My husband is a medical doctor and, to the best of our knowledge, I know of no M.D.s in the southern tier who perform acupuncture. As it is, I drive 1 ½ hours one way for my treatments and of course pay out-of-pocket for these services. The reason is simple: acupuncture works and is safe. Unfortunately, many people in our area are unwilling or unable to drive great distances to a city for acupuncture treatments performed by M.D.s who are not even experts in Chinese medicine.

For these reasons I encourage you to consider passing "The Acupuncture Insurance Parity Bill" (S.3635 and (A.6202). Thank you for your time in this matter.

Sincerely,

Susan E Lawrence

Susan Evans Lawrence

Susan Evans Lawrence
P.O. Box 1766
(b)(6)
Ellicottville, NY 14731
(b)(6)

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A non-profit organization
www.feingold.org

Feingold® Association of the United States

A dietary connection to better behavior, learning, and health

December 5, 2000

A simple elimination diet is among the oldest and most conservative forms of medical treatment; but in the United States it is viewed as an alternative.

For a quarter century the Feingold Association has shown families how to reduce or eliminate many behavior, learning and health problems by making simple adjustments in their grocery shopping – by selecting familiar brand name foods that are free of synthetic dyes, artificial flavors and certain preservatives.

This is an inexpensive, effective technique that any family can easily implement. We have a 25-year track record of considerable success, and the scientific validity of this program is supported by double blind, placebo-controlled studies published in peer-review journals.

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 the very government agencies and professional organizations that should embrace it.

National Institutes of Health
National Institutes of Mental Health
Centers for Disease Control
US Department of Health & Human Services
Food and Drug Administration
US Department of Agriculture
US Department of Education
American Dietetic Association
American Medical Association
American Academy of Pediatrics
American Academy of Child and Adolescent Psychiatry

The sad fact is that a doctor who suggests diet, rather than drugs, as a first option to help children, risks losing his license.

Jane Hersey, National Director, Feingold Association of the United States

The Feingold® Association of the United States
Box 6550 • Alexandria, VA 22306 • (703) 768-FAUS

A simple, conservative medical approach to ADHD

The risk-free program that has helped America's children for twenty-five years is the first place to begin.

Hyperactivity is not new; neither are learning difficulties. But by the 1970s pediatricians in the United States were alarmed by the growing numbers of children they saw who had difficulty behaving, focusing and functioning normally. When one of their respected colleagues reported that he had successfully treated many of these youngsters with a simple diet, his work was enthusiastically received. After 8 years of clinical research and the publication of papers on this work, Ben Feingold, M.D., presented the information at the 1973 conference of the American Medical Association. Feingold was chief of allergy at the Kaiser Permanente Medical Center in San Francisco, had taught pediatrics, and was considered a pioneer in the fields of allergy and immunology.

The diet eliminates these synthetic additives:

Artificial colors (these are derived from petroleum)
Artificial flavors (these can be manufactured from countless natural and synthetic substances)

Initially, aspirin and foods that are believed to contain a chemical related to aspirin, are removed; once a favorable response is seen they may be reintroduced one at a time.

Feingold found that about 1/3 of the children improved significantly; 1/3 improved to some degree, and the other 1/3 did not show improvement.

Later, he would also remove the anti-oxidant preservatives BHA, BHT, & TBHQ. After this, the success rate increased, and by the time of his death in 1982 the diet had been further refined, and the success rate was over 70%.

What Feingold named the "Kaiser-Permanente Diet" gained wide publicity after the American Medical Association arranged for press conferences to be held around the country, and sent Dr. Feingold out to tell of this new information. Feingold called for research to identify the scientific basis for the successes he was seeing in his patients; he knew this would be a formidable task and that it could take many years to understand how certain compounds affect our behavior, ability to learn, and our general health. He suggested that the research begin with food dyes since there were only a few of them still permitted to be used. It would be several years before the first studies were completed, but after only a few months, the AMA abruptly, inexplicably, dropped their support.

Even before the 1973 AMA conference, the lobby representing the interests of the food, chemical and pharmaceutical industries was busily engaged in damage control. The lobby, called the "Nutrition Foundation" used many tactics to address what they appear to have perceived as a threat.

After the medical association had their change of heart, Random House asked Feingold to write a book directed to parents, and in 1974 *Why Your Child Is Hyperactive* was published. Grateful parents who had benefited from this book began to form support groups, and in 1976 they established a national non-profit organization and named it the Feingold Association of the United States.

The role of the Association was, and remains, that of:
1. helping people use the program, and
2. generating public awareness of the potential role of foods and food additives in behavior, learning and health.

The Association:
- Identifies brand name foods that are free of the unwanted additives.
- Prints this information, and literature to guide families through using the program. (This includes a Handbook, recipes, menu suggestions, information on finding undyed medicines and non-food products, information on other non-profit organizations that offer various types of assistance on related problems.)
- Offers on-line and telephone help in finding suitable brand name foods and resolving non-medical problems.
- Provides information to interested persons and organizations.

For the past 25 years the Feingold Association has provided information and assistance to families in the United States and abroad. The Association is composed primarily of parents and professionals who donate their time, and do what they can to help other families. We rely on membership dues and fundraising from member families to meet the bulk of our expenses. Like all groups of this type, people donate their time and energy because they receive the reward of seeing the program work effectively for the great majority of families. We have not conducted academic research and do not have the resources to track the outcomes on an ongoing basis. We are hopeful that an unbiased resource will someday fully evaluate the success rate of this program. Our own informal tracking suggests a success rate of between 75% and 86%.

There have been many criticisms of the Feingold Program.

Most are based on information that is not supported by fact such as:

Criticism: "The diet is restrictive."
In fact, the Feingold Program allows foods of all type, including: meat, dairy products, grains, most vegetables, some fruits initially (with the remainder added later). All types of foods are permitted, including candy, ice cream, cookies, junk food, pizza, soda, Big Macs, etc. Families select from among the many acceptable brand name products included in the Feingold *Foodlists*.

Criticism: "Children hate being on the Feingold diet."
Since they can still have their favorite types of food (in the versions that are free of the unwanted additives) they generally do not have to give up anything.

Criticism: "The Feingold diet cuts out sugar, chocolate, refined grains, etc."
This is not true and has never been the case.

Criticism: "It's expensive to follow this program."
Initially, families replace the unallowed products with new ones, but after that there need not be an increase in cost.

Criticism: "Everything in the supermarket contains additives."
The Feingold program only cuts out three groups of additives (plus synthetic sweeteners). Most food additives are not eliminated.

Criticism: "One bite of the wrong food can sabotage the diet."
If a child is sensitive to a particular substance, and eats it, he will probably experience a reaction; but this does not destroy the diet. The family simply deals with the reaction and when it is over, avoids the food/additive in the future. Children soon learn what they can and cannot tolerate, and follow the regimen that works best for them. Typically, once a person has followed the diet for a year or more, reactions diminish.

Criticism: "The improvement is due to a placebo effect. The improvement is due to increased parental attention."
The newer studies were designed to eliminate this. One of the earliest studies (Harley study at the University of Wisconsin) showed that neither placebo effect nor increased parental attention were factors. If the positive effects were the result of psychological factors, a person would be able to eat the prohibited additives and not experience a reaction.

Criticism: "The studies have shown that only a very small percentage (1% to 10%) of the children improve."
There are no such studies.

Criticism: "There are no studies that prove the Feingold diet works."
There have not been any studies of the Feingold diet as it is actually used. Portions of the diet (especially dyes) have been studied, and have yielded supportive results.
In 1998 the National Institutes of Health Consensus Development panel reviewed the scientific literature on diet for ADHD and called the research "intriguing," and "suggesting further research." The nonprofit Center for Science in the Public Interest published the report *Diet, ADHD & Behavior, a Quarter Century Review*, recommending diet as the first treatment to be tried.

Criticism: "Busy mothers cannot take the time to cook from scratch."
Most of the mothers using the Program work outside the home. They do not need to cook from scratch because the Association provides books listing thousands of brand name processed foods that are acceptable. Many of the major brands of food are available in versions with and without the prohibited additives (i.e., Nabisco, Duncan Hines, Hellmann's, Kraft, Kellogg's, Coca-Cola, Pepsi-Cola, Breyer's, Lender's, Pillsbury).

Criticism: "A child will not receive sufficient nutrition if he is on the Feingold diet."
The contrary is true. Eliminating the above synthetic additives invariably means the child will eat more nourishing foods. Removing oranges for a few weeks will not put the child at risk of becoming deficient in vitamin C. There are many allowed fruits and vegetables that are very good sources of this vitamin.

The Feingold Association's position on the use of stimulant drugs

The Association does not take a stand for or against drugs. Instead, we believe that parents and professionals have the right to have complete, accurate information on all of the potential options. We do believe, however, that it makes sense to try the least invasive options first, resorting to drugs if other interventions do not help, or offer only partial help. Some of the children who are using the Feingold program are also on stimulant medicine. In many cases parents report that by using diet, the physician can reduce the dose and the child can achieve the same level of effectiveness. Of course, we encourage families to request an undyed version of any medicines used.

When used appropriately, drugs can offer many benefits, but they are not always used appropriately for children with learning, behavior, or health problems. We would like to see children receive careful screening to rule out the many things that can trigger attention/behavior problems. We believe that too little attention is given to ruling out illness, and that initiating stimulants without considering them may only mask the symptoms and make them harder to identify.

Behavior/learning problems can have many causes.

Some examples of problems that might contribute to overactivity or inattention include:

Sensitivity to food additives
Salicylate sensitivity
Psychological factors
Heavy metal exposure (lead, mercury preservatives in vaccines, excess copper)
Gluten or casein intolerance
Deficiencies – such as low zinc or magnesium levels, essential fatty acids
Hypothyroidism,
Elevated levels of phenylalanine
Inefficient production of enzymes
Lactose intolerance
Food allergy
Environmental allergy
Vision problems
Auditory deficits
Language delays
Sensory dysfunction
Fine or gross motor control deficits

The Association believes that children with learning/behavior problems deserve to receive the same careful evaluation provided for children with other symptoms. Underlying sensitivity, deficiency, physical illness or dysfunction should be ruled out.

A brief trial of a simple, inexpensive elimination diet is one such test. It is not an alternative form of treatment, but rather a very traditional, conservative medical approach.

The current diet of many American children represents a risky experiment.

There has been a drastic increase in the use of petroleum-based food additives in the United States, along with a dramatic increase in ADHD, yet this important clue to the puzzle is generally overlooked. Unlike drugs, food additives have not been required to be evaluated for behavioral effects before being added to the food supply.

Synthetic dyes that are prohibited from use in foods may still be added to drugs and cosmetics. Small children are the most likely patients to receive medicine with synthetic colors and flavors. Surely, the small child who is sick is at great risk. If a dye is deemed unsafe for use in food, why is it allowed in pediatric medicine? *

Some countries have a low rate of ADHD, and there are significant differences in the diet of the children in those countries compared to the diets of children in the United States. The epidemiological studies that could shed light on a possible connection are not being conducted.

The ingestion of more and more synthetic chemicals by children and infants in the United States is generally ignored despite the published studies that link these additives to disturbed behavior and learning difficulties.

The practice of feeding large quantities of non-nutritive chemicals to young children is neither conservative nor traditional. Likewise, the use of Schedule II drugs on very young children is, in our judgment, neither conservative nor traditional.

* *The New England Journal of Medicine*, October 5, 2000 reported three deaths suspected of being caused by the addition of Blue dye No. 1 to the foods of critically ill patients.

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the relationship between foods/food additives and learning/behavior problems

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Kurtz

Divider Title: _____

Subj: **URGENT - Corrected version**
[redacted]: 30/11/00
[redacted]dk64m@nih.gov

Subj: **URGENT - Corrected version**
Date: 30/11/00
To: whccamp@mail.nid.gov (Doris Kingsbury)
CC: PaulKurtz, pksksh, SkeptInq

URGENT

Dear Ms. Kingsbury:

Please substitute the attached corrected copy for what I sent you yesterday. It was sent out without its being proofread. I very much hope you can include this.

Cordially,

Paul Kurtz

KURTZ
MONDAY
1:00 PM

==========

Dear Ms. Kingsbury:

Please provide my response to the 4 questions to the Commissioners:

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

I do not think that it should be integrated. I deplore the efforts to do so. The term "conventional medicine" is as a misnomer. What is labeled as "conventional" is modern scientific or evidence-based medicine. Many or most CAM therapies on the other hand are "conventional" and ancient, such as traditional Chinese medicine, Qigong, or spiritual importations from India.

Scientific medicine is a relatively recent development in human history, especially since the nineteenth century, when increased knowledge of physiology and human anatomy was refined. There have been a number of brilliant researchers who have contributed to our understanding, such as Claude Bernard, Louis Pasteur, Robert Koch, and Joseph Lister. Theories about the nature and transmission of infectious diseases, such as diphtheria, tuberculosis, malaria, typhoid, tetanus, polio, and the development of vaccines had important roles in immunization. Likewise important were the advances in epidemiology, public health, and sanitation. In the twentieth century endocrinology advanced--with the discovery of insulin, cortisone, and sex hormones. In the field of nutrition researchers discovered the role of vitamins. There have been significant new diagnostic tools, such as X-ray imagery, CT scans, mammography, and sonograms, to mention only a few. The great strides in surgery have been impressive, including cardiology, neurosurgery, and organ transplantation. The discovery of antibiotics has made enormous contributions to the cure of infectious disease. We should add to this the discoveries of DNA, biogenetic research, gene therapy, and other innovations on the frontiers of research. All of these achievements have led to the reduction of infant mortality and the extension of life spans. As part of this process was the development, beginning in 1904, of rigorous standards of medical eduction in medical schools. Thus we see the remarkable effectiveness of modern scientific medicine--all for the benefit of humankind.

They key factor in evidence-based medicine is that any new diagnostic techniques and therapies be submitted to rigorous double-blind clinical tests. Unfortunately, CAM therapies, in our view, have not been adequately tested. Too often the claims of their validity have been anecdotal or highly subjective uncorroborated reports by practitioners and/or their patients, some of these based upon the placebo effect.

Surely, we cannot lump all CAM therapies together and make a blatant indictment. Each has to be examined objectively and [redacted]rtially. Scientific medicine admits that fallibility and skepticism is part of its process of inquiry. On the other hand, we should insist that the public be safeguarded against unproven cures, untested therapies, quackery by practitioners and manufacturers out to make a profit.

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

I do not think that there should be universal access and delivery of CAM products and nostrums. This will tend to weaken what is one of the finest health-care systems in the world based on scientific testing. CAM could undermine the line between genuine and pseudoscience. Each claim to validity must be tested by impartial neutral observers not simply their advocates. If a therapy proves to be effective, then it becomes part of scientific medicine. It is vital, in our view, that this Commission represent not simply proponents of CAM, but scientists and physicians who are skeptical of its claims.

3) If current CAM utilization trends continue, what consumer protection should be implemented?

CAM seems to be growing. I think the public should be protected. The government has an obligation to act against spurious or fraudulent claims. The free market--in selling adulterated goods and questionable services--needs to be monitored. The misuse of taxpayers funds needs to be safeguarded. The great issue is the health and welfare of the American public. Government sponsorship of questionable CAM therapies would be a disservice to the public interest.

4) What policy recommendations do you have for the Commission?

I would strongly urge as a first step the repeal of the 1994 Dietary Supplement Health and Education Act, which freed herbal medicines and dietary supplements from regulation by the FDA. Prescription drugs are required to be tested. There are no such safeguards for dietary supplements. There are now some 20,000 such supplements--including herbal and homeopathic remedies--on the market. Many of the manufacturers make false and misleading claims. Many have dangerous side effects. Some may have positive results. In any case, the packages should be properly labeled--there should be "truth in labeling." Those deemed to have possible noxious side effects by misuse should require a prescription.

Second, similar regulations should be enacted against other false claims--such as quack cancer cures, crash diets, Chelaton therapy, iridology, therapeutic touch, and magnetic therapy. This is particularly the case where patients avoid scientific medicine and substitute alternative therapies, believing that since they are offered by the health-delivery system, they must be effective. There needs to be peer review, as in scientific medicine, but not simply by the practitioners in a field, but by other objective and neutral scientific reviewers.

Paul Kurtz, Chairman, Committee for the Scientific Investigation of Claim of the Paranormal; Publisher, The Scientific Reveiw of Alternative Medicine.

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Meeker

Divider Title: _____

Presentation by William C. Meeker, DC, MPH, Director of Research
Palmer Center for Chiropractic Research, Davenport, Iowa

To the

White House Commission on Complementary and Alternative Medicine Policy
Washington, DC
December 5, 2000

Questions for Session II: Clinical and Cost-Effectiveness of Selected CAM Services

Please provide references that best describe the clinical and cost-effectiveness data for access to and delivery of chiropractic practice.

A selected bibliography is appended to this report. Particular attention should be directed to two government sponsored monographs about the chiropractic profession. One was commissioned by the province of Ontario, Canada, (Manga, 1993) the other by the U.S. Agency for Healthcare Research and Quality (formerly Agency for Health Care Policy and Research). (Cherkin, 1997) Another major reference is the recent, "Job Analysis of Chiropractic," published by the National Board of Chiropractic Examiners, which is based on a major random survey of chiropractic practices in the U.S. (Christensen, 2000)

Relative to the clinical effectiveness of chiropractic practice, please summarize the data regarding the following measures: specific health conditions, populations (age, sex, occupation, etc.), practice setting (including whether chiropractic only, or in conjunction with conventional medicine), type of practitioner.

One indicator of chiropractic mainstreaming is the steadily increasing use by patients in the U.S., which has tripled in the last two decades from about 3.6% in a 1980 survey (Von Kuster, 1980) to an estimated 11% in a 1997 national random telephone survey. (Eisenberg, 1998) This translates to an estimated 190 million patient visits to chiropractors in a year, or about 30% of visits to all CAM practitioners. In surveys of patients seeking alternative care, chiropractors are utilized more often than any other CAM provider group. (Eisenberg, 1998) Payments for chiropractic services in the U.S. total approximately $8-10 billion annually.

Although spinal adjustment and manipulation is practically synonymous with chiropractic (chiropractors deliver over 90% of the manipulations in the U.S., (Shekelle, 1992)) chiropractors also provide a variety of other treatments and counsel to patients. Physical therapies such as heat, cold, electrical modalities, and rehabilitation methods are very commonplace. (Christensen, 2000; Mootz, 1997) Therapeutic exercises and general fitness recommendations are usually made to a majority of patients, and many receive advice about nutrition, vitamins, weight loss, smoking cessation, and relaxation techniques. (Hawk, 1995) Many chiropractors use other forms of CAM therapy, with emphasis on massage, acupressure, and mineral and herb supplements. (Hawk, 1999)

Studies demonstrate that chiropractic patients generally represent a cross-section of U.S. population demographics. Patients come from all age and occupational groups, economic and educational levels. Patients less than 18 years old account for approximately 12%, and patients 65 years and older make up approximately 15% of the chiropractic patient population. (Coulter 1996; Christensen, 2000)

Studies confirm that the chiropractic case-mix is predominately musculoskeletal in nature with about 50% of patients complaining of back pain; the remainder with head, neck and extremity complaints. (Christensen, 2000; Shekelle, 1991; Hurwitz, 1998) Approximately one-third of all patients who seek professional care for low back pain consult chiropractors in a primary health care role. (Deyo, 1987; Shekelle, 1995; Carey 1995; 1996) Furthermore, about half of the patients seeking chiropractic care have chronic symptoms. (Hurwitz, 1998; Hawk, 2000) Typically, approximately 5% seek care for other types of conditions. Recent studies also document that a proportion of patients attend chiropractors for general health concerns, prevention and a feeling of well-being, often receiving standard health advice, most often with regard to physical fitness and nutrition. (Hawk, 2000; Rupert 2000a; 2000b)

Clinically, chiropractors direct spinal adjustments to a dysfunctional joint "lesion" known as a subluxation. This is characterized as a form of joint strain/sprain with clinically associated hypomobility, malalignment, local and referred pain, inflammation, and muscle tension. (Gatterman, 1995) Subluxation in the chiropractic context primarily connotes a functional and not necessarily an anatomical entity. In theory, subluxation prevents the body from operating at an optimum healthy level. At least five mechanical and neurologic mechanisms have been proposed and these are listed below

Proposed Mechanisms of Spinal Manipulation

Action	Mechanism
Mechanical/anatomical	Alleviation of an entrapped facet joint inclusion or meniscoid, which have been shown to be heavily innervated (Giles, 1987; Bogduk, 1985)
Mechanical/anatomical	Repositioning of a fragment of posterior annular material from the intervertebral disc (Bogduk, 1985; 1981)
Mechanical/anatomical	Amelioration of stiffness induced by fibrotic tissue from previous injury or degenerative changes that may include adaptive shortening of fascial tissue (Arkuzewski 1988; Lantz, 1995)
Neurological/mechanical	Inhibition of excessive activity in the intrinsic spinal musculature or limbs and/or facilitation of inhibited muscle activity (Blunt, 1995; Bolton, 2000; Budgell, 2000; Suter, 2000).
Neurological/mechanical	Reduction of compressive or irritative insults to neural tissues (Haldeman, 2000).

Intriguing effects on neurophysiological and musculoskeletal function have been noted and these support the results from clinical trials. They include: increased range of joint

motion, [Mierau, 1988; Nansel, 1989] increased pain tolerance, [Terrett, 1984] reduced muscle activity, [Shambaugh, 1987] and muscle reflex responses. [Herzog, 1999] The nervous system may be affected by manipulation as suggested by experiments examining capillary blood flow, [Harris, 1987] serum levels of beta-endorphin, [Vernon, 1986; Christian, 1988] and substance P. [Brennan, 1992] A biomechanical picture of manipulation is beginning to emerge from studies on the forces involved and the resultant kinetics and kinematics. [Herzog, 1995] This is an area of intense scientific discussion and study.

There are numerous case-studies and observational outcome studies on the clinical effectiveness of chiropractic care. This summary will only focus on the experimental randomized controlled trial data. To date, at least 70 randomized clinical trials of a broadly defined spinal manipulation procedure can be found in the English literature. Most of these studies have been conducted on patients with low back, neck and head pain, with a few on other conditions. The clinical trials include placebo-controlled comparisons, comparisons to other treatments, and pragmatic comparisons of chiropractic management vs. common medical management. [Von Tulder, 1997; Hurwitz, 1996]

Results of RCTs of Spinal Adjustment/Manipulation (Please see list of references.)

Condition	# of RCTs	Positive, Equivocal, or Negative
Acute back pain	10 3	Positive Equivocal
Subacute and chronic back pain	8 6	Positive Equivocal
Mixed acute and chronic back pain	10 4	Positive Equivocal
Migraine headache	2 1	Positive Equivocal
Muscle tension headache	4 1	Positive Equivocal
Cervicogenic headache	1	Positive
Acute, subacute, chronic neck pain	4 7	Positive Equivocal
Dysmenorrhea	1 1	Positive Equivocal
Infantile colic	1	Positive
Enuresis	1	Equivocal
Asthma	2	Equivocal
Premenstrual syndrome	1	Positive
Carpal tunnel syndrome	1	Equivocal
Hypertension	1 1	Positive Equivocal

Forty-one RCTs of spinal manipulation for treatment of acute, subacute, and chronic low back pain have been published. Twenty-eight favored manipulation over the comparison treatments in at least a subgroup of patients, and the other 13 found no significant differences. No trial to date has found manipulation statistically or clinically less effective than the comparison treatment. Eleven of the low back pain trials included a

placebo arm and 8 of them demonstrated an advantage to manipulation. (Koes, 1996) Eleven RCTs of spinal manipulation for neck pain have been conducted, four positive and seven equivocal. Seven of 9 RCTs of manipulation for various forms of headache were positive.

The treatment effect sizes estimated by the majority of RCTs of manipulation on musculoskeletal pain appear to be clinically and statistically significant. Systematic reviews and meta-analyses in the early 1990s made cautiously positive or equivocal statements about the effectiveness of manipulation for low back pain, neck pain and headache, and called for higher quality studies. (Shekelle, 1992; Hurwitz, 1996; Koes, 1996; Anderson, 1992; Assendelft, 1995; Aker, 1996) A 1997 systematic review (Von Tulder, 1997) of manipulation for low back pain concluded that there was sufficient evidence to recommend manipulation for chronic back pain, but that there was weak evidence for acute back pain. The most recent review (Bronfort, 1999) used a slightly different method of analysis taking into account study design and quality, and concluded there was moderately strong evidence of benefit of manipulation for acute and chronic back pain. There was insufficient evidence for or against the effectiveness of manipulation for sciatica.

Using formal consensus processes, the Quebec Task Force on Whiplash-Associated Disorders in 1995, concluded that spinal manipulation had at least "weak cumulative evidence," and recommended that a short regimen of spinal manipulation may be used as a therapeutic trial for neck pain. (Cassidy, 1995) The U.S. Agency for Health Care Policy and Research in 1994 similarly concluded that spinal manipulation was safe and effective for acute low back pain. They reviewed all clinical trials available at the time and found no other treatment to have stronger evidence. (Bigos, 1994) Other countries for example, the U.K., Sweden, Denmark, and New Zealand, have also developed practice guidelines for the treatment of low back pain and have arrived at essentially similar conclusions.

The treatment of disorders not generally thought to be related directly to the musculoskeletal system by manipulation has been supported mainly by clinical experience and case reports. In the past few years, RCTs for primary dysmenorrhea, hypertension, chronic asthma, enuresis, infantile colic, and premenstrual syndrome have been completed with variable results. Two systematic reviews, one on extant trials at the time (Bronfort, 1996) and one recently on asthma sponsored by the Cochrane Collaboration (Hondras, 2000) concluded that the results so far do not argue convincingly for or against the utility of spinal manipulation for these kinds of conditions. Additional research is obviously needed in this area.

Although additional research is necessary, spinal adjustment/manipulation is already one of the most studied treatments for back and neck pain. (Bigos, 1994; Von Tulder, 1997) It should no longer be considered "investigational" in nature when compared to standard medical and other treatments in common use for common musculoskeletal conditions.

Describe the cost-effectiveness of chiropractic care provided as a stand-alone therapy with chiropractic care that is provided in conjunction with conventional medicine as part of an integrative approach.

To date, there are no formal cost-effectiveness studies that have compared chiropractic care to chiropractic care integrated with conventional medicine. Although settings exist where chiropractors work alongside medical doctors, these have not been subjected to this sort of analysis. In addition, typical chiropractic care is a case-management approach that emphasizes spinal adjustment, but also uses other procedures and lifestyle advice such as for exercise and nutrition, which might be considered "conventional." Finally, there are studies that indicate high rates of referral from chiropractors to medical physicians and a growing rate of medical doctors referring cases to chiropractors. (Curtis, 1992; Mainous, 2000) Patients fall into one of three categories: those that require only chiropractic care, those that need co-management, and those that need specialty medical care alone. Logically, co-management of patients only requiring chiropractic care would seem to be a waste of health resources, unless it can be shown that improved outcomes are the result.

Compare the costs of chiropractic care with those of conventional medicine for the same or similar health conditions.

The relative cost-effectiveness of chiropractic and medical care has not yet been convincingly demonstrated, although approximately 40 studies in this area have been published in the past three decades. Most studies have been retroactive and actuarial in nature, using claims databases that may not accurately reflect actual total costs, episodes of care and the clinical experience of doctors and patients. Furthermore, most studies have failed to compare equivalent patients, measure clinical outcomes, and include both direct and indirect costs in the analysis. Sophisticated economic analyses have been lacking. To date, there is still not a single prospective randomized trial comparing chiropractic care to conventional medical care with properly assessed economic and clinical variables as outcome measures.

However, despite variation in study quality, the preponderance of information from a number of studies indicates that chiropractic services are equal to or less expensive than common medical treatments. Cost advantages for chiropractic care, particularly for back pain patients appear possible. The most recent and best done single study indicates that chiropractic care substitutes for medical care in occupational low back injuries, and that there may be a cost advantage relative to disability expense as well (Johnson, 1999).

The most comprehensive review of the cost-effectiveness of chiropractic management of low back pain was undertaken by a team of health economists at the direction of the government of Ontario, Canada. (Manga, 1993) Conclusions strongly favored a much greater inclusion and integration of chiropractic services.

Fourteen of seventeen retrospective actuarial reviews from 14 different jurisdictions in the United States prior to 1981 concluded that the total costs for injured workers managed by chiropractors were lower than similar cases managed by other providers (Johnson, 1985). In 16 of the studies, less time loss from work was reported in patients under chiropractic care. (Johnson,1985) Publications after 1981 provide additional data regarding cost-comparison trends, and have improved on the descriptive methodology used in the earlier studies. A review of low back and neck sprain/strain claims data in Iowa reported average

case payments to medical providers at $352 and $223 for chiropractors. (Johnson, 1989) A review of Utah claims indicated that overall compensation costs were 10 times greater for medical physicians compared to chiropractors. Mean medical costs were $684 for medically managed claims versus $527 for those managed by chiropractors. (Jarvis, 1991) Additional studies from Florida in 1988 and Oregon in 1991 reinforce these trends. (Wolk, 1988a; 1988b; Nyiendo & Lamm, 1991) Similar data was also reported in Australia. (Ebrall, 1992)

A recent well-designed study from a private workers compensation carrier in California reported that for equivalent populations of patients, the health care costs of chiropractic and medical care were similar ($1044 vs. $1075). (Johnson, 1996a) However, indemnity costs (related to lost work time) under chiropractic care were substantially less making the average total claim costs (health care plus indemnity) under chiropractic care 20% less ($1526 vs. $1875. The most recent and sophisticated actuarial review of one California insurer's database on 185 closed claims between 1991-1993 concluded that medical and chiropractic management costs of non-surgical, low back work injuries is nearly equivalent. (Johnson, 1999) Medical costs, temporary disability, and permanent disability costs were considered.

Two years of large fee-for-service claims data records were examined in one study. Total health care costs as represented by third party payments were significantly lower for those patients treated by chiropractors. (Stano, 1993) Total adjusted cost differences ranged from $291 to $1722 over the two-year period. (Stano, 1994) Stano noted that outpatient costs tended to be slightly lower for patients exclusively using medical services, but lower hospital costs for patients under chiropractic care more than offset these additional costs. (Stano, 1994)

Stano & Smith (1996) subsequently compared health insurance payments and patient utilization patterns for episodes of low back conditions care, controlling for differences in clinical (eg, diagnosis, severity, episodes of relapse) and insurance coverage characteristics. They reported that costs were higher for episodes where the medical doctor was the first contact provider. Chiropractors were also more likely to retain the patient for subsequent episodes.

In contrast, Shekelle (1995) concluded that chiropractors had significantly more visits per episode, and the highest mean outpatient cost per episode. Disparity in the conclusions drawn between Shekelle and Stano may have resulted from differences in the data pool and study methods. Shekelle's study was observational in nature and reviewed evidence collected from the RAND Health Insurance Experiment data from the 1970's. Data on 1020 episodes of back care, totaling 8,825 visits by 686 different persons was evaluated.

Total health care costs for comparable cases of neck and back pain for members in a health maintenance organization (HMO) who sought chiropractic care and other treatment methods over a one-year period showed that care, prescription and imaging costs were lower in the group managed by chiropractors. Patient satisfaction and surgical rates were nearly identical for both groups. (Mosely, 1996)

Carey [1995] reported a comparison of outcomes (functional recovery, return to work, complete recovery from back pain, satisfaction) and cost of care for patient management by chiropractors, orthopedists and primary care physicians in both urban and rural regions of North Carolina. Clinical outcomes were assessed by telephone interview. Results were similar for all groups, although satisfaction was highest in those treated by chiropractors. Chiropractic costs were extrapolated from numbers of visits based on state-wide average costs per visit (not actual reimbursement). These estimated costs were highest for chiropractic and orthopedic care and lowest under management by primary care physicians. However, these differences may be accounted for by the fact that medical delivery was provided under managed care, while all of the chiropractic cases were fee-for-service.

The effects of dynamically evolving delivery systems of care severely complicate the design, implementation and analysis of true cost-effectiveness studies and will need to be dealt with in future efforts.

Summarize patient satisfaction data.

Chiropractors generate very high levels of patient satisfaction. A recent essay opined that much of chiropractic's success and perhaps its most important contribution to health care might have to do with the patient-physician relationship. [Kaptchuk, 1998] Analyses from anthropological and sociological perspectives have suggested that treatment by a chiropractor, especially for many patients with chronic pain, can generate a sense of understanding and meaning, an experience of comfort, an expectation of change, and a feeling of empowerment. [Coulter, 191995; Oths, 1993; Coulehan, 1985] The hands-on and compassionate "can do" clinical behavior of the typical chiropractor seems to be concrete, reassuring and immediately satisfying to many patients. Consumer-oriented surveys, observational studies and randomized trials leave little doubt that chiropractic patients are very satisfied with the treatment they receive, often at rates much greater than with other health professionals. [Cherkin, 1989; Sawyer, 1993; Carey, 1995; Cherkin, 1998] In one study, chiropractors were retained as primary provider by a much greater percentage of their patients (92%) who had a second episode of back pain care than were medical doctors. [Shekelle, 1995]

Describe current significant barriers to the access and delivery of chiropractic care.

Chiropractors have only marginal statutory roles in many integrated delivery care systems such as HMOs, the U.S. military, Federal government health plans, Medicare and Medicaid. Regulations should be examined and revised to be inclusive and equitable.

Chiropractors are only marginally included in studies of health care resources and delivery systems.

Chiropractic institutions receive virtually no financial support from Federal government programs designed to support and enhance health professions education and practice.

Please suggest specific policy recommendations that would improve the access and delivery of chiropractic care to consumers, including legislative or regulatory recommendations.

Increase funding for health services research that targets access and delivery issues with regard to the chiropractic profession.

Recommend that the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health, the Health Resources and Services Administration, and others develop research agendas that include consideration of chiropractic and other CAM professions.

Ensure that chiropractors are treated equitably in health delivery and reimbursement systems.

Prohibit discrimination based on type of practitioner license in all Federal health delivery and reimbursement systems such as Medicare, Medicaid, the military, etc.

Mandate the inclusion of chiropractors on all appropriate advisory councils, policy committees, task forces, etc. that deal with health issues at the Federal level.

Discuss whether chiropractic practice should be delivered as stand-alone care or should be integrated with more conventional therapies.

Both. Chiropractic care should be delivered as a stand-alone clinical practice AND it should be integrated in conventional health delivery systems that provide appropriate access and choice to patients. By history and habit chiropractors believe themselves to be primary health care providers, and chiropractic practice demonstrates many primary care attributes. However, this becomes a contentious point in the PCP gatekeeper vs. direct access issue in reimbursement and delivery systems when non-chiropractors control the flow of patients. Chiropractors and their patients are accustomed to direct access and chiropractors are trained to handle it appropriately.

Since chiropractic is a profession and not simply a procedure, the issue of chiropractic integration is a complex systems problem that must be examined at a variety of levels. CAM procedures and professions can be more easily integrated at some levels than others and there can be varying degrees of integration at the various levels. This is currently the case with chiropractic. These levels of integration include the following:

- The patient, or health consumer level
- The clinical management or health practitioner level
- The reimbursement and/or care delivery system level
- The regulatory and policy level
- The cultural, social and political level

Chiropractic is arguably very well integrated at the health consumer level in terms of use and satisfaction, and there is some evidence for a certain degree of integration at the clinical and reimbursement levels. Some examples can be cited.

On the other hand, chiropractic is not well-integrated in the sense of coordinated, interdisciplinary clinical behavior with conventional medical doctors. The following model of a continuum of integrative clinical practice makes this distinction clear, and it can be applied to most forms of CAM practice. It does not apply to the direct learning and use of CAM procedures by medical practitioners themselves. From top to bottom professional autonomy declines and shared expertise and professional communication increases.

- Parallel practice
- Collaborative practice
- Consultative practice
- Coordinated practice

Today, the majority of CAM is in the form of parallel practices. Patients choose and integrate their own health care and find ways to pay for it. Communication between practices is minimal. Some CAM is moving into a collaborative practice mode with case-by-case exchanges of information and referrals. There is evidence that chiropractic is increasingly moving into this stage with increasing referral rates both ways, but data are few. Consultative practice consists of the giving and taking of expert advice and integration occurs at the practitioner-to-practitioner level instead of at the level of the patient. Coordinated practice as it applies to CAM is very rare and undocumented. In this mode, a formal management function is added to the case-management decision-making process that may be subject to administrative review. PCP gatekeepers may function in this role. This kind of practice may only be feasible in large organizations with sufficient infrastructure to support it. Furthermore, excellent teamwork attitudes, values, and skills are essential.

Combining the integration level model with the continuum of practice model yields interesting observations that deserve additional study. For example, chiropractic is well integrated at the patient level, and increasingly so at the reimbursement/payor level. However, due to the nature of the way in which reimbursement systems are organized, chiropractic may continue to operate only in the parallel and collaborative practice modes. In other words, true multidisciplinary and interdisciplinary practice may be very difficult to obtain. Furthermore, whether or not this is a bad thing is debatable. Perhaps integration should be kept at the patient level; perhaps the dilution of professional autonomy necessary for consultative and coordinated practice will eliminate the attributes of CAM that make it attractive and effective. There is no data on this issue.

Finally, there are significant challenges to true interdisciplinary practice even within the established medical delivery system now, and CAM represents the special challenges of diverse disciplines, "turf" issues, non-standard practices, administrative and other resistance to change, history, habit and lack of experience, data, and knowledge. These

will all have to be addressed simultaneously in order for true integration to occur. (Bielinski, 2000)

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Molony

Divider Title: _____

White House Commission on Complementary and Alternative Medicine Policy

December 4, 2000

Good afternoon Commissioners.

My name is David Molony. I am a professional acupuncturist and the Executive Director of the American Association of Oriental Medicine. The AAOM was founded in 1981 and is the oldest and largest national organization for acupuncture and Oriental Medicine professionals. We were instrumental in creating the national certification and accreditation commissions for acupuncture and Oriental Medicine in the early 1980s, and for passing licensing statutes in many of the 39 plus states for which such laws currently exist.

Over one billion people in China have ready access to surgical and pharmaceutical medicine of European origin, as well as to acupuncture, herbal, and manual medicine of Chinese origins. The providers of these primary care services include nearly three-quarters of a million Doctors of Conventional Medicine and a half million Doctors of Traditional Chinese Medicine. These two different systems of medicine co-exist harmoniously because China's citizens have equal access to, and a basic understanding of, both systems. Their Medical Doctors were raised in a country familiar with its own traditions, and their Doctors of Traditional Chinese Medicine have training that is an evolving system of medicine that is balanced with a year or more of Conventional diagnostic and therapeutic principles and procedures. Both professions are thus reasonably well prepared to help patients make informed decisions about their health care options. We highly recommend looking at the Chinese model for the harmonious co-existence of traditional and modern, CAM and non-CAM therapies and professions.

The AAOM supports similar direct access to Oriental Medicine professionals in this country who are well trained and licensed as primary health care providers, as professional acupuncturists are in a growing number of states. We also support direct access to Oriental Bodywork Therapists, whose standards of practice leave little potential for confusion of their services as a substitute for comprehensive medical diagnosis and treatment. We suggest the Commission can reduce the cost of health care on a national level by recommending direct access to qualified Oriental Medicine professionals through federal programs and by suggestion to State Governors and Secretaries of State on its use in public benefit programs such as Worker Compensation and MediCare, as well as at private clinics, hospitals, and through state regulated health plans.

Oriental Medicine has historically had a strong tradition of preventative wellness and self-care, and we are taught to serve as "guides," or "navigators" to health and wellness, or, as it is traditionally phrased, as "farmers" who "cultivate" our patients' health. We communicate from a functional and energetic perspective as well as from the Conventional mechanical and biochemical perspective. We have found that open and direct communication increases patients confidence in our care, improves patient compliance, empowers patients to take more responsibility for their own heath, speeds recovery, and often reduces the need to access more costly and possibly more dangerous interventions. If prevention is to be recognized for its cost-savings and its more obvious health benefits, then Oriental Medicine has a great deal to offer. .

Unfortunately, our profession faces constant interference with patient access to our services from the existing medical establishment, and we are asking for your help to alleviate the situation.

We ask the Commission to encourage fair and meaningful integration and collaboration between and within all health care professionals by recognizing us as experts in our own field of medicine, which includes acupuncture, herbal medicine, manual therapy, Taiji, Qigong, and other modalities viewed within the perspective of Oriental Medicine. We suggest that you encourage a more open and competitive market in which our profession can fully participate in health care access, delivery, research, and administration. We ask that the Commission recommend policy changes that ensure direct access to credentialed Oriental Medicine providers through public benefit programs, private health insurance, and to promote this through public education. Lastly, we ask the Commission to support policies that will return to Americans their rights to freedom of health care choice and delivery. Only in America, could the citizens be so free in so many ways, yet have the fundamental and natural freedom to health care choice be so coercive.

We would like to thank the Commission for your efforts to improve health care in America, and to integrate old traditions and modern innovations to create a new medicine for a new millennium.

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Divider Title: Nordstrom

American Chiropractic Association

DEDICATED TO IMPROVING THE HEALTH AND WELLNESS OF AMERICA, NATURALLY.

Testimony
Of the
American Chiropractic Association
Before the
White House Commission on Complementary and Alternative Medicine Policy
December 4, 2000

On behalf of the American Chiropractic Association, I appreciate the opportunity to provide comments to the White House Commission on Complementary and Alternative Medicine Policy. My name is Dr. Bruce Nordstrom I am a practicing doctor of chiropractic from the District of Columbia. I am also the Washington, DC delegate to the ACA. This afternoon, I encourage the commission to focus on wellness.

A key principle behind chiropractic care as well as many other complementary and alternative therapies is wellness. These alternative and complementary practices have a history and a focus of promoting health, and increasing the quality and span of life. For example, in my practice, in addition to providing chiropractic spinal manipulation or adjustment, I also counsel my patients on among other things diet and exercise to promote their well-being.

The role of chiropractic in the health care system has been described in a paradigm that was unanimously adopted by all the chiropractic college presidents and supported by the ACA. A copy of the paradigm is attached in my formal statement. This paradigm emphasizes a philosophy focused on wellness. Doctors of Chiropractic seek to optimize health, by recognizing that the body's innate recuperative power is affected by and integrated through the nervous system. Within this paradigm, a doctor of chiropractic establishes a diagnosis and uses chiropractic case management to promote health.

It remains a challenge of how to encourage insurers to recognize and reimburse providers for the promotion of health. Increasingly complex life styles, flaws in workplace ergonomics, longer life spans, increased survival from serious injury have created an inherent need to move from injury/disease management to a more primary care role that is wellness oriented and focused on preventative care. Insurance companies are slow to move in this direction. Payors must be encouraged to offer preventive alternative therapies as paid insurance benefits rather than a patient paid responsibility. In the case of chiropractic, coverage remains limited in terms of reimbursable services. These coverage constraints restrict a patient's ability to seek the treatment they need to promote their well-being.

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By providing for early conservative chiropractic intervention, we may prevent many conditions that have neuromusculoskeletal origin from becoming more chronic and requiring more invasive procedures. One other aspect is the potential decrease in iatrogentic disease from intervention both medical and surgical that may have high risk for the patient. In fact, a 1999 Institute of Medicine publication entitled "To Err is Human: Building a Safer Health System" found that a substantial body of evidence points to medical errors being a leading cause of death and injury. Using conservative treatment provided by CAM providers could prove to be an important part of the solution to this problem.

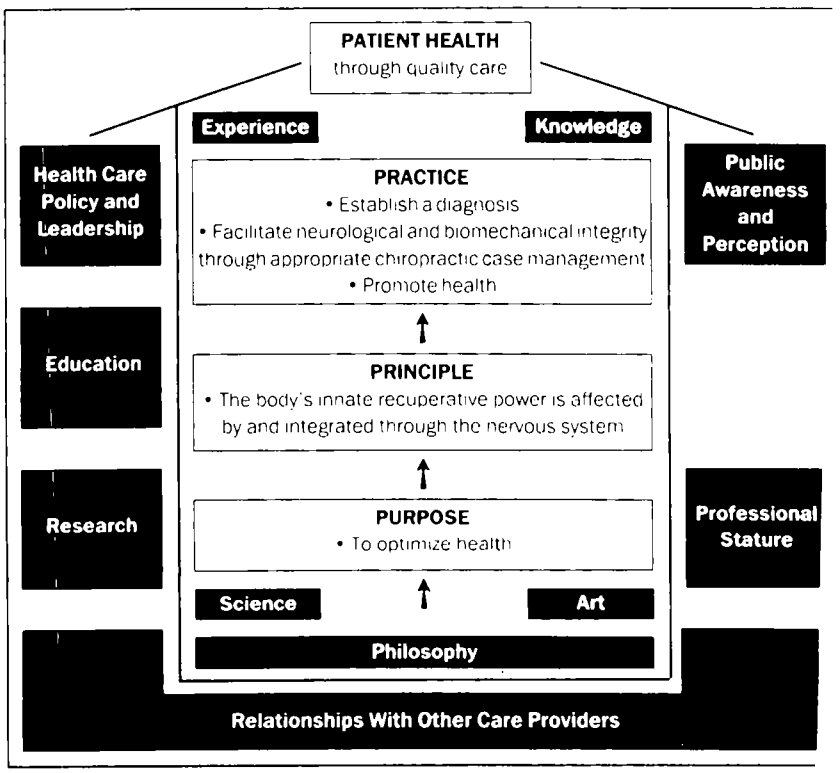
Payors as well as policy makers need to understand the value of illness/injury prevention and wellness and realize the lost productivity, compromised quality of life and the cost of health care dollars that are associated with failed treatment approaches. However, creating the value associated with these practices means bringing wellness back into the health care equation. The value of health care delivery in the context of a wellness paradigm has been virtually lost in budget neutrality wars, administrative benefit cuts and other scenarios as an expense that the patients must pay themselves. Once payors and policy makers begin to see the bottom-line cost savings involved in wellness and the promotion of health, one would hope that they embrace early and regular wellness interventions as a viable option. The ACA urges the Commission to incorporate the overall recognition of the cost-effectiveness of wellness and the promotion of health as provided by a CAM provider in its final recommendations to Congress.

I would like to provide the commission with an example of a chiropractic primary care physician model in Illinois that stresses prevention over disease care and the remarkable cost savings this organization has had. Alternative Medicine Inc., (AMI) has a contract with HMO Illinois to utilize chiropractors as primary care physicians. AMI is a fully integrated medical delivery system that uses doctors of chiropractic as the portal to entry for all medical decision-making. AMI stresses prevention, using pharmaceuticals and surgery only as last resorts. Although the pilot program is still in its infancy, AMI is cutting costs. According to Richard Sernat, MD, president of AMI, since its inception, AMI has reduced the rate of hospitalization, procedures, surgery and everything to do with inpatient care by approximately 75 percent compared to the values of allopathic treatments.

The current health care system needs to allow for better-coordinated care between medical doctors and alternative providers and stress the importance of prevention. Medical students must be encouraged throughout their schooling to refer their patients to complementary and alternative care providers. In addition, it is critical that Doctors of Chiropractic and other alternative care providers be included in interdisciplinary teams that center on early patient intervention is critical. As health care costs continue to rise, policy makers and payors must consider recognition and full reimbursement for wellness and preventative practices as a viable option to contain costs.

Managing health care risk before it becomes unmanageable must rank as equally important as other business risks such as shifts in competition and market share. Including insurance reimbursement for treatment protocols that result in improved overall patient health, often at lower cost is a fundamental first step in the right direction.

Thank you for the opportunity to provide the views of the ACA. In closing, I would like to leave with the Commission this book entitled "The Chiropractic Profession" by David Chapman Smith. I hope that it will be a valuable resource to the commission as they move forward. Now, I would be happy to answer any questions you may have.


PATIENT HEALTH
through quality care
Experience
Knowledge
Health Care Policy and Leadership
Public Awareness and Perception
PRACTICE
• Establish a diagnosis
• Facilitate neurological and biomechanical integrity through appropriate chiropractic case management
• Promote health
Education
PRINCIPLE
• The body's innate recuperative power is affected by and integrated through the nervous system
Research
Professional Stature
PURPOSE
• To optimize health
Science
Art
Philosophy
Relationships With Other Care Providers

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Plumlee

Divider Title: _____

I am Lawrence A. Plumlee, a physician, formerly medical science adviser at the US EPA, and today representing the National Coalition for the Chemically Injured. We are concerned that chemical-pharmaceutical industries have turned toxicology into a laboratory specialty designed to rapidly move new products to market, while asserting that many chronic manifestations of toxicity are psychogenic in origin. Such manifestations of chronic toxicity include many cases multiple chemical sensitivities, autoimmune diseases, fibromyalgia syndrome, and chronic fatigue syndrome. There is great need for much more research to investigate the role of toxic chemicals in these syndromes. By failing to do this, patients are subjected to dangerous and ineffective psychiatric drugs which prolong the illnesses, thus selling more drugs because the causes are not recognized and eliminated.

Furthermore, because the medical profession is so heavily influenced by these industries, there has also been a lack of research to investigate the role of nutritional supplements in enhancing improved metabolic function in these syndromes. And even when scientific double blind studies have found associations, such as the benefits of the fatty acid eicosopentanoic acid in migraine, rheumatoid arthritis, and ulcerative colitis, there is a failure to communicate such nutritional data to physicians and thus to enable most patients with these diagnoses to receive such less toxic, effective treatments.

Another area requiring scientific research and better medical education is the induction of mild immunodeficiency by some toxic chemicals, with resultant superinfections by viruses, bacteria, parasites, and fungi. Often appropriate diagnosis and treatment of these infections will enable substantial gains in health, even though the body burden of chemicals or their damage, may remain uncorrected. Again, the effective use of antifungals for treating chronic fatigue syndrome has been shown in several double blind studies, yet the medical profession is not adequately educated about these studies to lead to changes in usual and customary treatments.

Government medical education is needed to balance the extraordinary influence of the pharmaceutical industry. It will be difficult to acheive this when government itself is so heavily influenced by this wealthy industry, but idealistic persons can often make progress by acting in the public interest when it places their own careers in jeopardy. Persons receiving public funds owe the public nothing less than this. When satisfactory grant proposals are not forthcoming, contracts must be let to accomplish this work.

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1. David Overstreet and Veljko Djuric: "Links between multiple chemical sensitivity and asthma in a rat model of cholinergic hypersensitivity". Toxicology and Industrial Health 1999; 15(5): 517-521. North Carolina researchers bred a strain of rats (Flinders Sensitive Line) which are much more sensitive to cholinergic drugs and chemicals than standard rats. When exposed to very low levels of cholinergic drugs, pesticides, or ethanol, these rats experience much more fatigue, asthma, diarrhea, chills, and aggressive/depressive behavior than control rats. The symptoms experieinced by the rats are very similar to those of human patients with multiple chemical sensitivity and/or asthma when exposed to pesticides or other cholingergic chemicals. Additional work with chemically sensitive lab animals may yield much understanding to this phenomenon in humans.

2. X van der Brempt, M. Mairesse, and C. Ledent: "Ketoconazole (K) in asthma: a pilot study". Journal of Allergy and Cinical Immunology, January 1994 (abstract). Belgian researchers entered ten corticosteroid-dependent asthmatic patients, who showed no evidence of a fungal infection, into a double-blind, placebo-controlled study. These observers found that four out of five of those treated with the systemic antifungal drug Nizoral improved after two weeks, while four out of five of the placebo group did not improve. No side effects of Nizoral were observed. They concluded that ketoconazole (Nizoral) might be beneficial in some asthmatic patients. Further studies are needed to investigate the mechanism of action and a possible steroid sparing effect of ketoconazole in asthma.

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Divider Title: Quevedo

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SUBMISSION ON HOSPITAL-BASED CENTERS
WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY
December 4-5, 2000. Washington, D. C.

The Center for Integrative Medicine at O'Connor Hospital
Sylver Quevedo, M.D., M.P.H.

QUESTION 1
Why and how did you decide to open your Center in a community Hospital?

I believe strongly in the vision of integrative medicine, that is, taking the best ideas and practices of both conventional and alternative medicine and combining them. To be sure, this is sometimes difficult but it is my conviction that this approach offers the best chance of healing and recovery for patients. Furthermore, the structured and disciplined dialogue between practitioners of alternative medicine and conventional medicine will be good for both groups. A broader and more encompassing paradigm of medicine will emerge that will be both more humane and more effective. In this sense Integrative Medicine may actually be the medicine of the future.

The Catholic Healthcare West organization, a consortium of over 50 hospitals, was interested in complementary and alternative medicine as a potentially new market area. They were impressed with the consumer interest and planning initiatives were explored in many hospitals. At O'Connor Hospital, we were able to form a physician focus group of established medical staff members who were quite committed to the Integrative Medicine vision. Because we were committed to integrating conventional and alternative medicine, the hospital and hospital community seemed the appropriate setting in which to develop this approach.

QUESTION 2
How did you determine the staffing and cam service mix?

Our planning group surveyed key medical staff members regarding various complementary and alternative medicine modalities with four basic attributes in mind: safety, efficacy, acceptability to the medical staff and availability of practitioners. This proved to be an important consensus-building exercise as it involved medical staff

leadership and many physicians who were not part of the planning effort. We held the conviction that as the medical staff became more familiar with CAM therapies, their resistance to them would diminish. This has happened and we are now developing the credentialing process to bring CAM therapies into the inpatient setting on the request of the medical executive body (chairs of departments).

QUESTION 3
What is the role of nursing in the access to and delivery of CAM products and practices in a community hospital based cam center?

All patients undergo initial holistic nursing assessment and for the most part are seen by an internal medicine physician for initial assessment prior to referral for complementary therapies as appropriate. Case Management is used as the principal mechanism for ongoing supervision of care. The physician acts as the team leader in case management reviews with the various practitioners and the holistic nurse.

QUESTION 4
What are the keys to your success?

In retrospect, the following principles have been important in our successes:

- We believed in the vision of Integrative Medicine: That it is the medicine of the future. This movement has already changed American medicine irreversibly.
- For Hospitals and Academic Medical Centers -- Credentialing in CAM is an inside job and must be led by physicians who already have standing on the medical staff or faculty.
- Medical care is ultimately a local endeavor, requiring local resources. When done well it is based on an intimate relationship and is done in community. Hence, integrative medicine approaches will be built on local resources, culture, history and each will have its own evolutionary trajectory. No single model of integrative care will suffice.
- A structured formal credentialing process is critical for hospitals and academic medical centers.
- A clear and well-articulated vision of what is meant by CAM or Integrative Medicine is essential to success.
- Where possible build on and into existing programs.
- Focus on relationship building with strategic partners.

QUESTION 5
What have you done to improve access to and delivery of CAM products and services to the underinsured, uninsured and medically underserved in your community?

We have provided a good deal of charity care in our Center to underserved and underinsured patients. However this is not financially sustainable without separate funding. We have seen that it is often patients with chronic illness who would benefit from Integrative Medicine approaches and they are often those with the least

resources. This is a major area for policy development as access to CAM services is limited for indigent patients. The current effort to include CAM in the services offered by Community Health Centers is a step in the right direction.

QUESTION 6
What policy recommendations do you have for the Commission? Please include your view on whether CAM should be accessed and delivered as a stand-alone or integrated with conventional care and why.

- I believe that it is preferable to have CAM services integrated with conventional care where possible. This does not have to be in a single setting but does require collaboration.
- "Culturally-Appropriate" Medical Care is Essential to Effectiveness – As we know from studies of the placebo effect, a person's belief system can have powerful effects on the efficacy of medical treatments. The vision of Integrative Medicine includes a respect for healing traditions that are sometimes regarded as outside the confines of western scientific medicine and provides an ideal perspective from which "culturally-appropriate" medical care can be delivered.
- Reform of Medical Education to include Integrative Medicine
- Broader insurance and financing for Integrative Medicine

Respectfully submitted,

Sylver Quevedo, M.D.
Medical Director
Center for Integrative Medicine

Submission on Hospital-based Centers

White House Commission on Complementary and Alternative Medicine Policy

December 4-5, 2000. Washington, D.C.

The Center for Integrative Medicine at O'Connor Hospital

Sylver Quevedo, MD, MPH

Initial Conception and Early Development

It all started for us in 1997. I had just left the medical faculty at Stanford and was doing nephrology and internal medicine at the O'Connor Hospital in San Jose, California. O'Connor, a 300-bed hospital, had just become part of the Catholic Healthcare West (CHW) organization, a large 50-hospital consortium with operations in California, Arizona and Nevada. A year earlier CHW had begun to develop a series of complementary medicine centers under the auspices of a new subsidiary they created called the American Centers for Health and Medicine. The flagship center was based in Phoenix, Arizona where CHW had acquired the practice of Sam Benjamin, MD. Dr. Benjamin had a large practice, which integrated complementary and conventional family medicine. He and Bernita McTernan (a Senior Vice President at CHW) championed the development of complementary medicine within the CHW organization. CHW and the American Centers group explored interest in complementary medicine among member hospitals through presentations in the San Francisco area. After attending one of these Sheila Yuter, then the Director of Business Planning for O'Connor Hospital became enthusiastic about bringing complementary medicine to O'Connor. She had a personal interest in it and saw the possibility of developing a new market where there was a good fit with consumer interest in the SF Bay area. Sheila convened a physician focus group on complementary medicine. I was part of the original group and shortly thereafter became the chief medical advisor to the hospital for the project.

Development History

- 1996 CHW Develops American Centers for Health and Medicine, Phoenix, Arizona
- 1997 O'Connor Hospital (OCH) Planning Group in Complementary and Alternative Medicine
- 1998 OCH Board approves plan for the Center for Integrative Medicine (CIM)
- 1998 CHW closes the Phoenix Center for financial reasons
- 1999 CIM opens

Figure 1

Sheila and I visited Phoenix several times during 1997 and 1998 and met with medical and administrative staff there. Dr. Benjamin had moved to New York to start another complementary medicine program at the State University of New York (SUNY) in Stonybrook. Dr. Howard Silverman, a family physician and educator had followed in the role of Medical Director. The Phoenix center was altogether impressive. It was beautifully designed with feng shui principles in mind, plenty of attention to color and interior décor, and good patient flow characteristics. It was a large facility of approximately 14,000 square feet centrally located in Phoenix but unaffiliated with a

hospital or medical complex. Physicians and associated practitioners were on salary in a staff clinic model doing exclusively ambulatory care. I was inspired by the effort in Phoenix and by the Integrative Medicine movement in general. Here was a great opportunity to reinvent medicine from a broader perspective, more humane, more encompassing in concept and practice. Our plan was to start a second site at O'Connor under the American Centers umbrella, but with attention to the unique aspects of our local situation (Figure 2).

Initial Plan for Organizing the CIM

- Analyze the strengths and weaknesses of our institution and community
- Begin a Focus Group. Include members of the medical staff, administration, and selected community partners.
- Design a program model
- Build on existing programs and practices where possible

Figure 2

Returning to California, we continued our meetings with the physician focus group. The hospital sponsored several physicians to travel to complementary medicine meetings. Each of us on the committee made presentations on the specific area that we were investigating. I was in the second year of a Divinity School program and had become interested in the intersection of medicine and spirituality. I also attended and reported on the NIH Consensus Conference on Acupuncture. Others presented on homeopathy, massage and bodywork, biofeedback, and more.

We surveyed key medical staff members regarding various complementary medicine modalities with four basic attributes in mind: safety, efficacy, acceptability to the medical staff, and availability of practitioners. This proved to be an important consensus-building exercise as it involved medical staff leadership and many physicians who were not part of the planning effort. Since a good relationship with the medical staff was a founding principle for the program we were attentive to the development of key relationships (Figure 3). We emphasized that we were building on a foundation of the "best" of scientific medicine and that we were committed to working with the medical staff. We searched for deeper elements common to all healing traditions and avoided an approach defined by specific modalities or complementary therapies. We were impressed with the "Manifesto for a New Medicine" so well stated by Jim Gordon. We worked with this paradigm to understand it, articulate it, and make it our own. It has proven to be a unifying ideology and very important to

Develop Key Relationships

- **Medical Staff:** Identify physician-champions, use physician member of the Focus Group to cultivate support
- **Executive Body of the Medical Staff: Develop** a credentialing process for practitioners of complementary therapies that this group endorses.
- **Administration:** Use Focus Group members again. Align Center goals with institution-wide goals in a strategic planning initiative
- **Community Partners**

Figure 3

Why Integrative Medicine ?

- Build on a foundation of the "best" of scientific medicine
- Work with the hospital, existing institutions, physicians, and the larger community
- Expand the dialogue on the meaning of health and healing

Figure 4

our success. Since this was largely uncharted territory we wanted to emphasize evaluation and research. Finally, our posture was that we had no "answers" and that our intention was to expand the dialogue on the meaning of health and healing (Figure 4). We chose to call our vision Integrative Medicine using the terminology promulgated so widely by Andy Weil (Figure 5). With this vision we developed plans for a model center. This was to include (1) an overarching Center for Integrative Medicine (CIM) which provided the administration and housed the practice, programs, and community activities (2) a medical practice which was physician led and supervised, and (3) an Institute which was intended to support education and research activities.

We remained in contact with the staff of the Phoenix program. They generously provided information on their experience and challenges. We became aware that they were having difficulty generating adequate revenue to support their operation. We studied their experience and learned from it. In our planning we decided on an initial program that required low operating overhead and did not use a staff model with physician or staff salaries. We designed a small space of 3500 square feet. We borrowed what administrative support we could from existing hospital staff and started with a very small increment of new staff. Only 2 full time equivalents were to be added, one nurse and one receptionist. All the other staff members were to be private practitioners brought on with contractual agreements where the majority of their income was to be derived from direct patient care or services in the programs provided at the Center.

A Vision for Integrative Medicine

- Holistic Approach
- Emphasis on Uniqueness of the Individual
- The Importance of Relationship and Community
- A Healing Partnership with Patients
- Self-Care
- Respect for Other Healing Traditions
- Working with Groups
- The Spiritual Nature of this Work
- A Relationship to Nature

Figure 5

In discussions with the physician focus group, we reviewed three possible scenarios for center development (1) a department of the hospital, (2) a joint venture with a private investment group and (3) a practice wholly owned by the physicians who started the group. The physicians involved all had established practices and were reluctant to assume the risk of starting a new group practice with many of the uncertainties involved. As a joint venture with private investors it was not clear whether the Center could develop freely without commercial pressures and that the hospital would be satisfied with its degree of control. During1998, the Phoenix program began having serious financial difficulties and was facing a solvency crisis. Catholic Healthcare West began to doubt the financial viability of the original Centers concept and were hesitant to continue the development of their subsidiary the American Centers for Health and Medicine. At O'Connor

Hospital, however a strong focus group had already developed and was gaining support from medical staff and hospital administration. Because of this, the effort continued in spite of misgivings regarding the financial difficulties of the Phoenix program. O'Connor Hospital decided to assume the risk itself and fund the initial investment. The Center for Integrative Medicine was to be an ambulatory care center within the Hospital structure. Approximately $400,000 was allocated to fund initial start-up and operations with the expectation that the Center would be reaching self-sufficiency within approximately 18 months. The above plan was presented to the medical staff leadership and hospital board and approved in the late fall of 1998. I was appointed Medical Director and Tim Levers became Program Director. Shortly thereafter implementation efforts began. We wrote principles of practice (appendix 1) and policies and procedures governing all of the complementary medicine modalities. We developed a credentialing strategy (appendix 2) and recruited professional staff. California State Health Department licensure review was carried out early in 1999. Health Department reviewers told us that we are one of the first Integrative Medicine centers affiliated with a hospital to be reviewed and licensed in California. On May 12, 1999 the Center was opened for patient care and programs.

Initial Structure of the Center for Integrative Medicine

- A Center of the Hospital, licensed as an ambulatory care center, participating in institution-wide quality assurance activities, under Department of Medicine
- Physicians are all members of the Hospital Medical Staff
- Treating body, mind and spirit
- Team approach to individual patients, physicians act as team leaders
- Classes and group therapy to augment individual care
- A commitment to work with referring physicians
- Emphasis on evaluation and research

Figure 6

Key Assumptions and Decisions Used to Develop the Business Plan and Program.

- Physicians or doctoral level professional staff would direct all program areas.
- All physicians would be members of the hospital medical staff.
- A structured formal credentialing process that paralleled the medical staff process would be used for the practitioners of the complementary therapies. Formal quarterly reports on Center progress would be provided to the Medical Executive Committee.
- Program success was predicated on a good relationship with the hospital and its medical staff.
- Third party payers would not be major source of revenue or support for development.
- Direct patient care would not provide sufficient revenues to support all Center development. Diversification of revenue sources would be necessary. Revenues would be sought from

work with classes and groups, events, retail sales, and grant programs. Overhead should be kept at a minimum.
- Incentives for practitioner income and practitioner productivity should be aligned.
- There is sufficient interest on the part of consumers and the medical staff to support the development of integrative medicine in this community.

Key Clinical Elements

- Physician Services
- Holistic Nursing
- Acupuncture and Traditional Chinese Medicine
- Therapeutic Massage and Bodywork
- Biofeedback, Hypnotherapy, Guided Imagery and Meditation
- Nutrition
- Psychological Care and Spiritual Guidance
- Programs in: Women's Health, Spirituality and Medicine
- Education and Support Groups

Population Served and Methods of Triage and Co-management

The Center was initially designed as a consultative service with an emphasis on working with referring primary care physicians. Patients are referred by physicians and self-referred. During the first year of operations, all patients were accepted including those with marginal ability to pay. This is now being changed and a timeshare model is now being developed. Each practitioner will pay an hourly charge for use of the facility and will determine his or her own billing and collection procedures. All patients undergo initial holistic nursing assessment and for the most part are seen by an internal medicine physician for initial assessment prior to referral for complementary therapies as appropriate. Case Management is used as a principal mechanism for ongoing supervision of care. The physician acts as the team leader in case management reviews with the various practitioners and the nurse provides day to day continuity in terms of patient management. The major challenges of this clinical model have been:

1) The achievement of "integration". It requires significant commitment of time and effort to organize and integrate the care across different modalities. It is quite possible for complementary medicine to be offered in quite the same way as conventional specialty medicine with fragmentation and little or no communication between various practitioners. All providers of care must be committed to integration and collaboration or it will not occur. It is often a challenge to discuss cases because various practitioners sometimes use entirely different paradigms of care. Similarly, there is no standard case format or language consistently used to describe symptoms, signs, disorders, treatments or progress. Hence discussions are often idiosyncratic. Discussion of cases is sometimes quite a cross cultural experience. So it is a challenge for the physician acting as a team leader to translate across paradigms and try to "integrate" the care in order to achieve the desired outcomes.

2) A second challenge has been creating cohesion among a group of individual private practitioners. Since we are not operating as a staff or formal group model, there is little incentive for the individual practitioners to meet outside of patient care to discuss cases, talk

about standards of care, learn from each other's approaches and explain the language and logic of their own approaches.

Fiscal Realities

The practice was initially intended to be a fee-for-service practice. We fully expected that third party coverage would be minimal for many of the complementary therapies that we hoped to offer and that authorization, billing, and coding would be time-consuming and difficult. We intended to give patients a "super-bill" so that they could bill their own insurance. However, as part of the hospital we were obligated to operate under the existing hospital contracts and accept third party coverage and contractual rates. During the first year of operation billing was handled centrally by administrative support staff. This proved to be cumbersome since coding for diagnosis and treatment in complementary medicine was difficult. Many claims were denied. In general, third party payment for complementary therapies has been poor. Physician's services have generally been reimbursed by third party payers and so have some acupuncture services. However, massage and bodywork, biofeedback, hypnotherapy, guided imagery and much of psycho-spiritual care has been paid directly by patients or written off as a loss.

At present approximately 40% of our patients are fee for service and the remainder have third party coverage. We are now changing to an arrangement in which each practitioner pays a proportional timeshare rent for the use of the facility and defines billing and collection procedures for himself or herself directly with the patient. Practitioners will then do their own billing and collecting and decide if they will accept third party payers.

Prospects for Growth

During the first year of operation, patient utilization grew at approximately 20% per month to a stable total patient volume of approximately 300 patient encounters per month. We have not yet provided primary care for patients and have continued primarily as a consultative service. However, consistent requests by patients for primary care in our setting have led to plans for this in the coming year. This should result in additional growth. However, for individual practices to grow, third party coverage will be necessary. Substantial out of pocket expenses are incurred by the patients under the current model and this has limited the availability of care for many patients. Our educational programs and conferences have developed nicely with substantial increases in scope, content, and attendance anticipated for the coming year. We are in the process of developing a credentialing process to bring Integrative Medicine into the hospital. Our initial agreement was that credentialing for the complementary therapies would be limited to the outpatient setting. However, as the medical and nursing staff has become conversant with these therapies we have had numerous requests for acupuncture, massage therapy, Reiki, and integrative medicine consultation for inpatients. The medical staff leadership has asked the Center to design and lead this effort. This is intended to pave the way for bylaws development for a Department of Integrative Medicine in the hospital as part of the medical staff organization.

Research

Research and evaluation was emphasized during program planning. This was very important to the medical staff leadership, as they were hesitant to enter into the area of complementary medicine without this emphasis. Physician or doctoral level lead individuals were established over each of the modality areas with overall program responsibility residing with the medical director. A quarterly report to the medical executive committee at the hospital is regularly given

concerning utilization and program growth and development. All patients complete a baseline and periodic health status measure (SF-12) as part of their usual care. However, quality assurance, patient outcome assessment, and formal protocol driven research with institutional review are still very much in the design phase. One study has been approved but not yet implemented. We are committed to participation in clinical research, including multi-site studies. The medical staff, the center administration and the individual practitioners are all interested in participating in clinical research. Clinical research and health services research would enhance the credibility and stature of the Center in the eyes of medical staff, the hospital and larger community.

Philanthropy

We have not solicited or received any major grants or donations from benefactors. We are only beginning discussions concerning the development of an Institute to support the Center activities.

Appendix 1

CENTER FOR INTEGRATIVE MEDICINE
AT O'CONNOR HOSPITAL
PRINCIPLES OF PRACTICE

The members of the Center for Integrative Medicine shall endeavor to practice the following principles of holistic health care:

1. In the practice of holistic healthcare, the goal is healing the whole person, body, mind and spirit.

2. The practice of self-care and personal development is integral to holistic health care and is a continuous process. The effort to balance what one gives to self and to others is essential to achieve and maintain wholeness.

3. Professional staff shall approach health care practice with a sense of sacredness about their work. In so doing, they create and enhance the healing environment. They make it conducive to wholeness by bringing a spiritual perspective that conveys meaning and purpose in life.

4. Catholic Healthcare West core values: Dignity. Collaboration, Justice, Stewardship, and Excellence shall be practiced in the Center.

5. Recognizing the uniqueness of each individual patient, the professional staff shall endeavor to render care that is consistent with the patient's preferences, interests, culture and beliefs, family background, and hopes and dreams.

6. Professional staff will practice interventions grounded in the theory of Integrative Medicine based on research and evidence where available and with a commitment to developing new knowledge, approaches, and evidence. They will use conventional scientific approaches, while simultaneously exploring new methodologies necessary to elucidate a broader paradigm of health and healing.

7. Professional staff will encourage and allow patients to take responsibility for their own self-care, providing support, education and resources to the patient. They shall be willing to give up control of information and "knowing what is best" in order to minimize co-dependence and encourage autonomy of the patient.

8. Holistic Healthcare regards both intellectual and empirical knowledge and intuitive and empathic knowledge to be important in the care of patients.

9. Professional staff is committed to the study and acceptance of other healing traditions.

Text by Deborah Quevedo, RN

Appendix 2

Center for Integrative Medicine at O'Connor Hospital

Credentialing Plan

Philosophy - The Center for Integrative Medicine at O'Connor Hospital is an innovative effort to bring together, under one roof, a number of practitioners of Integrative Medicine. Integrative Medicine uses the broadest concept of health and healing and approaches the patient holistically, with attention to body, mind and spirit. In this effort, physicians, nurses, acupuncturists, massage and physical therapists, nutritionists and psychologists will work together in a team effort to provide holistic health care to patients. A credentialing strategy, which seeks to apply the highest possible standard for all practitioners, has been developed after thorough discussions and review of the experience in other states and in other institutions. An internal program of review and approval for qualified practitioners, which is formal, structured and periodically reviewed, is herein presented. Such a program will develop standards which will assure that all of it's practitioners are in compliance with external regulatory agencies but will simultaneously seek to further refine and develop these standards and promulgate them regionally and nationally with a concerted effort to education, research and quality improvement.

Responsibility – The Credentials Committee of the Center shall hold the principal responsibility for credentialing for Integrative Medicine. The Medical Director will chair this committee. The Administrative Director will hold an ex-official position. Representatives of the credentialing body of the medical staff will be asked to serve to serve on the committee, as well as other individuals external to the Center but holding key positions at the O'Connor Hospital. Outside individuals will be asked to serve in areas where special expertise is required.

The physicians will be credentialed through the traditional medical staff system.

Methodology - Screening of applicants will be carried out in order to determine licensing, certification, training, competence, malpractice history, and recommendations from colleagues and peers. Screening materials will then undergo verification and the applicant's general desirability will be based on screening, interviews and pre-censorship where appropriate. The Medical Director will make the recommendations to the Credentials Committee and approval or denial will follow. Credentials Committee action will be reported to the administrative officers by the Medical Director.

Within each of the complementary medicine areas, the scope of practice, the responsibility and authority of practitioners and the methods of performance evaluation and practice monitoring will have been established in the policies and procedures governing the center.

Performance Measurement - In an activity, which will be defined subsequently, the credentialing committee will also engage in performance measurement and monitoring for practitioners. The principal approach herein will be educational, but efforts will be made to conduct patient satisfaction studies, to process patient feedback, to review incident reports and practitioner comments and complaints.

Patient's Outcome Monitoring Program – A program is being developed in collaboration with the Stanford Center for Disease Prevention and the Complementary and Alternative Medicine Program at Stanford to conduct ongoing outcome studies of patients treated at the Center. Systematic collection of data on both clinical and functional outcomes will be part of the "usual care" process. More formal protocol driven clinical studies will also be conducted periodically.

Presented to Medical Executive Committee January 8, 1999.

BIOSKETCH

Sylver Quevedo, M.D., M.P.H.
Dr. Quevedo graduated with honors in biology from the University of California at Berkeley. He earned his medical degree at Harvard Medical School, while simultaneously earning a Masters of Public Health at the Harvard University School of Public Health. After training in Family and Community Medicine he worked in and developed Community Health Centers for several years. His postdoctoral training further includes Internal Medicine, studies in law and public policy at Stanford Law School and a fellowship in Nephrology and Medicine at Stanford University Medical Center where he was Robert Wood Johnson Foundation Clinical Scholar. He was subsequently Clinical Assistant Professor of Medicine at Stanford and Medical Director of the Artificial Kidney Unit at the Santa Clara Valley Medical Center.

In 1995, he joined the O'Connor Hospital Medical Staff in the practice of Nephrology and Internal Medicine. His areas of interest are quality of life and disease reversal in chronic illness, the phenomenology of healing, the intersection of spirituality and medicine and the comparative study of healing traditions. He is the founding Medical Director of the Center for Integrative Medicine at O'Connor Hospital in San Jose, California.

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002. resume	Sylvestre Quevedo (partial) (1 page)	nd	b(6)

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OA/Box Number: 43238

FOLDER TITLE:
WHCCAM Meeting Testimony, December 4-5, 2000 [2]

2011-0568-S
kc886

RESTRICTION CODES

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

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P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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Freedom of Information Act - [5 U.S.C. 552(b)]

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CURRICULUM VITAE

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CURRENT POSITIONS

Medical Director
The Center for Integrative Medicine
at O'Connor Hospital
455 O'Connor Drive, Suite 170
San Jose, CA 95128

Attending Physician
Department of Medicine
O'Connor Hospital
2105 Forest Avenue
San Jose, CA 95128

Consultative Nephrology and Internal Medicine
South Valley Nephrology Associates
2039 Forest Avenue, Suite 301
San Jose, CA 95128

PROFESSIONAL ACTIVITIES

1989-1998	Clinical Assistant Professor of Medicine Department of Medicine Stanford University School of Medicine Stanford, CA 94305
1989-1995	Attending Physician Department of Medicine Santa Clara Valley Medical Center 751 South Bascom Avenue San Jose, CA
1989-1995	Clinical Assistant Professor of Medicine Department of Medicine, Division of Nephrology Stanford University School of Medicine Stanford, CA

1989-1994	Associate Chief, Division of Nephrology Medical Director, Artificial Kidney Center Santa Clara Valley Medical Center San Jose, CA
1995-2000	Consulting Physician Nephrology & Internal Medicine Kaiser Hospital, Santa Clara, CA and Santa Teresa Hospital & Medical Center San Jose, CA
1991-1994	Member, Vice-Chairman and Chairman, Board of Directors, Professional Group- Santa Clara Valley Medical Center, Inc. San Jose, CA
1988-1994	Member, Board of Trustees American Kidney Fund Rockville, MD
1992-1995	Member & Chairman, Board of Directors Transpacific Renal Network Sausalito, CA
1992	Member, Medical Review Board Transpacific Renal Network Sausalito, CA
1988-1989	Attending Physician Nephrology and Internal Medicine Santa Teresa Hospital and Medical Center 260 International Circle San Jose, CA
1985-1987	Staff Physician Medical Clinics Santa Clara Valley Medical Center San Jose, CA
1982-1985	Clinical Assistant Professor of Family, Community and Preventive Medicine Department of Family, Community And Preventive Medicine Stanford University School of Medicine Stanford, CA

1981-1984	Associate Member, Medical Staff San Jose Hospital and Health Center San Jose, CA
1981-1988	Member, Advisory Council Member, Latino AIDS Education And Prevention Committee Chairman, Committee on Medical Education South Bay Area Health Education Center San Jose, CA
1980-1983	Private Consulting, Health Services Development
1979-1980	Member, Medical Staff St. Mary Corwin Hospital Pueblo, CO
1980	Member, Perinatal Care Committee and Emergency Disaster Committee St. Mary Corwin Hospital Pueblo, CO
1979-1980	Member, Medical Staff Parkview Hospital Pueblo, CO
1979-1980	Member, Project Review Committee Southeastern Colorado Health Systems Agency Colorado Springs, CO Performed certificate of need reviews, proposed use of Federal funding reviews and regional planning
1978-1979	Chairperson, Task Force on Ambulatory Care Data Policy Committee of the Southeastern Colorado Health System Agency Colorado Springs, CO
1976-1980	Medical Director and Staff Physician Pueblo Neighborhood Health Centers, Inc. 1213 North Elizabeth Street Pueblo, CO Organized and developed a new community health center, community-based and federally-sponsored.

1976-1980	Clinical Instructor Department of Preventive Medicine University of Colorado School of Medicine, Denver, CO
1976-1977	Instructor, Department of Political Science University of Colorado Denver, CO

EDUCATION AND POSTDOCTORAL TRAINING

1996-1998	Divinity Student The Center for Spiritual Enlightenment 1146 University Ave. San Jose, CA
1985-1988	Clinical Scholar Robert Wood Johnson Foundation Department of Medicine Stanford University School of Medicine Stanford, CA
1985-1988	Postdoctoral Fellow Division of Nephrology Stanford University Medical Center Stanford, CA
1983-1985	Resident Physician Department of Medicine Santa Clara Valley Medical Center and Stanford University Affiliated Hospitals Stanford, CA
1980-1982	Postdoctoral Studies in Law and Public Policy Stanford Law School Stanford University Stanford, CA
1975-1976	Internship Department of Family and Community Medicine University of Arizona School of Medicine And Affiliated Hospitals Tucson, AZ
1973-1975	Master of Public Health (MPH) Harvard University, School of Public Health Boston, MA

1971-1975	Doctor of Medicine (MD) Harvard Medical School Boston, MA
1968-1971	AB with Honors in Biology (Zoology) University of California Berkeley, CA

PROFESSIONAL CONSULTING

1999-Present	Extreme Health, Inc. Alamo, CA 94507
1998-2000	O'Connor Hospital San Jose, CA
1993-1995	Spectra Renal Labs Milpitas, CA
1982-1983	Consulting Physician National Farmworkers Health Group Salinas, CA

Developed and implemented plans for a private medical group to serve members for the United Farmworkers Union Board of Directors.

1980-1982	Acting Medical Director and Staff Physician Family Health Foundation of Alviso Alviso, CA

Together with Dr. Paul O'Rourke, devised and implemented a corporate reorganization of a community health center with a ten million dollar budget, multiple sources of public funding and facing financial crisis due to decremental funding.

1980	Consulting Physician Benton-Franklin Rural Health Clinic Northwest Rural Opportunities and US Department of Health and Human Resources 1908 North 4th Street Pasco, WA 99301

Organized and developed a new health center for migrant farmworkers in conjunction with a local economic development corporation and US Department of Health and Human Services.

SCIENTIFIC AND PROFESSIONAL ASSOCIATIONS

American Association for the Advancement of Science
Washington, DC

American College of Physicians
Chairman, Health and Public Policy Committee of Northern California
Member, Membership and Awards Committee
Philadelphia, PA and San Francisco, CA

American Public Health Association
Washington, DC

Committee on End Stage Renal Disease
Institute of Medicine
National Academy of Sciences
Washington, DC

Council on the Kidney in Cardiovascular Disease
American Heart Association
Dallas, TX

California Academy of Science
San Francisco, CA

Foundation for Mind Being Research
Los Altos, CA

Institute of Noetic Sciences
Sausalito, CA

New York Academy of Science
New York, NY

Society for General Internal Medicine
Task Force on Social Responsibility
Washington, DC

Society for Scientific Exploration
Stanford, CA

CERTIFICATION AND MEDICAL LICENSURE

1985	Diplomate, American Board of Internal Medicine
1976	Diplomate, National Board of Medical Examiners
1980-Present	California License G042355
1976-1983	Colorado
1980-1983	Washington and Arizona

INVITED PRESENTATIONS

"Complementary and Alternative Medicine: Practical Applications and Evaluations-The Center for Integrative Medicine at O'Connor Hospital, Catholic Healthcare West" Presentation given in San Francisco, CA on October 15-17, 1999. The Stanford Center for Research in Disease Prevention at the Stanford University School of Medicine and Center for Alternative Medicine Research and Education, Beth Israel Deaconess Medical Center, Harvard Medical School.

"Cross-Cultural Issues in the Assessment of Health Status." Presentation given at the Technical Assistance Workshop #2. March 2-4, 1993, New Orleans, LA. Center for Medical Effectiveness Research, Research Centers on Minority Populations. Agency for Health Care Policy and Research, US Health Care Financing Administration.

"Quality of Life in the Treatment of End Stage Renal Disease." Testimony on behalf of The American Kidney Fund before the Institute of Medicine, National Academy of Sciences. May 5, 1989, Chicago, Illinois.

"The Epidemic of Renal Failure among Native Americans." Testimony before the National Kidney and Urologic Diseases Advisory Board. National Institutes of Health. March 17, 1988, Los Angeles, California.

PUBLICATIONS

Articles and Book Chapters

Quevedo S.G. Quality of Life in Patients with End-Stage Renal Disease: A Clinician's View. American Kidney Fund Nephrology Letter, May 1992; 8:13-20.

Quevedo S.G. Renal and Electrolyte Disorders. In A.A. Louis, Handbook of Difficult Diagnosis. New York: Churchill Livingston, 1990.

Quevedo S.G. The Apparent Epidemic of Diabetes and Renal Disease Among American Indians. Nephrology News and Issues, August, 1989.

Quevedo SG, Young JH, Carrie BJ, Holman HR. Continuous ambulatory peritoneal dialysis: bridging the gap between evaluation and practice in chronic illness. Annals of Internal Medicine, 1986; 104:430-432.

Kappy M, Levinson D, Quevedo S, et al. Failure to thrive: a case study in comprehensive care. Journal of Family Practice, 1976; 3:659-664.

Johnston D, Kerr D, Pyeritz R, Quevedo S, et al. Biosocial medical education. Boston, MA, 1974.

Johnston D, Kerr D, Pyeritz R, Quevedo S, et al. The program in biosocial medicine. Harvard Medical Alumni Bulletin, 1973; 48:20-25.

Johnston D, Kerr D, Pyeritz R, Quevedo S, et al. The curriculum. New England Journal of Medicine, 1973; 288:541-542.

Abstracts

Quevedo SG. Estimating the impact of illness in a Spanish-speaking population. Robert Wood Johnson Foundation, Princeton, NJ. 1987.

Quevedo SG. The public hospital as provider of last resort: the case of uninsured patients with end stage renal disease. Robert Wood Johnson Foundation, Princeton, NJ. 1986.

Quevedo SG. The Decline of Quality and Access in Health Care for Minority Populations. Minority Health Issues Conference Proceedings. University of California School of Public Health. Berkeley, CA. 1987.

COMMUNITY SERVICE AND VOLUNTEER ACTIVITIES

1996-1997	Member, Interim Board of Directors Family Health Foundation of Alviso San Jose, California
1975-1976	Physician, Clinic of the Traditional Indian Alliance. Tucson, AZ
1974-1975	Member, Committee of Admissions Harvard Medical School Boston, MA
1973	Participant, National Conference on Health Manpower, Department of Health, Education and Welfare, Division of Health Manpower, Howard University, Washington, DC
1971-1974	Member, Advisory and Admissions Committee, Harvard University Health Careers Program Cambridge, MA

1969-1971	Member, Honors Students Society University of California Berkeley, CA

LANGUAGES English and Spanish

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Divider Title: Rohrbacher

12/5/00

To: White House Commission on Complementary and Alternative Medicine

From: Michael J. Rohrbacher, PhD., MT-BC,
Director of Music Therapy
Shenandoah University
Winchester, VA 22601

re: oral statement on behalf of the Certification Board for Music Therapists, Inc.

Opening remarks: Good afternoon. My name is Michael Rohrbacher. I serve as Director of Music Therapy at Shenandoah University in Winchester, Virginia. On behalf of the Certification Board for Music Therapists, I wish to thank the Commission for the opportunity to present the following five points regarding the profession of music therapy and its credentialing process.

1. Definition: As defined by the American Music Therapy Association, music therapy is the use of music in the accomplishment of therapeutic aims: the restoration, maintenance, and improvement of mental and physical health. Music therapists work with individuals of all ages who require special services because of behavioral, social, learning, or physical disabilities. Employment may be in hospitals, special education programs, mental health centers, substance abuse facilities, nursing homes, hospice, rehabilitation, correctional facilities, prevention and wellness, or private practice. Over 3,700 individuals currently hold AMTA membership. The AMTA sets standards and identifies competencies for the practice of music therapy, and establishes criteria for the education and training of future music therapists. Nationwide there are 69 undergraduate music therapy programs, 25 graduate programs, and 159 internship sites approved by AMTA.

2. Credentials: The Certification Board for Music Therapists, Inc. (CBMT), was created in 1983 to serve as the credentialing body for music therapists. CBMT is administratively and financially independent of the American Music Therapy Association. The mission of CBMT is to evaluate individuals who wish to enter, continue and/or advance in the discipline of music therapy through a certification process, and to issue the credential, Music Therapist-Board Certified (MT-BC), to individuals who demonstrate the required level of competence.

3. Accreditation: CBMT is a member of the National Organization for Competency Assurance. CBMT is accredited by the National Commission for Certifying Agencies (NCCA). The NCCA accreditation standards address areas certification boards must adhere to, including organizational structure, exam development and administration, test validity and reliability, recertification requirements, public protection and information, and responsibilities to candidates, certificants, employers and the public. CBMT has been accredited by NCCA since 1986.

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4. Representation: Persons holding the credential, MT-BC, have successfully passed the CBMT certification examination, demonstrating the knowledge, skills and abilities necessary to practice at the current entry level of the profession. To be eligible to sit for this national examination, candidates must have completed an undergraduate degree in music therapy or equivalent, including the 6 month internship, from a program approved by the American Music Therapy Association. The CBMT national examination is now offered at over 100 computer-based testing sites throughout the United States. The examination itself is updated every five years to remain current with the profession. This is accomplished through a nationwide, job analysis survey distributed to credentialed music therapists. CBMT also offers a Recertification Program in which board certified music therapists must accrue 100 continuing music therapy education credits every 5 years in order to demonstrate continued competence and growth in current music therapy practice. Board certified music therapists must also adhere to the CBMT Code of Professional Practice. Today, there are approximately 3,400 credentialed music therapists.

5. Use: Increasingly, the MT-BC is used by consumers, employers, personnel boards and facilities to identify competent music therapists. For example, the state of Wisconsin requires civil service agencies to contact CBMT to determine if an applicant for a music therapy position holds a current MT-BC credential. The Michigan State Department of Education requires MT-BC for employment in special education. Also, in Winchester City and Frederick County, Virginia, where I am from, all music therapy contracts in public school special education programs and at the Winchester Medical Center require music therapists to hold the credential, MT-BC.

Summary: To summarize, national certification programs such as those accredited by the National Commission for Certifying Agencies, including CBMT, offer credentialing standards consistent with state licensure in a cost effective and uniform manner. Again, I thank you for this opportunity to present information on the profession of music therapy and its credentialing process.

For further information, please contact:

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Evan Pugh Professor of the Solid State Emeritus • Professor of Geochemistry, Emeritus • Professor of Science, Technology & Society, Emeritus • Visiting Professor of Medicine, University of Arizona • Distinguished Professor of Materials, Arizona State University

December 4, 2000

Submitted to:

White House Commission on Complementary and Alternative Medicine Policy
c/o Department of Health and Human Services, Washington, DC

Comment on the Access and Delivery of Complementary and Alternative Medicine Services: Use, Effectiveness and Delivery Systems.

These comments are made by Professor Rustum Roy, Visiting Professor of Medicine at the University of Arizona, and Founding Director of the Materials Research Laboratory at Pennsylvania State University. He is also a Founder and Chairman of Friends of Health, a 501(c)(3) organization, and of its Science Advisory Committee. Friends of Health provides the bridge from the Whole Person Healing (our preferred term for CAM) community to the community of traditional scientists and engineers.

The Commission has focused this hearing on two very important issues facing the nation, and I address them in turn.

1. It is obvious that with the tidal wave of citizen and patient interest in whole person healing, healthcare providers will have a difficult time keeping up with let alone having "access to CAM practices and interventions."

   This is a critical issue which needs some kind of emergency intervention. Among the half-million physicians in the U.S., it is highly unlikely that more than a few percent could be said to have "ready access to CAM practices." What can be done? The University of Arizona's Program in Integrative Medicine, under Professor Andrew Weil, is the acknowledged leader in the field. Yet it has been training only four fellows per year. While its pioneering curriculum development has triggered a dozen similar programs in various Universities, this will do very little for the general population of physicians and other providers. The University of Arizona's current Distance Learning program for off-site providers could handle perhaps 400 per year (actually 42

in Year 1). This program has been carefully thought out and fully developed, and a dozen other institutions have developed or are developing their own versions of it. What it needs is a vast expansion and copying with local adaptations by other organizations, not only Universities.

For the healthcare providers to be made even literate in whole person healing, and to be competent to refer patients to whole person healing practitioners, will require a crash program on whole person healing by on-line and other distance learning methods.

For patients, the print and broadcast media have been the principal educators. This will continue and indeed expand as whole person healing becomes ever more mainstream. The main help to be given here would be to fund activities by the major University and other institutional leaders to provide sound input to these media channels.

I want to point, however, to two populations that are missed by this process. First are the mainstream (non-PBS) public. Demographics from Professor Andrew Weil's newsletter confirm that these devotees of whole person healing are definitely upper-middle class. Information and education and possibly routes to access need to be rapidly disseminated, especially to the economic lower half of the U.S. population. The marketplace cannot do this. A crash program using not-for-profit agencies such as churches, community agencies, etc., will help.

The second population – the scientist, engineer population – is a very special and significant one. The reason for this is that this group is often cited as being critical of the value of whole person healing, indeed of its validity. Here the remedy is more specialized. An ear-marked program at the $1 to $2 million per year level funded under whole person healing in a new separate education program targeting scientists and engineers could help meet this need.

2. In order to meet all these needs it is clear that new separate programs for "whole person healing related education" are needed. This is <u>not</u> research. The program could be jointly administered by whole person healing agencies, possibly NCCAM, and the National Science Foundation (using the latter's experience in science education). Ramping up from $10 million to about $30 million in 3 or 4 years would be an appropriate level of effort.

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AMERICAN ACADEMY
OF MEDICAL ACUPUNCTURE

5820 Wilshire Boulevard, Suite 500
Los Angeles, California 90036
213 937 5514 • 213 937 0959 FAX

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

RE: December 4-5 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 foundations in conventional biomedicine and ancient Chinese medical theory and practice, Medical Acupuncture has become an integrated therapeutic model, incorporating the best of classic and contemporary acupuncture traditions and conventional western bio-pharmacology. A physician who practices Medical Acupuncture offers a uniquely comprehensive approach to patient health care -- 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 approximately 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, both classical and contemporary, all represented in the AAMA's membership. The training and practice requirements for membership in the AAMA are based on international standards of the World Health Organization, the World Federation Of Acupuncture-Moxibustion Societies, and The International Congress For Medical Acupuncture And Related Therapies (WHO, WFAS, ICMART) and have served 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. 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. 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 should appropriately fall under the purview of the respective stated 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 than 4,000 hours of allopathic education and licensed to practice medicine in their State. Many of our members will additionally pursue a post-doctoral specialty training program involving 5000 or more hours over the course of many years. 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, and The International Congress For Medical Acupuncture And Related Therapies (WHO, WFAS, ICMART).

After completing comprehensive training, medical acupuncture physicians are eligible to sit for an exhaustive examination which may lead to board certification through the American Board of Medical Acupuncture, following additional educational requirements, practice experience and professional references. This examination is the most comprehensive measure of expertise in the multiple disciplines of acupuncture in the world and is considered internationally as a model of excellence.

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. In addition, 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 denied. 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 biopharmaceuticals. 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, insist 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. 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 is 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.

Written Testimony

White House Commission on Complementary and Alternative medicine

December 4-5, 2000
Washington, D.C.

Testimony presented by:

Christopher Hobbs, L.Ac., A.H.G.

- **4th generation herbalist and botanist with 32 years of experience**
- **Licensed Acupuncturist and clinical herbalist (California, Oregon)**
- **Founding member, American Herbalists Guild (only national herbalists association)**
- **Teacher, author of 20 books on herbal medicine and CAM (over ½ million copies sold)**
- **Founder of The Living Farmacy, community-based herbal training center**

Preface

I would like to preface my testimony with a few philosophical comments. Please consider that medicine and healing do not have to be based on a completely rational view of the world. Remember that throughout the ages we have gone through many cycles of beliefs about the meaning of health and disease and how best to create higher health within our societies. It was Rene Dubos who said that throughout human culture we have gone through cycles of embracing the "hygeia principle" and the "asclepias principle" (Dubos, 1965). Hygeia is the goddess of health and represents maintaining a high level of health in a society by paying attention to the causes and prevention of disease, rational living, and practicing healthy habits like good diet, exercise, and balanced activities throughout the day. Asclepias was the protophysician, and thus represents a society of people who live however they choose, with no regard for healthy living and prevention of disease through discipline and knowledge of health and disease, expecting the physician to heal them when they grow sick. Today we appear to be on the cusp of a great transformation in the way we look at health and disease. Keeping an open mind and heart are crucial for the coming changes.

Please think back to the mid-19th century, when physicians commonly bled people and administered arsenic and other toxic metals. Then think what our medicine will be like 150 years from now. Will the people in that time look back on chemo- and radiation therapy in the same way we view the methods of the 19th century? Since we don't know the evolutionary path of medicine over the next 150 years, we must be open to all possibilities. Your work could be an integral part of this evolutionary process. I invite you to listen carefully with an open mind and heart to all the testimony and believe in the power of the human spirit to create a wiser system of healing with much more emphasis on health than on disease; to place more focus on educating our children to adopt healthy habits early in life, embracing and believing in the value of health above all else; and to embrace the use of more gentle herbal medicines that follow the wisdom of the first acknowledged holistic physician, Hippocrates, who said, "First, do no harm."

If your mind believes, at least in part, that herbal medicine is quackery, I will say, yes, herbal quacks exist. Quack physicians also exist, and our health care system is rife with special interests determining what drugs are safe and how they are prescribed. Human evolution is slow, but I believe inexorable. Herbal medicine is so interwoven with the fabric of all societies of the world, so much a part of nearly all heritages. I believe that is one reason for its great explosion of popularity now. Herbalism has always been the "people's medicine" and allows for more personal choice and individual freedom.

Answers to questions provided by the Commission

1. Please provide references that best describe the clinical and cost-effectiveness data for access to and delivery of herbs/botanical therapies.

Very few studies were found on Medline and Healthstar relating to cost-effectiveness of herbal medicine. These studies should be funded to help learn how herbal medicine can be better utilized in today's health-care climate. Ashcroft and Po (1999) argued that cost effectiveness has to be evaluated in light of the effectiveness and safety of herbal therapies, which is often not available. Even so, they conclude that limiting access to herbs that have not been tested, but have been used safely over hundreds, if not thousands of years, would not serve the best interests of patients and would increase national health care costs.

When considering the cost-effectiveness and risk-benefit ratio of herbal medicines in today's heath-care climate, several factors are worth considering.

- At least 43 million Americans have no health care insurance
- The safety record of pharmaceutical drugs, costs, and their actual cost
- Medical errors, adverse drug effects are common and may be between the 4th and 6th leading cause of death in the U.S.
- Many ailments are self-limiting leading to non-essential doctor visits
- Doctors are trained in pathology and disease-management; herbalists are trained in health care and prevention; both aspects are necessary and both kinds of practitioners should work together side-by-side in the modern clinic or hospital
- Physicians are overworked...the average time to interruption is 50 seconds
- The general population in the U.S. is already choosing CAM over physician visits
- Herbal medicine offers personal empowerment, increased personal choice, increased options, and privacy

A closer look at some of these issues:

Millions of Americans are currently without any kind of health insurance, and nearly 1 in 7 women have no insurance. Americans used more CAM therapies in 1997 than visits to primary care physicians.

- Nearly 14% of women in the U.S., or 1 in 7, are without health insurance.[1]
- The number of Americans without health insurance has been growing steadily. According to a new census bureau report, 43 million people are without coverage, the highest in 5 years.[2]
- Half of elderly Americans who have private health insurance covering drugs still spend $500 to $999 a year out-of-pocket on prescriptions, according to a new report from the AARP.[3]

- Four out of 10 Americans used alternative medicine therapies in 1997, exceeding the visits to all U.S. primary care physicians. Americans paid an estimated $21.2 billion for services provided by alternative medicine practitioners.[4]

1. National Women's Law Center (NWLC), a nonprofit group, The University of Pennsylvania School of Medicine's FOCUS on Health & Leadership for Women and the Lewin Group, a health policy consulting firm.
2. CNN News report, Nov. 13, 1998.
3. AARP report, Sept. 30, 1999.
4. November 11 issue of The Journal of the American Medical Association (JAMA).

The Alternative to the Alternative, Pharmaceutical Drugs

Herb safety is widely discussed today. Medline and Healthstar yielded over 300 articles on herb safety, side effects, and herb-drug interactions. These articles are concentrated mainly on a handful of herbs like St. John's wort and report on only a few actual cases involving people. I believes that herb safety should be studied and reports of adverse effects from herbs reviewed for accuracy. For instance, St. John's wort is known to affect the way certain drugs are metabolized in the liver, and therefore its concurrent use with prescription and OTC drugs should be monitored (Ernst, 1999). However, studies have repeatedly found, even among thousands of patients, that widely-recommended standardized herbal supplements have few side effects when used without drugs and are generally well-tolerated, comparing favorably to placebo in many cases.

The CDC has few reports of adverse events from dietary supplements, and the FDA hotline, the source of most reported ephedra (ma huang) deaths in the U.S., is completely uncritical and not peer-reviewed. Anyone can call the hotline and report an adverse event, which is not checked for accuracy.

In contrast, over 2 million hospitalized Americans had a serious adverse drug reaction in the United States in 1994, with 106,000 deaths reported, when the drugs were taken as prescribed. The author concludes that this figure may be conservative (Peck, 1998). The number of deaths from all adverse drug effects in the U.S. is not known but may be substantially higher.

Despite popular perception, the FDA has no "gold standard" for the quality and number of tests necessary before a new drug is approved; this process is somewhat subjective, and may at times be swayed by commercial interests. A Sept. 25 *USA Today* article (2000) reported that more than half of the experts hired by FDA to make recommendations about the safety and effectiveness of drugs being considered have financial relationships with the pharmaceutical companies who make the drugs (Cauchon, 2000). Federal law prohibits experts with vested interests to participate in FDA advisory committees, but FDA has waived this restriction more than 800 times since 1998 and has kept exact details secret since 1992. These experts make decisions that affect the health of millions of Americans as well as influence billions of dollars in sales of approved drugs.

Freedom of Choice and Personal Empowerment is Essential to Hope and Healing

I believe the reason Americans choose CAM therapies so commonly is the feeling of control of one's own destiny this imparts. In our present modern health care system, physicians often have time to offer enough information about a patient's condition to satisfy their