# Performance Reporting

Voice: (301) 871.0010 Fax: (301) 871.0020
Toll Free: (877) 871.0010

PHOTOCOPY
PRESERVATION

Interview Overlapping Issues/Recommendations:

Reimbursement–requirements to be met and process; role of Medicare

Education–medical schools, public, research training

Standards, credentialing, and licensing

Dietary supplements oversight (DSHEA/FDA?)

Research; science base and health services

CAM practitioners in underserved and rural areas

Design of report; use of report

Tieraona Low Dog (Interviewer: Gerry)
Key issues and recommendations emerging or requiring further discussion

1. Get more of a handle on reimbursement. In cases where evidence shows effectiveness, how is this incorporated into coverage. Some private insurance companies are already incorporating some CAM modalities indicating movement in the direction of coverage. Greater concern about low income (Medicaid) and the elderly (Medicare).

2. Emphasize education.

> Recommend that medical schools include minimum (core) overview of CAM.. Essential to mandate that this be required, not voluntary in order to happen.
>
> Recommend heavily marketed, government-supported dependable information out-reach program to practitioners (including pharmacists) and the public. Develop a government-supported web site clearinghouse; collaborate with public libraries nationally to make it accessible to all citizens; arrange for public health advertisement of the existence of site through radio, TV, newspapers, pamphlets in public malls, super markets, libraries, etc., and include information on how to use the site. Include guidance on how to access or link to other dependable information.

3. Importance of consistency of standards. Recommend standardization of requirements state to state regarding licencing, certification, educational standards for practitioners; acupuncturists, message therapists, etc.

4. DSHEA: Revisit?? At least recommend adequate support (funding) to carry out its provisions as currently written. Also, Commission should look at the Report of the Commission on Dietary Supplement Labels (Ken Fisher).

5. Too soon to support CAM under NHSC in rural areas when we're not able to get nurse practitioners yet. Conventional care needs to come first.

6. Report should be "conservative," well thought out, with carefully chosen and focused recommendations.

Process for discussion of report

Recommend large group discussion so all Commissioners hear everything and can respond. Not enough time and less efficient to depend on small groups followed by large group discussion. Jim Gordon will have to draw out members that tend to be quiet during full Commission discussions and make sure their ideas are heard.

How to use July and October meetings
Base October meeting on discussion of draft report in July and the follow-up items that are identified.. July 1 dinner availability: Yes

Bill Fair (Interviewer: Gerry)
Key issues and recommendations emerging or requiring further discussion

1. Concern about what will happen after the Commission's report is released; its important to avoid its relegation to a shelf somewhere.

2. Strong argument to support the study of the effectiveness of CAM products and practices, and elevate the philosophy of disease prevention; for example, there is growing concern about the increasing number of young adults developing diabetes. As has been shown with cardiovascular disease (Ornish data), life style changes would likely go a long way in reducing the incidence of diabetes cases. Include health education in the public school curriculum as a continuum from pre-kindergarten through senior high school.

3. Because of participant turnover, commitment on the part of HMO's and other insurance companies to disease prevention is weaker than it should be. Medicare is a good place to start because of its stable participation.

4. Before reimbursement can be considered, the issue of quality must be addressed. CAM professional societies must set standards and states must license and oversee CAM practice. The CAM community must be represented on state Boards.

5. Education is key. Educational requirements must ensure quality, not only justify reimbursement.

6. Growing consensus of among the Commissioners that herbal supplements are in need of more oversight; e.i., standards of quality, absence of contamination (purity), and truth in labeling. Also, greater emphasis on tracking of adverse reactions by FDA requires attention.

July 1 availability: Yes

## ınce Concerns

Bernstein explained how it is possible to create an effective and ethical no-fault clinic.

• Kathleen Golden, ASNY chair emeritus, stressed the importance that insurance parity could play in helping new practitioners stay out of less than reputable no-fault clinics.

It appears from the topics covered at the meeting that the healing art of acupuncture is gradually moving toward the same destination as Western allopathic and chiropractic medicine. This destination is driven by a profit-oriented value system. If American practitioners focus only on the financial potential of acupuncture and Oriental medicine (OM), we run the risk of undermining its efficacy. At this moment in our nation's history, acupuncture and OM have reached the cusp of America's mainstream medical field. As practitioners, we cannot afford to undercut the strength of authentic Oriental medicine at this historical juncture. Indeed, we have the opportunity to conduct ourselves as honorable custodians of OM as it gains increasing public interest and respect. We can make it our job to maintain OM's authenticity, because its authenticity is what gives OM its profound strength and clinical efficacy.

In an age of managed care, MDs and chiropractors had to change their practice strategies in order to exist financially. This has to lead to overbooked and overstressed doctors trying to practice the healing arts in

### *A Letter From the Acupuncture Society of New York*

### Evolving No-Fault Practices in New York State

The Acupuncture Society of New York (ASNY) has been promoting the growth and preserving the integrity of the acupuncture and Oriental medicine profession in New York since 1990. ASNY is interested in securing acupuncture's continued inclusion in patient care under the provisions of 'no-fault' regulations in New York State.

ASNY is aware that there is room for increased involvement on the part of New York State regulating bodies to provide guidance to 'no-fault' clinics regarding patient care and billing practices. The ASNY board of directors offers the following recommendations to begin the process of assessing and improving quality of care and billing practices:

· Provide acupuncturists with strong guidelines for standards of patient care.

· Acupuncturists use and document a method of assessment based on the basic principles of acupuncture and Oriental medicine and the tradition of that individual's training, (i.e., palpation, pulse and tongue assessment).

· Acupuncturists use appropriate clinical recordkeeping in accordance with SOAP (subjective, objective, assessment, plan) standards. All recordkeeping includes detailed initial visit documentation. Follow-up treatment notes include form of acupuncture treatment used, patient response to previous treatment, and progress.

· Acupuncturists spend an appropriate amount of time with a patient providing assessment, treatment and guidance consistent with that provider's tradition and educational background.

· Practitioners re-evaluate and alter their treatment plan if there is no reported improvement after several treatments, and make referrals to other providers when appropriate.

· All insurance company peer reviews for acupuncture treatment claims be done by a NYS - licensed acupuncturist.

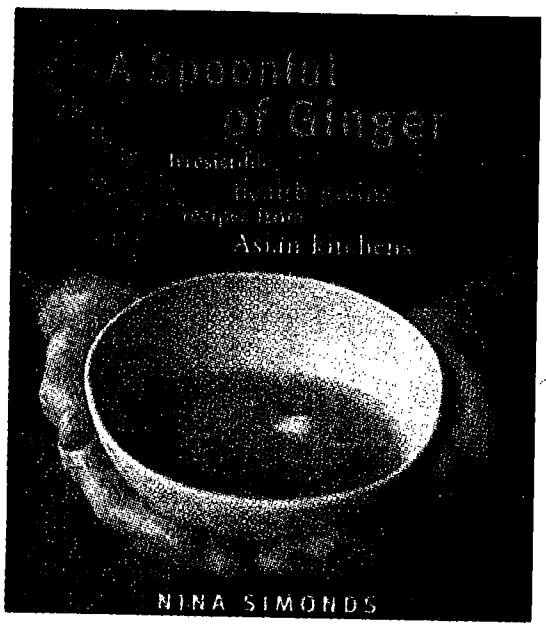
· All providers use ethical billing practices.

It is imperative that the profession of acupuncture and Oriental medicine not be assigned blame in this dialogue. The entire system of 'no-fault' needs to be reviewed and reformed. All providers of therapeutic service to an injured patient must be reviewed for appropriate and inappropriate practices.

ASNY, along with the other NYS professional associations, has a strong interest in providing leadership and information to encourage appropriate patient treatment. It is always the desire of the state associations to advocate for the best acupuncture and Oriental medicine care that can be provided to the patients of New York State.

t-selling author and authority on Chinese cooking, is
pan, where she studied spices, and caught up on the
a. In New York for the Asian Therapies for Cancer
greed to talk with *TCM World* about her work over a
o soup, sushi, and tea.

**ul of Ginger, is filled with recipes from Asian**
**d information about food for healing. Are there**




hen the season is Yang, we eat Yin vegetables and
ourselves. In winter, which is Yin, we are drawn to
ups and stews.

**as medicine in the Chinese culture. Can we learn**

it food for health, you're talking about prevention
l health. Foods and herbs are on a continuum.
and faster-acting. There is a relationship between
rs from an imbalance, so it is necessary to seek the
certain foods can be used to tonify the organs that
ce. There are certain foods that strengthen the
ormation is crossing over from East to West. For
e and oyster mushrooms have been the subjects of
ent of virulent forms of cancer. Looking at food this
f experienced doctors of Chinese medicine.

**e Western attitude toward food and health?**

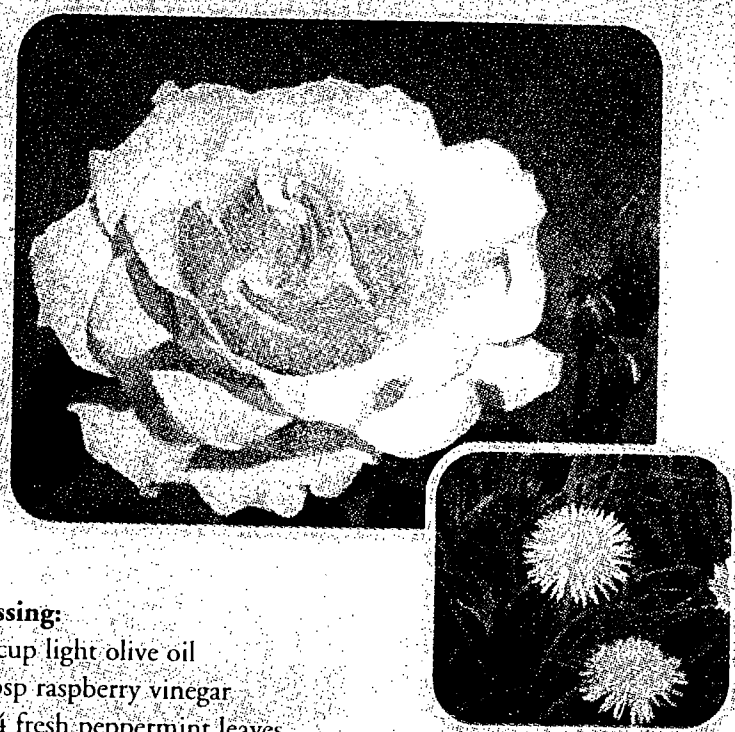
say "health" in relation to food; you say "pleasure."
erican public to be the enemy. When we talk about
ink in terms of deprivation and sacrifice, with
ne. There is a lot to be said about food purely for
need to find balance. Today, there is a new alliance
That's why doctors are promoting whole food.

## Dandelion Leaves and Rose Petal Salad

This pretty and unique salad can help promote healthy Liver function and beautiful skin.

***Ingredients***

Dandelion leaves, washed – enough for four servings
1/2 head of iceberg, romaine or other lettuce, washed, patted dry and torn into small pieces
1/4 cup roasted almonds (or any other roasted nuts you prefer)
Petals from at least four or five large rose blossoms (any color; petals are fragile, leave whole if possible)



**Dressing:**
1/4 cup light olive oil
6 Tbsp raspberry vinegar
3 – 4 fresh peppermint leaves
Fresh ginger root, four slices the size of a quarter
Salt to taste

**Directions:**

Tear dandelion leaves and lettuce into small pieces. Put into large salad bowl. In a blender, mix olive oil, vinegar, peppermint, ginger and salt. Place the salad on chilled plates. Drizzle dressing over salads. Sprinkle with roasted nuts and brightly colored rose petals. Serve immediately.

(Note: If you can't get dandelion leaves from your green grocer, you can pick young, tender dandelion leaves from your garden. Rose petals and dandelion leaves must be clean and pesticide-free.)

**Heart**

*continued from page 14*

in the Heart. A dull or pale complexion may signal a deficiency of blood. The tongue also reveals the Heart's health. In fact, the tongue

Summer, a time of maximum growth, is the season corresponding to the Heart and Fire element. In actuality, the Heart cannot stand too much heat. It relies on its protector, the Pericardium, to process any injurious factors, including excess

individuals to share concerns and information about "no-fault" clinics, insurance billing, discount referral networks, and insurance parity moderated by Michael Gaeta, L.Ac., board chair of ASNY.

The speakers on the panel included: Mark Feldman, DPM, podiatrist, head of Medical Cost Containment at the Robert Plan Insurance Company; Deanna Waldron, Esq., Attorney, ASNY board vice-chair, chair, ASNY Law & Legislation Committee Member, ASNY, Ethics Committee, and Steve Bernstein, L.Ac., ASNY board member, member, ASNY Insurance Relations Committee.

The panelists discussed the following key issues:

• Dr. Feldman discussed the issues surrounding no-fault clinics; namely, that many state and federal agencies are investigating these clinics for insurance fraud. Feldman outlined the billing procedure that satisfies insurance company requirements. He suggested that a practitioner should send the insurance company the patient's initial examination and patient progress notes with each bill.

• Deanna Waldron discussed the importance of insurance parity for the future of the acupuncture profession in New York. She discussed ASNY's planned trip to Albany to inform the state about acupuncturists' position on no-fault clinics and insurance in general.

• Steve Bernstein described how more than fifty percent of his practice is no-fault; he sees only ten patients per day, on average. Bernstein explained that he used to work in no-fault clinics, but left when he realized he could not effectively treat his patients under the trying conditions imposed by many high volume no-fault clinics.

It appears from the topics covered at the meeting that the healing art of acupuncture is gradually moving toward the same destination as Western allopathic and chiropractic medicine. This destination is driven by a profit-oriented value system. If American practitioners focus only on the financial potential of acupuncture and Oriental medicine (OM), we run the risk of undermining its efficacy. At this moment in our nation's history, acupuncture and OM have reached the cusp of America's mainstream medical field. As practitioners, we cannot afford to undercut the strength of authentic Oriental medicine at this historical juncture. Indeed, we have the opportunity to conduct ourselves as honorable custodians of OM as it gains increasing public interest and respect. We can make it our job to maintain OM's authenticity, because its authenticity is what gives OM its profound strength and clinical efficacy.

In an age of managed care, MDs and chiropractors had to change their practice strategies in order to exist financially. This has to lead to overbooked and overstressed doctors trying to practice the healing arts in ten-minute increments. It is a dangerous sign for our profession when entry-level practitioners, such as myself, dwell on how much to charge and how many minutes a treatment can last in order to be cost-effective rather than giving more consideration to which treatment strategy and techniques are beneficial to the patient. I believe we should learn from the past and from the mistakes of others. Let us not make the same mistakes.

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# ASNY Addresses Insurance Concerns

## By Jacques Deparideu, L.Ac.

The Acupuncture Society of New York (ASNY) held its first open forum on insurance-related issues on Sunday, March 25, at Pacific College of Oriental Medicine in New York City. The meeting was a welcome opportunity for students, practitioners and interested individuals to share concerns and information about "no-fault" clinics, insurance billing, discount referral networks, and insurance parity moderated by Michael Gaeta, L.Ac., board chair of ASNY.

The speakers on the panel included: Mark Feldman, DPM, podiatrist, head of Medical Cost Containment at the Robert Plan Insurance Company; Deanna Waldron, Esq., Attorney, ASNY board vice-chair, chair, ASNY Law & Legislation Committee Member, ASNY, Ethics Committee, and Steve Bernstein, L.Ac., ASNY board member, member, ASNY Insurance Relations Committee.

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- Deanna Waldron discussed the importance of insurance parity for the Bernstein explained how it is possible to create an effective and ethical no-fault clinic.
- Kathleen Golden, ASNY chair emeritus, stressed the importance that insurance parity could play in helping new practitioners stay out of less than reputable no-fault clinics.

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ASNY, along with the a strong interest in providing le appropriate patient treatment associations to advocate for medicine care that can be prov

Acupuncture • Therapeutic Bodywork • Health Seminars

# Crossings

a center for the healing traditions


Alaine D. Duncan, M.Ac., Dipl.Ac., Director

*Licensed Acupuncturist*

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Summer – is Yang. : eat Yin foods
Winter Yin . . . Yang

CAPS - hes

Joe Fins (Interviewer: Gerry)
Key issues and recommendations emerging or requiring further discussion

1. Overwhelming issue is protecting public safety. Consensus is emerging on the Commission that dietary supplements require more oversight. This view is consonant with public perception.

2. To ensure public safety, establish a surveillance system for adverse reactions. Involve FDA, the CDC (MMWR), FTC. Many CAM practitioners need training to recognize complications and report them to the appropriate public health agency, and allopathic practitioners need to recognize the medical history or etiology of complications related to CAM.

3. Promote research in the context of true scientific discovery. NCCAM and its collaborative efforts with other NIH Institutes should be viewed as a gateway to increased research support by all NIH Institutes (NCI example); i.e., integrate, not segregate.

4. Emphasize adequate support for research training that will produce the pool of researchers capable of designing sufficiently competitive applications for funding, which in turn will produce the critical mass of evidence needed to integrate CAM into medical practice.

5. In addition to the need for data from hypothesis-driven collaborative scientific studies of safety, efficacy, and mechanism of action, data on health services delivery, which are needed to assess the basis for access and for reimbursement, are not available. Recommend support for health services research; e.g., demonstration projects and small pilot studies supported by ARHQ, HRSA, to answer questions about the clinical effectiveness and cost effectiveness of CAM modalities as compared to standard conventional care.

6. To ensure public safety, recommend national standards for accreditation, and licensing of practitioners in all states as consistent with Federalism and the role of states in regulating medical education and licensing.

7. Support demonstration projects to look at the scientific basis for the diagnosis and treatment paradigms employed in various CAM practices before moving toward assignment as primary care physicians in underserved and rural areas so that these populations receive the same quality of medical care as other members of the public. There is a difference between the question of whether the training of nurses prepares them to diagnose and provide primary care, and the need to ascertain both the scientific basis of the CAM practice and the practitioner's competency, which is complicated by variations in standards and licensing.

8. The Commission needs to identify the key elements of an infrastructure or a process for moving the safe and effective integration of CAM into medical practice; demonstration projects are needed for such model as hospice programs.

Comments on report process

1. Commission needs another meeting. Too much time elapses between meetings. The process for hammering out differences, especially among a divergent group is very difficult and will require the Commissioners to interact more instead of sending in separate comments/changes. The completion timeline is too short for the number of meetings scheduled. There is not adequate time to respond to the text in a day and a half.

2. There needs to be provision for dissenting opinion should this be necessary. Interim report or final report?

3. Brevity and focus are important targets to pursue in developing the interim report. The report's objective should be the support of well-thought-out guidance for incremental change and building the infrastructure for the future.

July 1 dinner availability: Yes, late lunch or early dinner to give us time.

## Pollen, Geraldine (NCCAM)

**From:** Joseph Fins [jjfins@med.cornell.edu]
**Sent:** Friday, June 01, 2001 8:25 PM
**To:** Pollen, Geraldine (NCCAM)
**Subject:** Re: Phone Interview Follow-up

**Importance:** High

Gerry,
Good job. Pls see my additions in BOLD.
Have a good weekend.
Best,
Joe

>Joe:
>
>Here are my notes taken during our conversation. Please make
>additions/changes in ALL CAPS and send back to me by "return mail." Please
>no later than cob Monday, June 4.
>
>Thanks,
>Gerry
>_____
>Joe Fins (Interviewer: Gerry)
>
>Key issues and recommendations emerging or requiring further discussion
>
>1. The overwhelming issue is protecting public safety. Consensus is
>emerging that dietary supplements require more oversight. HOW THIS
>SHOULD BE DONE IS BEYOND THE COMMISSION BUT WE AGREE THAT .
>REGULATION IS NEEDED. WHETHER DSHEA OR NEW MECHANISM WILL BE
>REQUIRED IS AN OPEN QUESTION. ALSO NOTE THAT THE BLENDON ARTICLE
>SUGGESTS THAT THIS VIEW IS CONSONANT WITH PUBLIC PERCEPTION-- NOT
>NECESSARILY THE ADVOCATES WHO ATTENDED OUR MEETINGS.
>
>2. To ensure public safety, recommend the establishment of a surveillance
>system for adverse reactions. Involve FDA, the CDC (MMWR), FTC.
>THIS IS MADE COMPLEX BY THE FACT THAT MANY CAM PRACTITIONERS MAY NOT
>BE TRAINED TO RECOGNIZE COMPLICATIONS OF THEIR THERAPIES AND REPORT
>THEM TO PUBLIC HEALTH AUTHORITIES AND BY THE FACT THAT ALLOPATHIC
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>RELATED TO CAM. SEE EDUCATION BELOW.
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>3. Promote research in the context of true scientific discovery. NCCAM and
>its collaborative efforts with other NIH Institutes should be viewed as a
>gateway to OTHER NIH Institutes (NCI example);
>i.e., integrate, not segregate.
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>4. Emphasize adequate support for research training that will produce the
>pool of researchers capable of designing sufficiently competitive
>applications for funding, which in turn will produce the critical mass of
>evidence needed to integrate CAM into medical practice. THE LEVEL OF
>EXCELLENCE REQUIRED AT OTHER NIH INSTITUTES SHOULD PREVAIL AT NCCAM
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>5. In addition to the need for data from hypothesis-driven collaborative
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>services research; e.g., demonstration projects and small pilot studies
>supported by ARHQ, HRSA, to answer questions about the clinical
>effectiveness and cost effectiveness of CAM modalities as compared to
>standard conventional care. THIS DATA WILL BE ESSENTIAL PRIOR TO THE
>ESTABLISHMENT OF ANY NEW ENTITLEMENTS. AGAIN, AT THE RISK OF BEING

>REDUNDANT SUPPORT OF AN UNPROVEN OR UNVALIDATED CAM MODALITY IN THE
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>diagnosis and treatment paradigms employed in various CAM practices before
>moving toward recognition as primary care physicians in underserved and
>rural areas so that these populations receive the same quality of medical
>care as other members of the public. A HELPFUL ANALOGY WOULD BE TO
>NOTE THAT THIS IS DIFFERENT QUESTION THAN WHETHER NURSE PRACTIONERS
>CAN PROVIDE PRIMARY CARE. THEY TOO ARE ALLOPATHICALLY TRAINED AND
>THE QUESTION IS NOT WHAT INTERVENTION THEY MIGHT PRESCRIBE FOR
>CONGESTIVE HEART FAILURE BUT WHETHER THEIR TRAINING PREPARES THEM TO
>MAKE THE PROPER DX AND RECOMMEND THE PROPER TREATMENT. WITH
>NATUROPATHIC PRACTIONERS WE HAVE TWO ISSUES: THE FIRST IS THE
>SCIENTIFIC BASIS OF THEIR PRACTICE; THE SECOND IS THEIR COMPETENCY.
>THIS IS FURTHER COMPLICATED BY THE VARIABILITY OF STANDARDS ACROSS
>THE NATION.
>
>8. The Commission needs to identify the key elements of an infrastructure
>or a process for moving the safe and effective integration of CAM into
>medical practice; [example: integrating CAM into end-of-life care].
>EOL CARE MAY BE A MODEL THAT IS MOST EVOLVED AND THERE SHOULD BE
>FUNDING FOR ADDITIONAL DEMONSTRATION PROJECTS HERE TO SUPPORT
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>Comments on report process
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WHITE HOUSE COMMISSION
on
COMPLEMENTARY and ALTERNATIVE MEDICINE POLICY

MEETING ON THE ACCESS AND DELIVERY OF
COMPLEMENTARY AND ALTERNATIVE MEDICINE SERVICES

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Volume I

+ + +

Monday, December 4, 2000

8:25 a.m.

Hubert H. Humphrey Building, Room 800
200 Independence Avenue, SW
Washington, D.C.

**PERFORMANCE REPORTING**
Silver Spring, Maryland
Phone: 301.871.0010 Fax: 301.871.0020

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Chairperson:

James S. Gordon, M.D., Director
The Center for Mind-Body Medicine

Commission Members:

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Vice President for Education
University of Texas Medical Branch

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Dipl.Ac.(NCCAOM)
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The Bresler Center, Inc.

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Conchita M. Paz, M.D.
(Private Practice)

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Wildwood Medical Center

Donald W. Warren, D.D.S.
Diplomate of the American Board of
Head, Neck & Facial Pain

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Preventative Medicine Research Institute
Clinical Professor of Medicine
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Geraldine B. Pollen, M.A.
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Joseph M. Kaczmarczyk, D.O., M.P.H.
Senior Medical Advisor

# C O N T E N T S

CONTENTS (continued)

CONTENTS (continued)

P R O C E E D I N G S [8:25 a.m.]

DR. GORDON: Good morning, everybody. Welcome to this meeting of the White House Commission on Complementary and Alternative Medicine Policy.

At the beginning of our meetings, we sit for a moment quietly and bring ourselves into the room. So I invite everyone who is here with us today just to sit for a moment.

[Moment of silence observed.]

DR. GORDON: Thank you. It is nice, especially before a rich and complex meeting, to have a little time to sit and be quiet with each other.

What I would like to do is to begin by asking each of the new commissioners, and we do have some new commissioners, to introduce him or herself and say a couple of words, and then Dr. Steve Groft, who is our executive director, will be explaining what the work is that we are going to be doing today, and then I will be giving an overview of the development of CAM services and, in particular, some of the surveys of use of CAM services. Then, we will be moving into the testimony for the day.

It is wonderful to have all the commissioners, the commissioners who are here. Our friend and colleague, Dean Ornish, and his wife Molly just had a baby, and so Dean is not here today. We send our good wishes and our love to him, as he does to us. Then, we will be moving ahead.

David, do you want to begin.

DR. BRESLER: I am David Bresler. I am a professor in the medical school at UCLA. Effie Chow and I were just reminiscing that it was 1969 when we took our first acupuncture course together, so this is my 32nd year of doing acupuncture.

We started our research at UCLA in 1972, and we were the first medical center to get an NIH grant to begin acupuncture research. Back then we used to laugh hysterically about thinking that one day American medicine would take a real serious look at acupuncture and it would be integrated into traditional care, so that a primary care physician seeing a headache patient or a patient with other types of pain would recommend acupuncture first, and we fell on the floor laughing about the prospect of this.

Here we are today talking about this is a very real possibility. I am very excited to be here. I also have an interest in guided imagery, homeopathy, and many other aspects of complementary medicine which we have been doing some research over the years. So, it is great to be here.

DR. GORDON: Thank you, David.

Veronica Gutierrez.

DR. GUTIERREZ: I am a chiropractor from Washington State. I have been in practice for 36 years. One of the things I would like to achieve through my time and service on the commission is to raise the public awareness about the role of chiropractic as it relates to health, wellness, and quality of life.

DR. GORDON: Good. Thank you.

Linnea.

MS. LARSON: My name is Linnea Larson. I have worked as a social worker and a family therapist primarily in medically under-served areas. I have a particular interest in providing these services in those areas and a particular another interest in the relationship of these modalities to hospice care.

DR. GORDON: Thank you.

Don.

DR. WARREN: I am Don Warren. I am from Clinton, Arkansas. I am a general dentist. I practice holistic dentistry, I am a biologic dentist, and that I disagree with some of our colleagues that mercury is a poison, I think it is.

I use homeopathy, I use cranial manipulations through the Sutherland cranial technique of osteopathy. I believe that chiropractic is a big factor in holistic wellness, and to me the opportunity of being on this commission is an opportunity to make a difference, and I look forward to that challenge.

Thank you.

DR. GORDON: Thank you, Don.

Ming Tian.

DR. TIAN: My name is Xiao Ming Tian. I specialize in acupuncture and Chinese medicine. I am involved with clinical work in Bethesda and also I am involved with NIH, am an NIH clinical consultant on acupuncture. This program has been set up 10 years ago as a daily basis to provide service for NIH patients.

Also, I do clinical research with Georgetown Medical School NIH-funded. I treat fibromyalgia patients, and spend more time, more energy to study Chinese herbal medicine to treat osteoarthritis, fibromyalgia, osteoporosis, and sports injuries.

DR. GORDON: Thank you, Ming, very much.

Just so everybody will know everybody, we will go around with the other commissioners who we have gotten to know each other, but we are just meeting the new commissioners, many of us for the first time this morning. So, Conchita, would you like to begin.

DR. PAZ: I am Conchita Paz. I am in private practice and family practice in Las Cruces, New Mexico. I am happy to be on this commission.

DR. GORDON: We will just come right around, Buford.

MR. ROLIN: My name is Buford Rolin. I am health administrator. I work with the Poarch Band of Creek Indians in Alabama and I am very active on the National Indian Health Board and the National Congress of American Indians.

MS. SCOTT: Good morning. My name is Julia

Scott. I am president and CEO of the National Black Women's Health Project.

DR. LOW DOG: Good morning. I am Tieraona Low Dog. I am in private practice in family medicine in Albuquerque, New Mexico, where I work in an integrative medical center, and I have a special passion for herbal medicine.

SISTER KERR: Good morning. I am Charlotte Kerr. I have been a practitioner of traditional acupuncture and faculty member for 24 years, and before that, Assistant Professor of Nursing at the University of Maryland. I am real happy to be here and look forward to hearing from everybody. Thank you.

DR. JONAS: I am Wayne Jonas. I am a family physician and researcher at the Uniformed Services University of the Health Sciences in Bethesda.

DR. FINS: I am Joe Fins. I am a general internist and medical ethicist at Weill Medical College of Cornell University and New York Presbyterian Hospital.

DR. FAIR: I am Bill Fair. I was formerly at Memorial Sloan-Kettering and Emeritus there, and also at Cornell. Currently, I am chairman of the Clinical

Advisory Board of Health, spelled H-a-e-l-t-h, a complementary medical center in Manhattan.

MR. DeVRIES: I am George DeVries. I am chairman and CEO of American Specialty Health. We are a health services organization for complementary health care nationally.

DR. CHOW: Hello. I am Effie Chow. I am president of East West Academy of Healing Arts in San Francisco and I practice Chinese medicine and am Qigong Master and I greet all of you and welcome, and I look forward to hearing from you.

DR. BERNIER: I am George Bernier. I am vice president for Education at the University of Texas at Galveston. I am a hematologist/oncologist by background.

DR. GORDON: We have one member who will be coming later, who is Tom Chappell, who is the co-founder of Tom's of Maine. He will be along fairly soon. He is flying in this morning.

I am Jim Gordon. I am the founder and director of the Center for Mind-Body Medicine here in Washington, D.C., and a clinical professor at Georgetown Medical School. It is great to be with everybody again.

I now turn the meeting over to Steve for a few words.

DR. GROFT: Thank you, Jim, and welcome to everyone especially to the presenters who I guess we have asked to give a five-minute presentation. Many of you have traveled a great distance just to provide us your wisdom and experience and knowledge on CAM interventions, so I do thank you.

It is an awful lot to ask for you to travel that far just for a short period of time, but I think your expanded comments and recommendations that you will provide will be extremely helpful to the Commission.

I think if you just look at what you have seen the members of the Commission carry into the room is a massive document. We had our first meeting in July, a very, very thin thing, and the second meeting was about like this, and I am not sure where we are going by the end of March of 2002, but we are going to try to reduce the volume, but I want you to know that the information you see here is what you generate, it is not what we generated, so we thank you for doing that. It is extremely helpful. You know the issues as well as anyone

else, and we really are looking to you for the expertise.

The focus of this meeting is access to, and delivery of, CAM services. We originally had scheduled reimbursement to go along with this issue, but I think as we got into it, we realized how large both of these sections were, and so we are separating out the reimbursement. We will talk about that later on in the spring, so it will be quite a busy time the next two days.

We are going to be using a representative sample of CAM interventions, and, please, what we have today and what is presented, there are many, many more interventions that we could have selected, but I think we tried to look at those that have some evidence of clinical effectiveness and cost effectiveness, that we might be able to use it as examples for the Commission's report.

We wanted to look at model delivery systems or systems that could be utilized to integrate CAM services into conventional medicine, again, to be utilized within the report itself.

So, you will see the focus of the meeting

shifting a little bit as we go along, and we tried to keep it somewhat coordinated.

Michele Chang, who is over here to Jim's left, is the executive secretary to the Commission, has taken a tremendous role of putting this meeting together, and Dr. Joe Kaczmarczyk, who many of you know from his days with HRSA, has been the program analyst, policy analyst, has done a great deal of work, the bulk of the work just to get this meeting together and to talk with most of you in the audience about the presentations and the need to come and give us that information. So, I would like to thank both of them.

Two other people, who maybe you have seen, Doris Kingsbury, who is around, I am not sure, she may be outside, and Geri Pollen, if Geri is in the audience -- we have got a great working schedule. I am not sure where we have been or where we are going, but we are here today.

Again, if any of the staff members, if you have any concerns or needs, both the commission members and the audience, please see one of us and express your concerns or needs, and we will try to respond to them as

well as we can.

For the commission members, we are at the point where we have to start to thinking of recommendations. We need to develop an interim report by July. We will talk more about this later on. So, start to think about what recommendations you might want to see.

We have had two town meetings, town hall meetings, we will have a third one in January. This is our second major issues, so by the end of these two sessions, we will have some idea of what we might want to think about for further discussions.

We also need your guidance, if the format that we are presenting, if this is adequate to give you the information you need or however else you would like us to structure the meetings, so we will have time to discuss this as the two days go on here, so we are looking forward to your comments.

One last person that I would like to introduce is Jim Swyers. Jim is a medical writer/editor who will be helping us write and edit the report, so you know we are getting serious once we start employing a writer/editor we are starting.

I think we are ready to go and Jim is ready to go, and so we are anxious for a good session these next two days.

DR. GORDON: Thank you, Steve.

**Session I: Overview of CAM Utilization**

DR. GORDON: Just a couple things I wanted to say about planning of future sessions. Everybody here signed up I believe for at least one of the committees for future sessions.

This morning when Tieraona and George DeVries and I were talking, I realized how much they knew and how valuable their contributions would be in the area of education and licensure, so I asked if they would volunteer to be on those committees, and they graciously agreed.

So, what I want to do is encourage everyone here on the commission to please jump in, we really need everybody's thoughts and everybody's input to formulate these sessions just as we have done for this session, so come ahead if you are interested in participating.

Also, we are going to have one of the issues that was raised in the last commission meeting was having

time for us to get together both informally and also to have more discussion, so most of you were here at breakfast this morning, which was great, just to have time to hang out with each other, and at the end of the second day we are also going to have some time to review what has happened in these two days. A number of people said that that would be useful to do. So, if you look on the schedule, you will see that there is time.

The other thing I want to say is that we are going to make -- one of the great things about the way the commission is evolving is that so many more people from the community are coming and wanting to participate, and we have two full agendas of public comment, and we are going to do our best to add on some more time for those of you who also want to be involved in public comment, and I think that this is a very exciting development as the commission gathers momentum.

I just want to say a couple words about the Seattle meeting, which a number of us were present at in the town hall, and that it was, I think we all agreed because we talked about it afterwards, a very inspiring experience in that we saw a whole community which had not

only moved ahead to offer CAM and make CAM services much more available to the citizens, but that it truly had taken major steps toward integration at every level from the provision of services in the community to research projects jointly undertaken by CAM institutions like Bastyr and conventional medical schools like the University of Washington, to a public agenda set by the Washington State Insurance Commissioner mandating coverage of CAM services.

In a way, most impressively of all, at least to me, the passion of the King County Council for creating a more integrative medicine that would truly serve all the people in King County.

Several of them came and testified and they welcomed us to their council chambers, and, in fact, they are the ones that are responsible for pulling together the entire meeting, so it was very exciting and a real example, I think, and the summaries and transcripts of that meeting are being put up on our web site now, so everybody can take a look at them.

The other thing I want to say, both to the commissioners here and also to everybody in the audience

is that these town hall meetings are immensely valuable and they are valuable to us in shaping our recommendations.

They are valuable in terms of helping us to decide who we will invite here to Washington, and several of you are here because we have heard you in Seattle and now we want all of the commissioners to hear you.

They are also valuable, and this is really important, for helping communities to organize themselves and to get together. One of the things we heard from the people in Seattle was how useful planning for the meeting and working together was, not only in presenting material to us at the meeting, but also in advancing through thoughtfulness about integrative medicine in the community as a whole.

So, we urge all of you, our schedule of our meetings of our town halls is all up on the web site, and I would ask all of the commissioners, as we come to areas near you, to work with people in those areas to help to bring them in.

I am going to open the meeting fairly briefly and give a little bit of survey of some of the surveys on

CAM usage. This meeting, as Steve said, is really about services and service delivery and access to services.

So, we thought it would be useful to begin by sharing, that I could share a little bit of my perspective on the evolution of CAM services, and share with you some of the studies, some of the information from some of the many studies, and as Joe pulled together the abstracts and the papers for me, I saw how many studies there are now on the usage of CAM services in various communities for various kinds of illnesses at various ages. It is a rich literature.

I want to recommend both to the commissioners and to people in the audience I think a kind of nice summary of the surveys, which I hope we will be able to provide that to everybody. There is a paper by Jackie Wooten and Andrew Sparber called appropriately enough, "Surveys of Complementary and Alternative Medicine," and it is in the current Review of Alternative Medicine from 1999. It gives I think a very nice survey of all the surveys with some of the essential findings in the surveys.

I am not going to try to be encyclopedic in 10

minutes this morning. What I want to do is hit on a few highlights and then we can take a couple minutes if people would like to add thoughts to this overview.

As David was speaking earlier this morning and introducing himself, I was thinking back to the work that he and I began to do almost 25 years ago, and that I began to do at NIMH in the early 1970s, looking at this new field of holistic -- what we then called "holistic" medicine, and often still do call "holistic" medicine -- and thinking about the change is really quite extraordinary because, on the one hand, it is something that all of us felt in our bones might well happen and yet at the same time, we are both surprised and delighted that it is happening at this level, that we really are interested in creating a much larger vision of what medicine can be.

What we have seen in recent years is an acceleration of this process, an acceleration in people using these therapies, in the integration of these therapies into medical school and other professional school curricula, in the coverage of these therapies by insurance companies, and in the development of research

and of integrative programs.

I just want to touch a little bit on some of these developments and indicate how they relate to our mission as a commission.

Two of the more important studies in this area that have been done in recent years were by Eisenberg and his colleagues, the initial study on 1990 data, and the second one on 1997 data, on the use of alternative therapies by Americans.

I am sure these figures are familiar to most, if not all of you, but I am just going to go over a few of them very quickly.

The 1990 survey, which was published in January 1993 in the New England Journal of Medicine, showed that 34 percent of all Americans had, in 1990, used one or another alternative therapy as part of their health care and that they had then made 427 million visits to alternative care practitioners.

The 1997 survey, the figures were 42 percent and 629 million visits. That was more visits then to all primary care physicians. An American spent more money on that care, and the estimates vary from 27 to 34 billion

out of pocket than they did on visits to primary care physicians out of pocket.

Now, there have been a number of other studies that have been done, John Astin's study, for example, which also appeared in the Journal of the American Medical Association.

The numbers of people using alternative therapies -- and the definitions differ slightly, however, I would hasten to add that whatever the definitions, they include all of the therapies that are going to be presented this morning, on which data are going to be presented -- the numbers differ slightly, but the number of 40 percent stands as a reasonably reliable number across all populations.

One thing I do want to add, though, that was noted in the second Eisenberg study, and I think is very important for us here, is that that number is based on phone surveys of English-speaking people, and that there is a huge group of people in this country who do not speak English, for whom what we call "alternative or complementary medicine" is, in fact, primary care, and I think one of the charges of the Commission is to address

the needs of those people and to understand the importance of the contributions that those people make to our health care system, as well as the needs that they have from our health care system.

There are a few myths. One of the other things about the Eisenberg study that is very interesting is that in the last seven years, some of the things that have shown up are some of the usage of alternative therapies has increased somewhat, but the usage of some therapies has gone up at a much greater rate.

For example, there is 130 percent greater usage of megavitamin therapy in 1997 than in 1990, and 380 percent greater usage of herbal therapies and almost as great an increase in usage of homeopathic remedies.

So, this is another area in which we need to pay attention, understanding that some therapies are increasing steadily as, for example, the use of chiropractic, but that other therapies that were used very little are now being used a great deal more.

There are a few myths that have come up and that I think that the survey data, taken as a whole, tends to dissipate. One is that people who use

alternative therapies tend to turn their back on conventional medicine.

I think it is pretty clear from the surveys that that is not true at all, that in the Astin survey, for example, only 5 percent of those people who used complementary or alternative therapies felt somehow in opposition to, and totally disillusioned with, conventional medicine.

The rest of the people saw these therapies as very much a part of an integrative approach, so I think that is a myth or, if you will, a red herring that we are talking about something that is in opposition even though there may be reasons why people move away from conventional therapies.

The second myth is that this is essentially an upper middle-class movement, and I think partly because of the way the surveys are done, that people have tended to believe that, that it is better educated, mostly white people who use these therapies.

When you look at other populations, when you look at rural poor populations, or indeed a population of homeless young people in the city, in this case in

Seattle, Washington, who have access to CAM services, the utilization goes way up. So, for example, 70 percent of runaway and homeless kids were using CAM therapies.

When you look at minority communities -- we will hear some testimony later in the day from a program with which I work, ARRIVE, in New York, which is about 80 percent minority, HIV-positive, mostly, although not all, ex-prisoners -- the vast majority of those people are using complementary and alternative therapies because they believe they work and because they have access to them.

A third myth that sometimes comes up is that these are therapies that are used by the worried well or by people who are in life-threatening situations. Some of the interesting surveys are on people coming in for cardiac surgery and other kinds of surgery, which showed that prior to the surgery, anywhere from 70 to 80 percent of the people who are coming in for surgery are using one or more complementary or alternative therapies, particularly nutritional therapies and use of megavitamins.

I also think it is important to say that when

you look through the surveys, that although an earlier survey by Ernst and Kastle, that showed a very variable use of CAM therapies by people with one particular life-threatening illness, cancer, and their range was from 7 to 64 percent, more recent surveys, for example, Mary Ann Richardson's survey from the Journal of Clinical Oncology this July, or another survey, which was done in M.D. Anderson, or another survey by Kelly at Columbia Presbyterian Hospital on children, people with pediatric cancers, are showing that the figures of usage are anywhere between the high 60s and the low 80 percent of people with cancer are using these therapies.

So, it seems like especially in the area of life-threatening illness that there is a significant increase in the use of these therapies. The same is true with HIV and AIDS, and not only, I would add, among perhaps the better educated gay population, but also among people who are IV drug users who tend to have less education, that there is a major trend.

I was recently speaking at AIDS Day in New Jersey, and many of the programs there, there is close to 100 percent desire to use CAM therapies and up to 70 to

80 percent of the programs, and there is some interesting surveys that have been done on that, as well.

Now, not only are CAM therapies being more widely utilized, but physicians are increasingly willing to refer to CAM therapists. A couple of studies that have been done, one by Berman in the Journal of the American Board of Family Practice and another by Astin in the Archives of Internal Medicine show an increasing willingness of physicians, particularly of primary care physicians, to refer to complementary and alternative practitioners.

Eighty to 90 percent are willing to refer to people who work with hypnosis and biofeedback, imagery, and other mind-body therapies. About 40 percent are referring now in both of those surveys to acupuncturists, and these physicians are also extremely eager for information about the therapies.

The data on medical schools show that the physicians to be in allopathic medical schools are also very eager for these, to learn more about these therapies, and the study that was published by Wetzel and Eisenberg and others in JAMA in 1998 showed that 64

percent of all medical schools were offering at least elective courses in these therapies, and I would imagine, based on my own observations, the figure is significantly higher now.

Now, a few problems arise, and these are some of the problems that we are going to be addressing here, a few of the sort of areas that we clearly need more information.

One is -- and this is the primary purpose of today's meeting and, as well, of tomorrow's -- is we need more data on effectiveness and cost effectiveness, and this is why we have called in all of you whom we have called in to present to us. We have asked you the question: Are these therapies working, in which areas, what are the limitations, and what is the data on cost effectiveness, so-called?

We also need to work much more on the issue of integration, and this is something that we have talked about, talked continually about, but I think is central and I think we are going to be called on to make recommendations in this area.

Here are 40, perhaps 50 percent of the people

in the United States using these therapies with life-threatening illnesses like cancer and HIV, up to 70, 80 percent of people, how well are these therapies currently integrated, and we are going to hear today about some models of integration, and we are going to be asking those of you who are presenting data on those models how we can improve on it, what are the lessons you are learning, how well is it working, what more would you like to do.

In many areas, integration is not working terribly well so far. As I reviewed the studies on treatment of HIV, it was very, very interesting and very disheartening that very few of the people who are HIV-positive talked about their use of CAM therapies to their physicians.

There is an interesting study, some of the studies as low as 17 percent, and when you ask people, as I have done, why not, they say because every time I start to bring it up, my physician seems very uncomfortable, and I don't want to upset him, and I don't want him to be angry with me.

On the other side, there is a very interesting

study that I read for the first time by Winnea showing that only 26 percent of physicians who are treating HIV-positive people are asking them whether or not they are using CAM therapies even though 36 percent of the physicians themselves use CAM therapies.

So, there is something of a disconnect, and I think on both sides we have to consider how do we encourage people to talk with their physicians, how do we encourage physicians to talk with their patients, and how do we encourage more integration.

This is not only confined to the area of HIV. There was another study on surgical procedures, cardiac surgical procedures. Only 17 percent of people getting ready for cardiac surgery told their physicians about the CAM therapies they were using, and, of course, many of those people were using therapies that might affect coagulability, so they might make for an operative risk by not talking about the use of therapies.

The other thing that I found interesting is that 48 percent of those people did not want to talk, deliberately did not want to talk, and did not want to ever talk with their physicians about their use of CAM

therapies because they were afraid of the response that they might get.

So, I think there are a lot of possibilities for us today. I think, number one, we are being asked very strongly by the people who are using these therapies, we are asked for help in determining which of them work and which of them don't work and in which situations.

We are asked by the people who are providing coverage for the people who are using these therapies how can this be done, what is the cost effectiveness, how can we still survive as an entity and provide coverage, how can we provide standard medical coverage and coverage for these therapies.

We will come back to some of these issues when we focus on reimbursement in the spring. Right now what we are focusing on is what is the data that we have, but I think we always need, as a number of you have said in the last meetings, we always need to have in our mind how is this going to fit into a schema of reimbursement.

If these therapies are effective, what kind of models of integration should we be recommending? This is

an important issue, and we will be hearing from some people with models of integration.

If physicians are interested, what kind of information, what kind of education do they need, and physicians do seem increasingly to be interested, what kind of information, as, for example, the information that is being presented to us, and what other information do they need to be presented with.

Finally, how can we encourage, since we know that if these therapies are available to people, if they are available to people with cancer, they would use them, if they were available to poor people and people of color who are HIV-positive, they would use them, if they are available to homeless people and homeless children, they, as well as middle-class people with significant education, will use these therapies.

So, the final challenge and where we come down to with this meeting, is how do we, having sorted out or having helped sort out which of these therapies seem to be most effective, how do we not only find out the information that we need to determine more definitively which are most effective, but as we determine this, how

do we make sure they are available in an integrative way to everyone in this country.

Let me conclude with that, and if there are any additions or comments, we can spend a couple minutes on them.

Charlotte.

**Commission Discussion**

SISTER KERR: Just a quick question. When you mentioned the 380 percent increase, and you said it was herbal and homeopathic, did they separate that?

DR. GORDON: No, those are separate. It is 380 percent for herbal. There is about a 300 percent increase for homeopathic.

SISTER KERR: Is there, by any chance, any relationship to when marketing began with the herbal products?

DR. GORDON: The suggestion has been that the relationship is to DuShea, in part, yes, and therefore to marketing, as well. That was a suggestion made by actually several different surveys that showed that increase in herbals.

Wayne.

DR. JONAS: Just along those same lines, which, Charlotte, I think you are getting at is kind of behind the statistics are the reasons why there is the increased access or utilization, and I think if we are going to address access, we need to begin to delve into those.

Along those lines, as you know, Jim, there was a book that has just come out on the social dynamics of CAM use, and this was actually the result of a conference that the OAM sponsored, we sponsored with the University of Toronto about two years ago, which looked at a number of surveys, as well as detailed qualitative assessments as to why individuals actually were interested, how they were using them, how are they getting information about them, and what the influence circles were, so I think this would be important information. I am sure we will get some of that.

DR. GORDON: Thank you. One thing that I just want to mention, and I am glad you reminded me, is that a couple of the factors that are really important are, number one, people coming up against the limitations of what is available in conventional medicine, but also, and equally importantly, it would seem a different kind of

relationship with CAM providers that people perceive and often find.

John Astin certainly talks about a congruence of world view, and I think in another sense -- and this again gets to the whole reimbursement issue -- time spent is a major issue, and I think we do have to pay attention to that, that regardless of what people are doing, they are spending more time, they are listening more, they are paying attention more to the whole person who is in front of them, and that is one of the shaping factors.

Joe.

DR. FINS: Jim, did you come across any data linking increased utilization of CAM therapies with decreased access to health insurance and sort of the overall question of access in general, because I have increasingly heard of some who are disenfranchised, marginalized members of our community turning to CAM, not as an alternative, but as a substitute for proven convention therapy, and I think we need to put that on the table because I think we wouldn't want to see this as a substitute, but only as an alternative, as an integrative approach, and not as a substitute.

DR. GORDON: I haven't come across that. Have you, Wayne, or has anybody else?

DR. JONAS: Yes, actually, a couple of the surveys that you mentioned, very few -- and this is why actually I mentioned getting behind just the statistical data to try to find out why people are doing this, and in some of the homeless data, there is evidence that they don't have access, they don't go and seek the conventional types of care, and yet, they seek remedies on their own of a variety of types. So, whether that is due to the fact that they would or not, I don't know.

On the other hand, individuals that do have health insurance, then, it is often the lack of reimbursement then is actually an interference with them. They would say "I would go get it if, in fact, it was reimbursed." So, I think it could work either way.

DR. GORDON: I would actually interpret the homeless data somewhat differently. The people I work with, the reason they don't go is not because they don't have access to it.

They don't like the way they are treated, because poor people, street people know you can always go

to a hospital, and hospitals are often places that street people sleep even when they don't go for care, but they often don't feel they are cared for when they go there, and I think that that, rather than the absolute denial of access, is the major factor.

The people I work with, a lot of them do live on the street, and that is what they will say, and not just street people, but sort of working poor people.

I think any of us, well, we know if you go to a city hospital system, you wait for a long, long time, and if you can go to a clinic -- and we will be hearing from some of the clinics here and also in New York where people go where they see someone within 20 minutes or half an hour instead of waiting four or five hours, but I think we might want to take a closer look at those issues, too, and see what is going on.

Thank you. We can come back and discuss this context and some of these issues at the end of tomorrow afternoon as we pull together everything that we will have learned in two days.

Let's call the first panel.

MS. CHANG: If the following speakers can come

up to the panel, we will take four at a time here - Dr. Meeker, Dr. Kail, Patricia Culliton, and Joyce Frye, and Tiffany Field actually. We will have to get another chair, sorry about that.

DR. GORDON: We need another chair and a little more table.

It is wonderful to see you all and we welcome you, and I think we will try to provide a little more table space from now on. Beyond that, we are very glad to have you and we are going to be forced to ask you to be brief in your oral testimony.

Let me explain to everyone that is partly because there are so many people from whom we want to hear, partly because we want to have the commissioners have an opportunity to have a dialogue and to take more time with dialogue about the issues that are raised.

Also, we do welcome -- and I want to say this again to all of the people who are presenting -- we do welcome not only the written testimony that you have given us so far, but any additional written testimony that you have. We will be reading it and integrating it.

Let's begin with Bill Meeker.

## Session II: Clinical and Cost Effectiveness of Selected CAM Services

### Chiropractic Practice

DR. MEEKER: Good morning, everybody. Thank you very much for inviting me once again to address this panel. I am very honored to do that.

As you know, I am going to make some very brief commentary related to the things that I submitted already and hopefully, in our discussion later, will be able to give you a chance to kind of dive into some of the details.

I do want to say right up-front, though, that there are three very, very key references I think that the Commission should be aware of, and I mentioned them in my report.

Two of them are government-sponsored monographs, one by the U.S. Government, the Agency for Health Care Policy and Research, Monograph on Chiropractic. Another one, sponsored by the Canadian Government VIRGE made to this panel entitled, "The Effectiveness and Cost Effectiveness of Chiropractic Medicine on Low Back Pain by Pran Manger and a team of

economists, and then finally, a very recent monograph put out by the National Board of Chiropractic Examiners, which is a major survey and job analysis of chiropractic practices based on a random survey of practices in the United States.

I think these are very key documents that would be very useful to the panel as you look into this profession.

I also have a summary report of the Manger report here to pass out if anybody would like to have that.

I was asked to address the clinical effectiveness of chiropractic practice and to summarize the data regarding some specific health conditions, the populations, the practice settings, and the type of practitioner. I want to say right up-front that chiropractic is a very mainstream profession already. Chiropractors see about 25 million patients a year in the United States.

I also want to make the point, as I did once before, that when we are talking about CAM in general, we have to make a distinction between CAM professions and

CAM procedures and substances, because the issues for an entire profession, a CAM profession, may be a little more -- well, I don't want to say a "little more complex" -- I think they are quite more complex than simply dealing with innovative or new procedures or behaviors or substances that might be part of the CAM constellation of things. We have to keep that distinction in mind as we talk about integration and cost effectiveness and effectiveness in addition to everything else.

Chiropractors, of course, use spinal adjustments, spinal manipulations is their primary signature treatment. Chiropractors also deliver a great deal of other forms of care especially exercise and nutrition advice, health promotion, preventive advice, physical therapy modalities, et cetera.

So, when we talk about studies on the effectiveness and cost effectiveness of chiropractic, we are really talking about packages of various types of procedures, and it is very hard to distinguish one thing from the other, so most of my commentary is going to be today, I want to talk about effectiveness studies. I am going to be talking about randomized controlled trials of

spinal manipulation or spinal adjustment only. We are not talking about chiropractor care as a package. That has not been studied all that much, although there are some studies out there.

When I talk about cost effectiveness studies, however, we are comparing usually chiropractic care to medical care for some specific types of conditions. Usually, those have been workplace injuries, very often are for low back pain or neck pain.

In terms of the types of patients that go to chiropractors, it pretty much is a cross-section of demographic categories in the United States. Chiropractic patients come from all walks of life, all age and occupational groups, educational levels, economic levels, et cetera.

Patients less than 18 years old account for approximately 12 percent, and patients 65 years and older make up approximately 15 percent of the chiropractic patient population.

My goodness, that time sure does go fast.

There are about 70 randomized trials of spinal manipulation or adjustment for various types of

conditions, mostly head pain, back pain, and neck pain, and about two-thirds of those have shown advantage to manipulation. Manipulation has been rated as an effective treatment by the United States Government, by the UK, Denmark, New Zealand, Australia, and Sweden, and I think a few others, as well.

In terms of cost effectiveness studies, there are approximately 40 studies in this area. Those have all suffered from various methodological problems, and suffice as to say that at this point, it looks like chiropractic and medical care is about the same cost except that chiropractic patients tend to be much more highly satisfied with their care, a great area there for additional work.

I will try to quickly summarize. Let me say this about integration just quickly here. Chiropractic is very well integrated at the health consumer level and, to some extent, at the reimbursement and the delivery systems levels, but when it comes to true interdisciplinary practice, it is very, very rare and we have a lot of work to do in that regard, but when we are talking about interdisciplinary practice, it is really a

different animal than talking about integration at that level, you are talking about a much different animal than integration at the health consumer level.

DR. GORDON: Next is Konrad Kail.

**Naturopathic Medicine**

DR. KAIL: Good morning.

Naturopathic medical education trains family practitioners in preventive medicine and natural therapeutics. There are four accredited schools in North America which teach primary alternative mentalities of lifestyle modification, clinical orthomolecular nutrition, botanical medicine, energy medicine, physical medicine, psychological medicine, minor surgery, and obstetrics.

These schools teach about 200 classroom hours per modality. The scope of practice varies according to the jurisdiction and the licensure. The broadest scope jurisdictions include prescription and controlled substances and all routes of administration including intravenous.

It has only been recently with the advent of the National Center on Complementary and Alternative

Medicine that we have actually had funding to be able to look at outcomes. However, a Medline search of peer-reviewed literature showed between 300 and 7,000 citations in the peer-reviewed literature for these various modalities, however, all of these studies look at individual modalities, however, naturopathic medicine combines these modalities into treatment protocols. That has never been studied at all.

Also, there is a relative paucity of controlled clinical trials available for review. There is also only a short history of limited third-party reimbursement to look at utilization and cost effectiveness issues.

A 1996 study by Emsley, et al., published in Complementary Therapies in Medicine, compared the efficacy of orthodox medicine and manipulation, homeopathy, botanicals, and acupuncture in a variety of conditions.

On a scale of 1 to 5, with 1 not being effective and 5 very effective, manipulation scored about 2.14, botanicals 2.9, homeopathy 2.9, and acupuncture 3.6 compared to orthodox medicine, which was 2.48.

Orthodox medicine was rated most efficacious in

severe, acute problems, but ranked less efficacious in less acute and chronic diseases.

The same study showed varying results when broken down by specific diseases. Patients of naturopathic physicians tend to regard them as their primary care physicians, although many also see allopathic physicians because of insurance reimbursement. Ninety-seven percent of those surveyed said if insurance was no issue, their naturopathic physicians would be their first and primary choice.

Potential cost savings come from several areas. Because patients are educated about how to stay healthier through lifestyle intervention and because the nutritional, botanical, and homeopathic medicines that are prescribed by their naturopathic physicians become a home medical chest, so to speak, for patients to treat themselves, patients require less office visits, and that greatly reduces the cost.

A survey done by John Weekes in 1996 showed that respondents actually used less pharmaceutical medication and actually avoided surgery and other procedures.

When you look at numbers of visits and duration of care, the average number of visits per year of naturopathic physicians was 2.6 when compared with 2.4 visits per year to orthodox family physicians. Sicker people required more visits, and duration of relationships was similar to family practice medicine.

The American Association of Naturopathic Physicians showed that when looking at cost comparisons of allopathic and naturopathic care for an acute problem, such as otitis media, minimal care costs were similar.

When looking at extended care for the same problem, the cost differential was large. Naturopathic physicians rarely need to refer patients for insertions of ear drainage tubes.

When looking at allopathic and naturopathic management of chronic diseases, the cost differential varies depending on the disease. For example, the cost of treating hypertension is almost identical in the two systems, but when looking at rheumatoid arthritis, the cost differential is large when comparing allopathic and naturopathic treatment.

Unfortunately, few third-party payers reimburse

for naturopathic medical care. Most patients still pay out of pocket for alternative care. The Abbott Northwestern Hospital consumer study done by National Research Corporation found that most people spent between 100 and $300 out of pocket in expenses for alternative care between 1993 and 1995.

Botanical and homeopathic therapeutics were rated as the most satisfactory of alternative treatments with dietary and chiropractic services being less satisfactory, however, in general, consumers were well satisfied with their alternative medical experience.

Naturopathic medicine is a stand-alone primary health care and is most effective in areas where allopathic disease management is least effective, that is, in prevention of disease and in chronic disease management.

The two systems of medicine complement each other well, and the American public would greatly benefit from their integration. Naturopathic medicine must be able to apply the same level of scrutiny that has been applied to conventional medicine in order for it to be proven safe and efficacious by use by the American

public.

I urge you to recommend greater funding for the National Center for the Complementary and Alternative Medicine, which is still funded at less than one-tenth of 1 percent of the NIH budget.

I also find it unfortunate that the vast majority of people who need this medicine the most have no access to it. I am referring to the elderly, the poor, and the disenfranchised who are unable to pay out of pocket for these services.

It is extremely important that you recommend inclusionary language for alternative medicine in entitlement acts, such as Medicare, Medicaid, Indian Health Service, and CHAMPUS for the military. Only then will third-party payers reimburse for these services to any great extent. Only then will the great majority of Americans be able to realize the right to choose the physician and health care services they want.

I will conclude with a quote from the U.S. Preventative Services Task Force. "Lack of evidence of effectiveness does not constitute evidence of ineffectiveness."

Thank you for your time and attention.

DR. GORDON: Thank you, Konrad.

Patricia Culliton.

**Acupuncture**

MS. CULLITON: Thank you. Good morning. Thank you very much for having me here. I am going to speak on acupuncture, cost effectiveness and clinical efficacy, and hopefully have a little bit of time to mention some policy items.

When Dr. Kaczmarczyk sent me a list of questions to answer for this commission, I looked at it and said, well, give me three years, a hefty budget, and turn me loose, I would love to find out the answers to these questions, but unfortunately, I had one week, and so I will do what I can.

Many of you on the panel know about acupuncture, and so I don't feel that I need to spend a lot of time talking about the clinical efficacy of acupuncture with its 4,000-year history and rapid growth in the United States, but it might surprise you to know that there have only been 79 NIH-funded projects to research the use of acupuncture, half of those being done

in the early seventies with people like you, and when the United States kind of first discovered acupuncture after we opened our relationships with China.

Thirty-eight studies have been done since 1992 with the funding of the Office of Alternative Medicine, so as the naturopathic data is similar to the acupuncture data in that it is in its infancy in being developed.

We do know that there are clinical efficacy studies. The National Institutes of Health held a consensus development conference on acupuncture in 1997, so that puts it in a different status I think than a lot of other alternative modalities, but in that consensus conference, only two areas of utilization for acupuncture were considered to have definitive data, and then there are several other areas that had positive trends.

So, again, I also would strongly recommend further research dollars for the research relative to the clinical efficacy of acupuncture, but clearly, we have a very good beginning to that from everything from angina. A lot of people think that acupuncture is useful for musculoskeletal pain and analgesia, but there are also good data on acupuncture for such things as breech

version and nausea and vomiting, dysmenorrhea, bladder disorders, et cetera, so the whole wide range of what acupuncture might be beneficial for, and, of course, the development of clinical pathways, et cetera, is yet to be accomplished.

Relative to cost effectiveness, there are no major cost effectiveness studies that have been done yet on acupuncture. There are several studies that were clinical studies that in the analysis of data, we are able to discover that people in the experimental group that received acupuncture had significant financial savings than people that were in the control group. Again, I would love to be involved or I would highly recommend that a large clinical effectiveness study or cost effectiveness study for acupuncture be implemented.

Because this is a policy commission, I thought, as I said, since so many of you are familiar with acupuncture data already, what I really wanted to devote most of my attention to is the consideration of some policies.

I think it is extremely important that medical education, nursing education include an overview of all

complementary medicine, and as Dr. Gordon said, that is happening already, but in 1957, all the practicing physicians in China were required to study acupuncture for two years. They weren't happy about it, but it certainly changed the health care delivery system in China after that.

I am not saying that I want you to request that all physicians suddenly go back to college for two more years, but to strongly recommend that CME courses and CEU courses be available specific to acupuncture, but for CAM modalities in general, I think is just absolutely necessary at this point.

Public education, some of the surveys that have been done on acupuncture, Eisenberg and the Paramor and the Robert Wood Johnson Foundation study, all done in 1997, say that less than 1 percent of Americans have ever tried acupuncture, and a 1999 landmark study said it is up to about 2 percent of Americans, but that a very small portion of the United States has even tried acupuncture. Since we do tend to think that the data supports clinical and cost effectiveness, I would like to see a public education program implemented, as well.

One thing that is very dear to my heart is public health, and I would like you to consider a school loan forgiveness program for those people going to acupuncture school, that would commit themselves to work in public health agencies after graduation.

I know I just have a few seconds, but I want to say that I am involved with the National Acupuncture Detoxification Association, as well as other acupuncture organizations, but thousands of Americans right now are being deferred from prison into acupuncture programs for first-time felony cocaine offenses. Forty percent of the drug courts in the United States use acupuncture as their primary treatment.

The estimates are that it is between 30- and $40,000 per year for a one-year incarceration, and thousands of people have avoided incarceration by the use of acupuncture in the drug court program.

That cost savings is staggering, and nobody has really looked at those numbers, but we can just extrapolate those numbers that just relative to public health, the cost savings to the American health system I think are absolutely staggering. I encourage you to

consider that.

Thank you.

DR. GORDON: Thank you very much.

Joyce Frye.

## Homeopathy

DR. FRYE: Good morning and thank you for the opportunity to join you today.

According to the World Health Organization, homeopathy is the second most widely practiced form of medicine around the globe. The International Homeopathic Medical Organization LIGA has thousands of members in five continents in over 40 countries.

Unfortunately, although there are an estimated 2,500 medical practitioners using homeopathy in the U.S., research on both clinical efficacy and cost effectiveness has suffered from limitations that are common to all of the CAM practices.

Thus, our assumptions about the advantages of fully integrating homeopathy into the U.S. health care system are augmented with international and historical data, as well as a 200-year collection of thousands of case histories.

The most useful summary of clinical efficacy is provided by the meta-analysis of 89 placebo-controlled trials published by Lynde, et al., in Lancet September 1997, indicating that patients using homeopathy were two and a half times more likely to have a therapeutic effect compared to placebo in a variety of conditions.

References to a number of additional studies on treatment of specific conditions are included I believe in your handout.

The most complete data on cost effectiveness comes from the French Government report on 1991 Social Security statistics which demonstrated significantly reduced costs using homeopathic versus conventional medical care.

The total cost of care in the office setting for a physician utilizing homeopathy was approximately one-half of the total cost of care provided by conventional primary care physicians even when factoring in the cost of fewer patients seen per homeopathic physician, the overall cost per patient under homeopathic care was 15 percent less, and savings increased the longer a physician had been using homeopathy.

Additionally, in a further review of the data, the number of paid sick leave days by patients under the care of homeopathic physicians was three and a half times less than patients under the care of conventional practitioners, and while homeopathic prescriptions, which are reimbursable in the French health care system, represented 5 percent of all medicines prescribed, they represented only 1.2 percent of all drug reimbursements due to their lower costs per prescription.

These data are particularly compelling in view of France's number one rank in overall health system performance, and number three rank in life expectancy according to the World Health Organization compared to number 37 and 24 for the U.S. respectively.

In the U.S., a small study surveyed 27 physicians specializing in homeopathy and compared them to the 205 general and family practitioners in the 1990 National Ambulatory Medical Care Survey.

The comparison tables and charts from that study are also provided in your handout. Again, although spending more time with patients, they ordered fewer tests and prescribed fewer conventional medicines for

similar conditions.

Homeopathy also compared favorably with naturopathic and acupuncture services in a Seattle study that concluded that homeopathy was the least costly and that patient visits to homeopaths were less frequent than to other alternative care professionals.

Patient satisfaction with homeopathic care tends to be high if for no other reason than the time a practitioner takes in listening to the story. However, a California study also surveyed patients regarding their clinical course.

Eighty percent of them had previously sought conventional care for their condition. After four months of homeopathic care, 60 percent reported improved overall health status and outlook, 70 percent reported at least partial improvement in their chief complaint, and 80 percent planned to continue homeopathic care.

Homeopathy is effective for a variety of health conditions throughout the continuum of care from pregnancy to the end of life without regard to age, gender, or occupation.

With respect to our colleagues, the organism is

certainly best equipped to respond to a homeopathic medicine when it is also well nourished and in musculoskeletal alignment, however, we see homeopathy as the first therapy to consider in many circumstances.

We have no data comparing costs from one setting to another, and I would propose that the most appropriate setting, degree of collaboration, and type of practitioner vary with the type and acuity of the condition being treated. Consider the following framework.

For minor viral infections and traumas, the most appropriate care setting is usually in the home. An estimated 3.4 percent of the U.S. population was using homeopathy in the 1997 Eisenberg study. It is difficult to assess how many physician visits might be avoided all together if public awareness of homeopathic self-care was widespread.

That, in turn, would decrease the accompanying long-term sequelae of inappropriate antibiotic use, increasing antibiotic resistance, and iatrogenic illness.

For more serious acute conditions, homeopathy may provide complete care in the hands of the primary

care provider. Indeed, in the flu pandemic of 1918, where over half a million Americans succumbed and the average mortality was 30 percent, less than 1 percent of patients treated homeopathically were lost, with some homeopathic physicians reporting treatment of thousands of cases.

In the realm of obstetrics, I have used homeopathy to treat nausea and vomiting, to arrest preterm labor, to convert breech presentations, to facilitate labor, thereby avoiding numerous hospitalizations, procedures, and intensive care days.

The framework goes on through the entire continuum of care.

I would like to just cover what we perceive as the current barriers.

DR. GORDON: We need to move very quickly, though.

DR. FRYE: Okay. Patients confuse the "h" words, holistic, herbal, and homeopathy, thinking that they are synonymous. The number of homeopathic medical practitioners is very limited due to expensive and prolonged postgraduate education and lack of CME

accreditation.

Insurance policies and billing codes are biased towards procedures rather than time spent, and nonmedically licensed practitioners, who wish to practice homeopathy, are similar to their counterparts in Great Britain and other countries, have uncertain legal status in the U.S.

DR. GORDON: Thank you, and we will come back to the recommendations in the discussion period. Thank you very much.

Tiffany Field.

**Massage Therapy**

DR. FIELD: Thank you for inviting me. I am going to talk about massage therapy, which I guess could be classified, along with acupuncture, as one of the oldest therapies. If one goes back to Hippocrates in 400 B.C., he said that medicine was the art of rubbing.

That has been pretty much forgotten. Massage therapy disappeared from the hospital scene. Perhaps you remember if you were hospitalized in the forties, you routinely got a back rub at least to avoid bed sores, but in the fifties, much of that disappeared from the

hospital networks.

According to Eisenberg and a number of those other epidemiology studies that have been done, massage therapy is among the top half dozen or so of the alternative therapies that are being sought by the American public, and the field of massage therapy itself is one of the fastest growing professions at least in the United States, so there is some sense of movement of the field being reinstated as a therapy.

There is not very much research on the effectiveness of massage therapy. Much of the research that has been conducted has come out of the touch research institutes over the last decade, and we have conducted approximately 83 studies in different areas from growth problems, for example, reducing prematurity and low birth rates associated with pregnancy, stress, and anxiety, enhancing the growth of preterm babies whose agenda once they are out of medical jeopardy is to gain weight.

A number of studies in the psychiatric area including attention deficit disorder, autism, depression, related addictions, such as eating disorders and smoking,

and then a number of pain syndromes including migraine headaches, low back pain, fibromyalgia, premenstrual syndrome, and so on.

Much of our recent work has been focused on autoimmune problems, everything from asthma to diabetes to dermatitis, and immune problems, namely, HIV and cancer.

I think the most exciting findings aside from the preemie growth studies, which I am going to elaborate on a little bit for the cost effectiveness part of this, but aside from that, I think the most exciting data are the data associated with the HIV and breast cancer studies showing that not only can we increase natural killer cells and natural killer cell cytotoxicity, such that the immune-compromised HIV victim, for example, will be less likely to die of opportunistic infections, but also in a recent study just published, we were able to alter the disease marker, the CD-4/CD-8 ratio in adolescents with HIV. So, I think those are some of the most exciting data that are coming out of the efficacy studies.

With respect to cost effectiveness, there has

been very little done mostly because the studies have focused on subjects who are clients who are not hospitalized, and so the cost savings cannot be determined, the hospital cost savings.

So, the only study that we have cost effectiveness data on is the preemie studies where we are able to actually determine the costs of hospital savings and the cost of the treatment, and to give you an example of that, eight years ago when 470,000 preemies were being born for a year in the United States, if they were to receive the massage therapy for the 10-day period that they did in our studies, they would be discharged six days earlier at a hospital savings of $10,000 per baby.

If you multiply that by the 470,000 babies, you have a $4.7 billion hospital cost savings. Now, an interesting wrinkle in that is that the other part of the equation that could not be determined is cost savings associated with using elderly volunteers to actually do the therapy, in which case we had reductions in stress hormones in these elderly people, we had fewer trips to the doctors' offices, and variables like that, that reflected that their health was better following giving

these preemies the massage therapy.

So, that is basically all I can say at this point. The research continues. Fortunately, the Center for Alternative Medicine has funded some new projects in the area of massage therapy, and the massage therapy associations are trying to get research training to the massage therapists, so there will be more people doing research.

Thank you.

DR. GORDON: Thank you very much. Thank you all. It was really extremely valuable and helpful to us.

For questions, the way we will do it is if the commissioners will raise your hands, and I will go around and just pick people in the order in which you raised your hands. Remember, we have set aside more time. We have about 20 minutes to ask this panel questions, so please make the questions brief and to the point, and let's engage them in discussion. We have them for 20 minutes or so.

Who would like to ask questions? Veronica and then David.

**Panel Discussion**

DR. GUTIERREZ: I would like to direct my attention to Dr. Meeker, and I would like to know how Palmer College and the consortium plan to address the clinical benefits of chiropractic care in patients without ailments, that is, the quality of life issues.

DR. MEEKER: As Dr. Gutierrez knows, Palmer has more the NCAM-supported centers in the United States, focuses chiropractic care, validity, effectiveness, and safety.

We address quality of life issues in all of the clinical trials that we are involved in right now, and we are looking, at least in a clinical sense, and we are also embarking on a very interesting basic science series of studies using some animal models to investigate what happens when we have spinal dysfunctions, fixations, et cetera, what happens to the physiology of the body when it happens.

We have discovered there are some very interesting effects that we have been able to create, and now we are working on whether or not we will be able to reverse those sorts of things. So, this is a very intense area of research, and we are looking at that as

quickly as we can with relatively limited resources right now.

DR. GORDON: David.

DR. BRESLER: We know that one of the things that will impact greatly on access and delivery is the extent to which we can teach patients self-management. I would just be interested very, very briefly on comments about how each you feel your professions are addressing this issue.

In pharmacotherapy, for example, we have over-the-counter medications that people can take for themselves and prescription medicine that they have to see professionals for. How much is chiropractic and naturopathic, how much within your professions is there a dedication to teaching self-management of your techniques to the public?

DR. MEEKER: There could be a long discussion, but the quick answer is that chiropractors are very interested in preventing the kinds of problems that arise, and primarily we are interested in the locomotor system, the way people move in their environment, and this, of course, leads to considerations of general

fitness, symmetry of movement and ergonomics, and the impact of those things on lifestyle, the effect of smoking, for example, which affects the spine, and the effects of nutrition, as well.

DR. BRESLER: But there are some simple manipulations, for example, that you could teach patients to do to each other. For example, is there interest within the profession to do that?

DR. MEEKER: I am not necessarily in favor of that. I think that it takes some skill to be able to figure out what needs to be adjusted and to be able to deliver the appropriate adjustment at the right time. I think there are some safety issues with respect to that.

DR. KAIL: Many of the therapeutic agents that people commonly use are available over the counter, so many patients, almost all the patients that naturopathic physicians treat are self-medicating at home.

The Weekes study that I mentioned also looked at training of home care for people, and it did show that the great majority of patients were treating themselves at home now, when they had to previously go to the doctor for care once they had been educated by the patients.

This also gets in the lifestyle issues. The biggest thing that reduces chronic degenerative disease is not taking any modality, it is changing lifestyle, and education about lifestyle and awareness about lifestyle actually increases compliance in the patients.

In my own study of my own patients, I got about 92 percent compliance in people following medication use at home, treating themselves at home, and following their lifestyle programs.

MS. CULLITON: Self-care is an integral part of Chinese medicine and acupuncture and dietary recommendations, exercise, such as Qigong and Tai Chi, but also I think just in general acupuncturists teach their patients how to do acupressure for self-care between visits.

But if I could just take a little extra time, and I don't know if it's in your book, the two pictures that I sent the pre- and post-, if you could find that in your books, a self portrait of a 16-year-old girl with Downs syndrome, ADHD, and nystagmus, and one week after wearing a acupressure tab, there was a second self portrait which I think, if we want to talk about public

health and public education, you know, who needs randomized controlled clinical trials when you can see how this one child, who was affected after one week, but the important part of this is that this was a technique applied by her mother.

The acupuncturist did an education session in a public school, taught the teachers and the parents how to apply an acupressure tab on the ear for their children, and so this kind of public education is what I was referring to earlier, as well.

DR. FRYE: The National Center for Homeopathy has affiliated study groups, which encourage anybody who wants to learn about homeopathy to get together in a small group, and it supports them with educational materials and conferences and volunteer regional coordinators, so that they can learn about how to use homeopathy for themselves and their families.

The most common sales of homeopathic products, though, are in the combination remedy realm where people just pick up a bottle of allergy or migraine, or whatever the combination might be, and actually, the teething product is the second overall leader in sales in that

category, but the feedback from the manufacturer on that product is that only 11 percent of the people who use it know that they are actually using homeopathic products.

So, we do have a big problem of translating the use of the product to understanding the bigger paradigm of homeopathy and how to use it more specifically.

DR. FIELD: A lot of our massage therapy studies are self-massage. All of the chronic illness in children's studies, the therapies are provided by the parents on a daily basis just before bedtime, so they can have intensive treatment.

A lot of self-massage is taught in the adult studies. For example, we just completed a carpal tunnel syndrome study that was entirely administered by people to themselves during the course of their work hours.

Then, of course, you have all those gadgets you can buy at Brookstone, chopper image, and brush yourself in the shower, and so on, just as long as you stimulate deep pressure receptors. We don't get any of the effects we talk about unless there is stimulation of the deep pressure receptors. Some of that you can get in exercise and sports, and so on.

DR. GORDON: Thank you all for your comments.

Wayne.

DR. JONAS: Thank you, Jim. I basically have three questions targeted to different individuals.

First, Bill Meeker. There are some good examples of integration, maybe not a lot, but there are a few good examples of integration. Could you help the panel and kind of pointing to some of those? You don't necessarily have to do it here, but if you could provide us with some examples of that, but if there aren't any, then, let me know right now.

My question actually to you is slightly different than that, unless you wanted to respond briefly to that.

DR. MEEKER: Go ahead, Wayne.

DR. JONAS: Okay. Was there a perception prior to some of the direct cost effectiveness studies that have been done in chiropractic, that chiropractic was more cost effective than many of the conventional therapies, was there a perception of that putting satisfaction aside for a minute?

DR. MEEKER: Satisfaction aside, studies go

back to the 1960s, comparing cost of chiropractic care versus cost of something else, and most of the studies before 1990 do demonstrate that chiropractic care is probably less costly.

Studies since 1990 using much more sophisticated techniques now have been a mixed bag in terms of which have turned out to be better. I think we can say that chiropractic care has now risen to the dubious level of perhaps being as expensive as medical care.

DR. JONAS: This really relates to my second question, is that there is a perception usually prior to direct quality trials that, gee, this is cheaper, I can do it and my patients are satisfied, which is usually the case.

In acupuncture and naturopathy and homeopathy, where there have been no direct assessments of cost effectiveness, I guess my question to you all is where do you think those studies should be directed, should we look at modalities, for example, which are easier to look at, and you can look at the cost add-on to that, or should we look at whole systems, because I know these

systems have their own philosophy and their own approach, which is much different than simply adding on a modality.

I think the lesson from chiropractic is when you look at a whole system, you get very different answers than when you are looking at a different modality. I wonder if there is any suggestions or comments on that.

DR. KAIL: From the naturopathic perspective, again, we never practice single modalities in individuals. It is always a whole system or a protocol which always includes lifestyle management, as well as various agents that might be applied to any given condition.

So, I think taking the modality approach really does disservice to the power of medicine. I think you have to look at the whole systems.

We certainly have been pushing in that direction at NCAM, trying to develop protocols that will look at whole systems, which is very difficult methodologically as you can see, but we need to overcome those difficulties and come up with new methods to look at whole systems and how it affects things, because I

think that is really where the cost effectiveness is going to be demonstrated.

DR. JONAS: I would wonder about that given the chiropractic data that is more sophisticated now than some of the others and developed. Also, one of the main problems is there is heterogeneous types of practices, so if there is, in fact, something that you are going to practice, that has to be systematized in some way.

Go ahead.

DR. MEEKER: Can I follow up? I should say this. There is not one single randomized controlled trial that has used the proper economic variables and analyses of chiropractic care that I know of in the world.

Economists argue vociferously with each other about the proper models to apply, as well, so this is not a simple question.

DR. JONAS: It isn't simple. In fact, it is very hard to do cost effectiveness studies in general in any area, and I think what a lot of you are referring to is not just cost effectiveness, you are talking about cost-benefit, not just, you know, does it work for this

particular thing, but what is the overall benefit that you are getting including satisfaction and other types of value issues that can be incorporated into cost issues.

Then, I had one question for Tiffany. What are the barriers to delivery of massage therapy in areas, such as neonatal or intensive care units where there has apparently been demonstrated quite remarkable, dramatic cost savings?

DR. FIELD: In neonatal intensive care, which I am most familiar with, there has been a no-touch or minimal touch policy. It is sort of shades of where we were two decades ago when we stopped feeding these babies because we thought that we shouldn't be feeding them, and similarly, now, we think we shouldn't be stimulating them because they will get physiologically disorganized.

So, it goes against a whole grain of education that these neonatologists have had, and it is going to take time and more data. There was a study that just came out showing not only is there weight gain associated with this kind of treatment, but there is increase in bone mineral content and the actual growth of bone.

So, this will be more convincing and with the

FMRIs that are going on, that will be more persuasive to neonatologists.

DR. JONAS: You are saying it is largely a conceptual barrier then.

DR. FIELD: Yes, we need underlying mechanism studies is what we need to persuade the physicians that these things are working.

DR. JONAS: Interesting.

MS. CULLITON: If I could comment on that, though, Dr. Jonas, I think there is also an issue of hospital privileging and credentialing for non-physician or nurse providers to come in.

I know I have been going through that in Minnesota where I run a program, and you can get a lot of people within a system to say yes, we would like that, and then there is still another barrier of actually getting permission for the massage therapist to come to the site.

DR. GORDON: Tiffany, I wonder if you could help us get some data on the controversy, if you would, about the sort of different views of growth and development and of what interferes and what facilitates

it.

DR. FIELD: Uh-huh.

DR. GORDON: Thank you.

Joe.

DR. FAIR: For Dr. Kail. I was struck by the study that was in your handout, the Emsley study, and I want you to comment on the quality of the data and whether or not there is a confusion between patient satisfaction, patient perception, and efficacy.

For example, in one of the slides, pneumonia is treated conventionally, you know, somewhat better than alternative therapies, but not dramatically better, on a five-point Liker scale.

Was this actually asking patients their perceptions of efficacy or was it a true marker of efficacy?

DR. KAIL: I believe most of this is patient perception because I think most of this was done through surveys of the patients. I don't think there was any real hard markers of efficacy really established in the study, but as I said, there is very positive studies, and this one seems to be one that represents at least

something that is out there around efficacy that looks at a whole lot of different modalities rather than a single modality.

DR. FAIR: Because there is a sort of statistical awareness that when patients are asked, they tend to over-inflate patient satisfaction in a whole range of surveys including in the airline industry, they will overestimate the true efficacy of the experience.

So, I am just wondering if you could make some concrete recommendations of the kinds of studies that you did bring a lot of this together, of the kinds of data that will be more convincing and more helpful in organizing the assessment of the disease categories that you are outlining here.

How would you design studies and what kind of data would you like?

DR. KAIL: Well, I think you are going to have to do clinical controlled studies of a whole system, but you need to step-wise it. Again, it is hard to do with a placebo, for instance.

So, I think comparing it to conventional care in a step-wise fashion where, for instance, such as if

you want to treat a clinical condition like, let's just say allergies, to pick one, that you start with what is parallel to conventional. So, they start with using antihistamines, decongestants. Well, you start with doing similar things using natural agents.

Then, they step up to doing some kind of desensitization procedure. Then, you step to doing a desensitization procedure using a natural agent. You compare them across the board for just medication use, symptom decline, and any objective parameters you could, antibody levels, cytokines, chemokines, something like that, and there are some trials that at least we are proposing to do that are going to look at those kind of issues, but I think looking at step-wise models that really compare conventional with the alternative models, I think that is the best way to get at that without trying to use a double-blind crossover placebo-controlled trial. I just don't think that those methods are going to work for looking at this medicine.

DR. FAIR: Thank you.

DR. GORDON: I have Tom, Bill, Charlotte, and Effie, and then we are pretty much going to have to stop

after that.

MR. CHAPPELL: Dr. Kail, I would like to explore your recommendation that the CAM be supported by Medicare reimbursement, Medicare/Medicaid. As you were saying in your report that both modalities, that is, allopathic and naturopathic integrate well, but I would like to understand, I think more specifically, how the orientation towards prevention of disease or promotion of wellness can be broken down into a reimbursable segment of time and services.

Can you help me understand, in your report, for instance, when you talk about the different treatments and modalities that are taught in the institutions of lifestyle modification, nutritional supplementation, herbal prescription, we are not just talking about chronic problems, but prevention.

How do you envision that reimbursement, what would that look like in your opinion?

DR. KAIL: As there are now, there are new codes that look at interventions that are more preventive. There are codes that you have for time allowed for discussion and education that are not being

used by the insurance industry right now.

They are still sticking to pretty much the old allopathic definitions of what time and reimbursement is used, but there are new codes that have been specifically set up for looking at time in educating patients on how to do lifestyle intervention.

In my own case, I usually spend an entire office visit talking about those issues, and after screening a patient, giving them information about what is appropriate for them to do, and then asking them to do that. But I think you have to build it into the office visit, which requires more time. You have to get away from the 10-minute office visit. I schedule 30-minute office visits for all my patients because a large part of what I do is convincing them to take better care of themselves.

So, that is reimbursable under most insurance schemes right now if you are looking at 30-minute visits, but it does take time to educate patients. You have got to give them a reason to do these things, and that is where the objectivity comes in of what you can measure, but it is an educational effort, and I think that is the