best way to do it, is build it into the office visits as far as time.

MR. CHAPPELL: Should I assume that Medicare and Medicaid are standards, in your opinion, for reimbursement?

DR. KAIL: Well, I think that is a standard of acceptance.

MR. CHAPPELL: That is my real question. Are we looking for credibility or economic sustainability?

DR. KAIL: I think the credibilities may come more from the research side. I think the economic stability is going to come from the reimbursement side, but you don't get one without the other is the problem, and I think that inclusionary language will allow more people to come forward, so that insurance companies can get better data.

Right now, for instance, some of the insurance companies that have been reimbursing are not reimbursing for certain programs anymore. I can give you one example. There was a program that put a cost of $7.00 per member per month for reimbursement for alternative services. That was not well advertised, and even though

there was a cohort of people that had access to this care that were seniors, because it was poorly advertised to the seniors and because it was such a great expense and not well sold to the buyers, it was an underused program that was not continued because of lack of use.

Well, had that been a different thing where it would have been more like 50 cents per member per month, which some plans have advocated, and it was well sold to the people that were buying it, the employers, et cetera, they would have had a better outcome and they would have continued that longer, and they would have had better statistics to use for their own utilization statistics.

That is proprietary information. There are granting mechanisms that the NIH have come up with now, that hopefully, actuaries and other people will allow a pool of information to stay in a non-proprietary fashion where we can get those utilization statistics out, but reimbursement is not going to come until there is better figures on utilization, and I think forcing that a little bit by inclusionary language in Medicare and Medicaid is the fastest way to get that to come forward.

DR. GORDON: Thank you.

Bill.

DR. FAIR: My background has been entirely, professional background, entirely in medical schools, so I am interested in education, and I will address this question to Patricia, but it is really a global question to the panel.

That is, how do we go about this education? You had mentioned, I believe, that training physicians in acupuncture, clearly, medical school, as jam-packed as it is, we can't train physicians to be acupuncturists and naturopaths and chiropractors and massage therapists, and so forth, so is this education better spent in terms of training medical students and physicians in the effectiveness and perhaps a cost benefit of these things as opposed to delivering the modalities themselves, or just how do we get this training and what kind of training should it be?

MS. CULLITON: Well, I agree with the second half of your statement or totally of your statement. No, I do not think that in medical schools we should try to incorporate into medical education that everyone become an acupuncturist and a homeopath, et cetera. It would be

impossible, unless we want our physicians to go to school for 20 or 30 years.

DR. FAIR: But Andy Weil, for instance, who started this integrated fellowship, that is an example of that type of approach.

MS. CULLITON: That is an example, and my division in Minneapolis is an example of a different type of approach where we are actually within the Department of Medicine at an academic institution, but all the providers are non-physician providers. Salaries are significantly less, et cetera, but there is also a wider depth of knowledge of a particular intervention when somebody has studied strictly Chinese medicine for five years.

So, my recommendation is that medical education should include overviews of what is out there, clinical and cost effectiveness, appropriate referrals, et cetera, and if physicians have a dream, have a path, I know there is an American Medical Acupuncture Association, and a lot of physicians really have taken very seriously into studying acupuncture.

Those options would be available, but that

isn't part of the curriculum that I am talking about that I would like to see in medical school education. It would be much more the overview of how to interact, appropriate referrals, those types of things.

DR. MEEKER: I agree with you. I think that the time is spent learning about those things with one additional thing, and that is training in interdisciplinary practice. A few health commissions have recommended that interdisciplinary behavior be explicitly taught in medical school, and I think that there is a big need for that.

It is difficult now even, and I think with respect to the CAM professions, there is even a greater need to train all health professionals, not just medical doctors, but CAM professionals, as well, in how to interrelate to each other.

DR. FAIR: So, you would recommend then that the various modalities under the CAM umbrella, if one could categorize all of them, would be an integral part of the education of medical students and young physicians?

DR. MEEKER: Not to the point of actually

performing them, but, as you said, to understand them.

DR. FAIR: Okay. Again, benefits and efficacy, and so forth.

DR. MEEKER: Right.

DR. KAIL: I think that distinction needs to be made very clear, though. I think there is a lot of allopathic physicians out there that go and take a couple courses in this and that, and then proceed to practice that without a full appreciation of all the other stuff that goes behind that culture.

I think it is very important that we make a big distinction between this is informational, so that you will have an appreciation for this modality and know whether or not you want to recommend it to a patient as opposed to this is the level at which you can start practicing this.

Again, I would recommend that if you don't have 200 hours of classroom, you probably shouldn't be reimbursed and you probably shouldn't be practicing that modality.

DR. FAIR: This is my concern. I think in New York, an M.D., and I may have been off in the numbers,

can get a license as an acupuncturist in something like 300 hours where it may be 3,000 hours for someone that goes the traditional route. I have no personal experience, but I just can't imagine that you could learn as much in a tenth of the time.

DR. FRYE: I see the situation in homeopathy a little differently. We actually have two levels of certification. At this point they are not terribly well established or disseminated, but there is an acute care level, as well as a sort of specialist level, and I think that given that homeopathic medicines are included in the FDA Homeopathic Pharmacopeia, that having at least primary acute level of training in homeopathy in medical school, along with your traditional training in pharmacy or whatever you might use to treat a particular condition is appropriate.

Certainly, going to the level of specialist training in medical school would be far too time-consuming, but I think acute level of training is entirely possible.

DR. GORDON: Thank you. We are going to have a chance, I think this is a very important issue to come

back to this for the education panel.

DR. FAIR: I have one question for Tiffany also. What are the barriers to massage in cancer patients, because I hear this a lot from massage therapists and also some physicians, although it is sort of lessening from physicians, but there was a time not too long ago, 20 years ago, when children with abdominal tumors, for instance, they would post signs on the bed, "Do not palpate," and I think this is still imbued in some of the massage therapists' philosophy. Am I correct?

DR. FIELD: My understanding currently is that the contraindications are coming from the massage therapists, not from the pediatric oncologists. The argument they make, the massage therapists are saying that basically, they are concerned about metastasis and the spread of cancer by the increase in blood flow and lymph, and so on.

DR. FAIR: Is that real or theoretical? I guess that is my question.

DR. FIELD: It is certainly not real, it hasn't been tested, but the oncologists will say, well, for the

same reason that you are concerned about the cancer being spread, we are concerned about blood flow spreading the immune cells. So, there is still a lot of controversy about that.

DR. GORDON: Charlotte.

SISTER KERR: I heard important speaking this morning on at least three points, and one was that caring time and listening healed touch was essential to healing, physical, mental, or spiritual, and that it was essential to empower people to heal themselves.

Tiffany, I was very edified to hear about your study with the elderly and the babies and to see the mutuality and the healing, and what I wanted to ask you and anyone on the panel is since the role of the prophet is one of imagination, what could you imagine could be done? I am looking specifically at grass-roots level at this moment of public health in your particular area that might have a significant effect within a local community.

For example, I could imagine that mothers sharing massage, you know, would decrease postpartum depression and probably a million other things, but a massage co-op, you know, in the community, come in and

you borrowed a massage.

So, I am wondering -- and it could come from other members of the panel -- is there anything there you could tell me now or, if not now, if you could give it to me later for the panel.

DR. FIELD: Well, I would like to say that I think that our elderly are a wasted resource and are beginning to present a lot of problem related to depression and touch deprivation, and so on, to the medical community, and I think that preschools, for example, could use elderly volunteers in a very big way.

That would get a lot of touch going. I don't know if you know, but a lot of mandates are out there now that children should not be touched even in preschool because of concern about the legal aspect of sexual abuse, and so on.

I can't imagine an elderly person being accused of sexually abusing a preschooler. I mean it is less likely than, say, a young man or something. So, I think that that would be one way to get grass-roots preventive care going for both sides, the elderly and the young people.

DR. KAIL: I think partially it is a quality of information problem. A lot of people are doing self-care, as we said, but a lot of it is based on poor quality information that is just in the lay press or especially multilevel marketed stuff. There is a whole lot of bad ideas being put out there by people that are uneducated and a lot of poor recommendations out there by people that have no training.

So, I think there needs to be some venue at the community level where people can tap into to get quality information about health care practices whether they be alternative or conventional.

DR. MEEKER: One last thing on this area. In terms of prevention and health promotion, wellness care, I think one of the biggest problems in clinical practice is that doctors of all stripes don't get reimbursed for that time, and if there was a way to recommend that billing codes, reimbursement systems, et cetera, would start to recognize that this an important part of clinical practice, that perhaps we could start changing doctors' behavior, that would soon start changing patient behavior, as well, but I think one of the biggest

barriers is at the reimbursement level.

DR. GORDON: Effie.

DR. CHOW: All the discussions that have taken place leading to this sort of more global and visionary question that I have is that we discuss about health promotion and education and teaching self care, and care, and giving time, and all that, is it appropriate to try and look at integrating this into a medical model or in your ideals and your dreams and your goals, what would you see your profession, how does it stand, as separate or integrated in a different way, setting a different parameter or paradigm, or trying to squeeze it into the mold that we have as a health care system?

I know you don't have time to answer this, but I certainly would like some written things back, but if you have some comments, I would really appreciate that.

DR. KAIL: Just a brief comment. I think that naturopathic medicine is inherently focused on prevention and self-care issue. I think that if there was an opportunity to have those issues addressed first in the medical model, that that would go a long way, whether that be integrating that care somehow by having them come

in as gatekeepers, and send them out to other people, I don't know, but I think that some venue where early on in care those issues are addressed at a stronger level than they are now would facilitate the whole process.

DR. GORDON: Thank you.

Tiffany, are you planning to replicate the study on preemies?

DR. FIELD: Well, we have done several replications, and now there are approximately five replications in other parts of the world using the same paradigm.

DR. GORDON: Could you give us that data, as well?

DR. FIELD: Yes.

DR. GORDON: That would be very helpful.

Tieraona, I know you want to ask a question.

DR. LOW DOG: Real quick. Thank you.

I think this is for anybody, but especially for Konrad. In Western medicine now, with the consort statement and a lot of work being done on trying to improve quality trials and trying to improve evidence, we are now looking at taking away many things, we are not

paying for as many things, and it is changing the way physicians practice medicine as we move more and more towards evidence-based medicine.

While I realize that there is just an absolute shortage of funding for CAM therapies in general, so it puts us in this place of a bind, is it a bit premature, are we putting the cart before the horse a little bit to want to include things that are not yet proven, it doesn't mean they are ineffective, but not yet proven to be reimbursed by an already overburdened system, such as Medicare and Medicaid?

DR. KAIL: I think that is the catch-22 question to end all catch-22 questions, how can you find out the information without large bodies of people having access to those types of care.

I think we are going to have to spend a few dollars to let some at least controlled groups have unlimited access to that care to see what happens.

I think you can do that in a controlled fashion, but I think that is going to have to come first, so that a good segment of the population, especially the poor people, I mean there is a perception that is

starting to change that it isn't white, Anglo-Saxon, Protestant, higher educated people, but I would like to see some more trials in specific populations, the elderly and the poor folks, small children, et cetera, that come forth.

But I think we are going to have to spend some dollars and give some open access to at least a few groups in controlled situations in order to get the data we need to know what to spend more dollars on.

DR. MEEKER: I think, Tieraona, that there are issues of equity, too. Chiropractors are not reimbursed in the Medicare system now even though spinal manipulations is one of the most studied forms of care for back pain at least, and is recommended by the U.S. Government, and yet we are treated as third-class citizens in the Medicare system.

So, I think what it really comes down to when we are talking about some of the stuff is not whether something needs to be proven or not before it is included, but whether or not the things that are already paid for actually have evidence, as well, and is equity being applied to the entire situation.

DR. LOW DOG: I would just like to say be careful of what you wish for because you might get it. I spent about seven or eight years trying to get medical assistance reimbursement for acupuncture in Minnesota, and we have it now, and I am glad that we do, but we get $12.00 reimbursement, we probably spend $20.00 on paperwork, and we would go broke if we only had a practice of people receiving medical assistance.

It is a wonderful gift to be able to offer that to an expanded community, but I think we have to be cautious in what we ask for.

DR. FRYE: I think it is important to us while looking for evidence, too, that we try to avoid doing just the quick and dirty studies that give us, yes, this modality works for this indication, where it is important to do more longitudinal kinds of studies to show whether doing this now actually helps to prevent further disease from developing five or 10 years from now.

DR. GORDON: Thank you very much. We are going to break now. I would invite you -- would you send us that information about the $12.00 reimbursement and $20.00 paperwork, please?

DR. LOW DOG: Sure.

DR. GORDON: And anybody else who has examples of that kind. Our charge is to make legislative recommendations, and we want to hear about it.

Thank you very much. We are going to take a five-minute break only and then we are going to start the next panel. We are a little behind time.

[Recess.]

DR. GORDON: We are going to begin with the next panel now. The first speaker will be Dennis Awang.

Herbs/Botanicals

DR. AWANG: I think the Commission for inviting me. I am neither clinician nor an economist, so my contribution to clinical and cost effectiveness would be related mainly to my familiarity with the literature in herbal medicine and for 24 years I was associated with the Bureau of Drug Research and head of the Natural Products Section in Health Canada. As such, I was involved in developing methodology for analysis of commercial herbal products and for providing guidelines for the regulation of these products.

As you probably know, the system for regulation

in Canada is somewhat different from what is in the United States. However, it would seem to me obvious that the potential for herbal medicines contribution to health care would seem to be fundamentally related to the ability of the consumer to have access to safe and efficacious products.

As it is now, judging the difference between different commercial products is very hazardous and limited mainly to the familiarity of the consumer with the manufacturer.

It seems to me also that the prime imperative for the health care system, and indeed for the regulatory agencies, to ensure that the consumer can have access to safe and efficacious products.

The large interest of physicians, health care professionals in herbal medicines recently has been concerned primarily with the ability to be assured of a consistent therapeutic medicinal effect from these products, and the plain fact is that knowledge of the nature of active principles and the mechanisms of action is severely limited.

Attempts have been mainly concentrated on

trying to characterize the substances chemically, but there has been such a glaring lack of success in identifying these active principles that I think the recent trend to develop into biological assays would seem to me to be the most promising combination, combination of chemical and biological assays to establish some basis for real standardization of these materials.

As it is now, there is very few examples where one can be confident about standardization for consistent effect.

I believe that the best contribution or recommendation I can make is that a system, such as that proposed by the World Health Organization for guidelines for the assessment of herbal medicines, be instituted to ensure proper identity and quality of both raw materials and finished products.

Most of the adverse reactions, for example, that have been recorded have been due to substitution, adulteration largely due to misidentification or linguistic confusion, and it seems to me that it is not wise to leave the establishment of the identity and quality of these materials to manufacturers, as the FDA

has recently suggested regarding the Aristalochia problem.

There is such a very broad range of scientific competence and technological capacity in this broad spectrum of manufacturers, that it seems to me that sort of reliance on manufacturers to ensure the identity and quality of these materials is wrong-headed.

Also, I think that the effort that has been made by the United States Pharmacopeia to establish sound monographs, and there are a number of agencies that have been involved in this, but I think that the approach of the United States Pharmacopeia is commendable, and I think that once they can get the proper group of people together to establish reliable, accessible assays and characterization of these materials, that we will advance the process considerably.

DR. GORDON: Thank you very much.

Christopher Hobbs.

MR. HOBBS: Good morning and thank you very much for inviting me today. I have certainly heard a lot of good things from other presenters and certainly agree with a lot of it. I am an herbalist and a licensed

acupuncturist in California and Oregon.

I have got a foot kind of in both worlds because my mother and grandmother were herbalists, and my dad was a scientist, so recently, for the last almost two years, we have received funding from a large pharmaceutical company, and we have been sifting through the literature on a hundred herbs in great detail.

So, I am pretty familiar with what literature is out there and what science is being done. Of course, the quality varies quite a bit, as you know. But, for instance, right now I am working on garlic. In our database we have about 2- to 3,000 abstracts to sift through.

Now, looking at all those abstracts, a lot of them are animal studies, a lot of them are in vitro studies, how many human studies have actually been done of good quality on herbs, how many herbs out there could you say that there really is good science, a medical researcher would be satisfied with the amount of evidence?

I would have to say that there are very few herbs probably that have met that kind of international

scientific standard. Maybe hypericum or St. John's Wort, ginkgo has a lot of evidence, and a few others, but when you really look at the vast majority of herbs, for instance, in the Chinese Pharmacopeia, there might be 5,000 herbs in the Chinese Pharmacopeia.

How many of those herbs have actually been looked at scientifically with good science? I would say very few especially with human studies.

I have submitted written comments, and I am in the process of looking at more studies on efficacy of herbs as far as cost effectiveness in our health care system, and I would be happy to put together another summary after I go home. I didn't really have much chance. I was only called at the last minute, so I haven't had a chance to write up the studies, but there are an increasing amount of studies out there.

Actually, on herbs, generally, when you look at the vast amount of research, it really is mind-boggling. I had no idea until I started really looking out there. We researched 26 international electronic databases and accessed a lot of foreign material, and there really is a lot out there to sift through.

Now, I have a few other comments just about herbalism in general. My feeling and my recommendation is that well-trained herbalists really should be involved in studying the safety and efficacy of herbs on a scientific basis because I would say that it is possible that many scientists have the view that herbs do not work until it is proven that they do work, whereas, an herbalist might have the feeling that they work, my feeling is that they work until it is proven that they don't work.

So, I think that the questions that we ask in designing studies are very important. Obviously, as Dennis was saying, the quality of herbal products is so important as when you really start looking at the cost effectiveness of herbal medicine, we have to take into account the quality of the herbs that are being used.

Now, a trained herbalist would know when to harvest the herb, what season, what part of the herb. This is a long history, a long tradition, and this type of traditional knowledge has been passed down from generation to generation, and can be quite detailed and quite complex, although it is again difficult to study

scientifically.

Another thing is that I certainly agree that herbs, as far as cost effectiveness and integration, work a lot better when used in a traditional system. For instance, many people today are using ginkgo for better memory, so they go into the drugstore and they buy a bottle of ginkgo for better memory, and this isn't always going to be that effective, whereas, if you go to a licensed acupuncturist or a herbalist that has traditional knowledge and traditional training, this is all integrated into a system whereby a person -- again, I spend at least a half an hour, maybe an hour with patients, and I consider myself their health coach. I really encourage people to believe in their own innate healing powers.

Herbal medicine really is a gentle medicine in the sense that after all the years I have practiced, I have seen really very few side effects. Yes, there are side effects, and I would never say that just because it is natural, it has no side effects, that is not true, but generally speaking, herbs are far safer than drugs.

Thank you.

DR. GORDON: Thank you. We understand we put you under time constraints, and we would very much appreciate you sharing those studies with us. It would be very helpful to us as we move ahead.

MR. HOBBS: Thank you.

DR. GORDON: Alan Gaby.

Dietary Supplements

DR. GABY: Thank you for inviting me. I am a medical doctor, and my hobby over the past 25 years has been collecting and looking at studies in the field of nutritional and herbal medicine.

I have been amazed at how many studies there are that are not known about in conventional medicine. Some of them are double-blind, placebo-controlled trials, some of them are case reports, some of them are uncontrolled trials.

What we are dealing with here is substances which are commodities, so therefore they are usually quite inexpensive, and with a few situations where this is not true, they are generally quite safe.

Having been in practice for 17 years, I have not had a single patient have to go to the hospital

because of an adverse drug reaction, and most of the people come in specifically because they are looking for other ways of treating their conditions.

There is a legitimate concern in conventional medicine that people will forego proven therapies and use these instead, however, when people are guided appropriately, and when they use their own common sense, this doesn't occur.

There are only some situations, there are just a few situations in conventional medicine where doing nothing is dangerous. For example, if somebody comes in and their joints hurt, and they are taking an anti-inflammatory drug which is giving them an ulcer, and you put them on niacinamide or glucosamine instead, and their joints don't hurt anymore, there is no danger of foregoing conventional therapy.

If somebody has migraine headaches and you put them on magnesium and vitamin B6, and they don't have any migraines anymore, there is no danger in them going off of their beta blocker.

There are other situations where there would be danger, for example, in congestive heart failure, but

even in that condition, if somebody is appropriately monitored, and you can demonstrate that their ejection faction has gone up and their New York Heart Association Classification has improved, then, one can cautiously wean an individual off of their medication.

So, nutritional therapy has a large body of evidence behind it, and it fits very much the allopathic model. It is just that we are using different substances. Interestingly, there appears to be more resistance against nutritional supplementation among academia than there is among some other CAM approaches.

As a matter of fact, there was a study published in the Archives of Internal Medicine by a conventional Ph.D. who provided evidence that there is a bias against micronutrient therapy among academia.

In support of his argument, he showed that textbooks almost universally neglect mention of vitamin E for the treatment of intermittent claudication even though there is evidence that it works as well as the drug that is conventionally used.

In addition, there is uncritical acceptance of adverse reactions, case reports where somebody is on six

hepatotoxic drugs and they happen to take a vitamin, and they develop liver toxicity and they blame it on the vitamin.

So, if we are going to move forward, we need to utilize the research that has already been done. This is one area of CAM where we actually could develop an effective and cost effective approach right now based on what has already been done.

I have given 10 examples in the handout. I just picked those because they seem to be reasonable examples. For example, $1,000 a month for growth hormone for a short child, 75 cents a month for zinc, which according to one study works approximately two-thirds as well as growth hormone. $3.50 a month to prevent kidney stones using magnesium and vitamin B6. $200 or more per month using the brand version of potassium citrate.

So, there are many situations where one can clearly demonstrate cost effectiveness. On the other hand, there is the possibility of over-utilization, because there is an inherent block against using prescription medications. People don't love to take their prescription drugs, where often they love to take

their supplements.

So, we need to develop, in order to ensure cost effectiveness, situations where it is appropriate to use nutritional supplementation, and perhaps Medicare and other insurance companies should pay for them as an alternative or as an adjunct, and that there are other situations where it may not be appropriate, such as the walking well who want to take their supplements as opposed to the walking wounded who are already spending thousands or tens of thousands of dollars.

As a final 23 seconds worth, I want to mention something slightly off of my scope here, and that is the identification of food allergy in the treatment of conditions. I saw people that have spent thousands of dollars on care that didn't work and in one visit they were cured of their chronic problem because they had a food allergy which was not identified.

So, we need to teach this in medical school, and the cost of care will come down by billions of dollars.

DR. GORDON: Thank you. Thank you for your superb timing, Alan, and also for these examples, very

useful.

Patsy Brannon.

Nutrition

DR. BRANNON: I, too, want to thank you for the invitation to speak to you about nutrition as a complementary and alternative medicine. I am a registered dietitian and a research nutritional biochemist.

I want to start by discussing nutrition as a very broad continuum in health care. It ranges from self-selected diet or dietary supplement choices by consumers with no consultation with any health care provider of any sort, to medical nutrition therapy in conventional health care ambulatory and acute care settings.

The recent Institute of Medicine report on the role of nutrition and malnutrition in maintaining health in the nation's elderly defines two tiers of nutritional services, and I think this is an important distinction to consider as you consider complementary and alternative medicine.

The first is basic or general nutrition

education or advice that can be provided by a variety of health care professionals including physicians, dieticians, nurses, chiropractors, dentists, physical therapists, clinical social workers, physician assistants, pharmacists, psychologists, and others.

The second tier, however, is nutrition therapy or medical nutrition therapy, which involves nutritional assessment, evaluation of nutritional needs, intervention, counseling, enteral, parenteral nutrition, and other modalities, as well as follow-up care. This is generally provided primarily by registered dietitians in a health care team of physicians, nurses, pharmacists, physical therapists, and psychologists.

Beyond these two tiers, however, exists the vast majority of information going to consumers about nutrition, and that is through the mass media. There are recent survey data that suggest that this is the primary source of information about nutrition for consumers and that fewer than 5 to 9 percent of consumers seek nutritional advice from a health care professional, such as a dietitian or a physician.

I am going to focus my remarks today on

nutrition therapy in part because I knew Alan was going to speak about dietary supplements and, in part, because this is the area where we have the best research base evaluation of clinical effectiveness and cost effectiveness.

This is not to say that we don't need to evaluate basic nutrition education, Tier 1 services, and that need remains high, and it is also not to say that we don't need to determine clinical effectiveness of other dietary interventions because we do.

Nutrition therapy is strongly supported by observational studies, consensus documents, systematic review, and extensive clinical trials of a wide variety of size for the following conditions: dyslipidemia, hypertension, diabetes, by reference obesity, and osteoporosis.

Evidence with less robust clinical trial data also exist for heart disease, predialysis kidney failure, and under-nutrition. Less robust data, relying primarily on observational data and epidemiological data, with less robust clinical intervention data exists for Alzheimer's, osteoarthritis, cancer, and other conditions.

The cost effectiveness of nutritional therapy has been examined in several contexts. There are two Lewen reports, one commissioned by the American Dietetics Association on Medicare benefits, and study was done in 1997, and I will leave a copy courtesy of the American Dietetics Association for you.

This estimates that a net seven-year cost to cover all Medicare beneficiaries for the nutritional therapy for the diseases for which there is strong data would be $370 million, an estimate savings including decreased hospitalizations and patient benefits at $1.2 billion for the same period. Savings is greater than the cost by the third year of this seven-year analysis.

Another study done by Lewen for the Department of Defense on tricare system estimates a net savings of $3.1 million per year by providing nutrition therapy.

A recent medical cost nutrition containment study that was done by the Oxford Health Plan on an expanded pilot program for the Elderly at Nutrition Risk in New Jersey and New York, which included 160,000 elderly patients, estimated a $10.00 savings per dollar invested in the program.

In a study by Gallagher and co-workers reviewed research on malnutrition in hospitalized patients and estimated a $4.20 benefit per dollar invested.

The clinical effectiveness I won't have time to summarize, but it is extensive. The cost effectiveness data are here for these studies, and the delivery was primarily by dietitians with adults in acute and ambulatory care settings.

We have one study that suggests there is a high degree of patient satisfaction with nutrition therapy, but more studies are clearly needed. We have a number of barriers to nutrition therapy, and I am going to echo the themes that have already been sounded.

The lack of recognition of nutritional therapy by dietitians and other nutritional professionals by Medicare and Medicaid in private practice health plans is clearly a problem.

Recommendations. We have legislation currently in Congress, H.R. 1187 and S. 660 to provide outpatient medical care coverage for medical nutrition therapy for diabetes and kidney disease, and we need this legislation, as well as to consider expanded Medicare and

Medicaid coverage as recommended by the Institute of Medicine report for the other chronic diseases for which nutritional therapy has been documented effective.

We need to reevaluate reimbursement systems, and we need to think about the research that is needed on efficacy, safety, and cost effectiveness, particularly on plant, food components, and phytonutrients for which many questions exist.

Thank you.

DR. GORDON: Thank you very much. We will look forward to the study.

Our final speaker on this panel we are actually giving 10 minutes to because he is talking about integration, so you can either take them all or take less as you choose. Harley Goldberg, who will talk about integrating a number of CAM approaches.

Integrated Overview

DR. GOLDBERG: Thank you very much. I am the medical director for Complementary and Alternative Medicine for Kaiser Permanente in Northern California, and I appreciate your inviting me to speak, and take a slightly different view.

We have heard some very compelling statements by a large number of presenters here, and I think you appreciate the difficulty of wrapping and lumping all of these issues together and calling it CAM when they actually need to be looked at independently in a case-by-case basis in order to evaluate effectiveness.

For the very reasons that your commission has been executed by executive order from the President, for the same reasons our executive director appointed a director of Complementary and Alternative Medicine to provide information on complementary and alternative practices to our physicians, to our members, to our health care providers of all types to coordinate a research program, to evaluate what education and training would be appropriate for providers that we were going to integrate into our program, and to identify what would be the appropriate access and delivery systems, much more than I could possibly cover in 10 minute, much less five.

So, we have taken a few steps to move forward and because of that, I was asked to discuss how we have gone about addressing these issues. By no means have we solved them all, but I will explain to you the steps that

we have taken in order to try to grapple with the issues.

First, our history. I explained briefly in your handout what Kaiser Permanente is, so that you can appreciate the size of the organization and the complexity of trying to answer some of these questions, but initially, we also did a survey much as Dr. Gordon reviewed the surveys at the outset of this meeting. It was published in the Western Journal of Medicine in September of 1998.

I will be glad to make that available to you if you need it, but it basically gave the same kinds of illustrations of data that you reviewed and showed that there was a very strong interest amongst our members and our patients, as well as amongst our physicians and clinicians in complementary and alternative medicine, and it outlines by breaking down, modality by modality, the percentage of interest.

Suffice it to say that 50 to 75 percent of our members were using, and are interested in using, various CAM modalities. How you define that always changes the numbers.

In addition, however, what was really

surprising to us was the same percentage was true for our physicians and health care professionals. That actually is what generated the appointment of my office, and the way we have recognized drivers for this issue basically is that there are two drivers. Members have a belief in, and demand for, CAM services.

Physicians have a request for evidence, physicians and all health care providers have a request for evidence and safety and effectiveness in order to know how to meet those demands. Therein is the tension, and to address that we basically chose which CAM areas to evaluate based on the prioritization of member interest and how to evaluate them was based on the physician requests for summaries of the evidence on safety and effectiveness, not unlike the discussions we have heard earlier today.

I guess I should say overall our approach to complementary and alternative medicine as an integrated health care delivery system is no different than that approach that we take to our overall program.

Our strategy is to incorporate services that are safe and effective treatments, providing the best

access and most efficient service, through integrating that in our health care delivery system. That means we have major medical centers and satellite facilities with providers of all types integrated throughout the State of California.

So, we approach CAM in precisely the same way. In order to do that, our advisory panel was appointed with representatives from education, research, executive offices, and clinicians involved in actually practicing modalities that were the primary areas of interest.

This advisory panel directed the process and made policy recommendations as we move along. The areas of interest that were revealed in the survey were grouped into general categories with all the difficulties that that might incur.

Those were manual therapies and movement programs, traditional systems of medicine. Subsets of that would be acupuncture. Mind-body approaches to medical care of which there are many, and nutritional supplements, herbs, and dietary approaches, as well.

Given the magnitude of these areas, we prioritized our work by differentiating, perhaps

arbitrarily, treatments that were for treatment of disease, and then methods for health promotion.

Those treatments that were used for treatment of disease were evaluated for safety and effectiveness, and, when warranted, would be considered for integration by physician referral.

Because of the nature of the fact that there is a disease state involved, we felt it incumbent upon us to be fully responsible for appropriately working up diagnosing, et cetera, and rolling treatment into that.

For those methods that were identified primarily as health promotion, they would be evaluated for integration into an integrated health education program that we have, that is integrated into all of our facilities, and that would be by self-referral as distinctly different from treatments for diseases.

The advisory panel then commissioned standing committees on education and research. The Education Committee has basically two charges, one to provide the summary of information to our physicians and health care providers, and the other to produce information along with our Health Education Department, in another

language, if you will, for membership, as we term the public or patients, all the same people.

The advisory panel commissioned multidisciplinary work groups for each of those areas that were lumped, if you will, to evaluate the evidence for safety and effectiveness for each of these areas.

Essentially, this amounted to performing systematic reviews, and as several people have talked about, how much literature there is out there, that is a daunting task.

Having been at it for a while, I can assure you that it is not as easy as it is to say, and we can talk about that a little bit more at the end, if you like, but systematic reviews basically drive the information.

All of this discussion is trying to put ourselves on a foundation of what works and what is safe or not safe, or what doesn't work or why, and that all skirts an issue that we need to talk about at the end about belief, which may be that interface between the public's demand and the clinician's need for evidence-based, placebo-controlled, randomized trials.

Having said that, the systematic reviews drive

the information that the Education Committee puts out for members and for clinicians. It also informs the research agenda that is driven to answer the questions unanswered, and therefore becomes the foundation of the work.

It is also used, this information is also used in consideration of what services to deliver. In general, to be considered as a treatment for a condition, that is, a treatment for disease, that is, we require that there is reasonable evidence of safety and effectiveness.

In addition, we ask that a quality assurance system be available before we take the next step of considering integrating something into a treatment program for treatment of disease.

Who provides the service and where is actually determined by very practical issues in the context of our overall integrated health care system, and we can talk about numbers of examples if we have dietitians involved and dietary care.

If we have various practitioners of manual therapies involved, where do those people actually live are they in the Ortho Department, in Physical Therapy

Department, are they in Primary Care, et cetera.

There are answers actually to all of these issues, but, in fact, what happens when you look at it carefully is that there are many answers. It depends on the size of the facility, if it is a small facility in a rural area versus a large medical center in a major area versus whether or not there is a specialty care process involved or primary care process involved.

Suffice it to say, it is not one answer, and it is not a simple answer, and it is not a restrictive answer. It is a "both and" answer, in other words, we can have, as we do, physical therapists in our primary care modules, as well as in our Orthopedics Department, as well as in a free-standing department and how we integrate who sees them, when and how is dependent on how the patient presents with their clinical condition and where.

So, we are considering systems further to deliver services when there is evidence of safety but effectiveness is unknown, which, as has been stated before by panelists, is largely the case.

When that is the case, actually, what we are

looking at is a self-referral system that is at patient's cost, and something that hasn't been talked about much, but should be, because it drives all of this really is who pays. You have to identify that, and basically, we are looking at various models to try to answer that.

It is not easy. There are many ethical issues involved. It is very difficult to sometimes determine when a therapy is a treatment of disease versus for health promotion.

We want to encourage health promotion, at the same time, who pays is an issue when you have a single dollar, if you will, pot to pay for all services, and I sit down in the Chiefs of Medicine peer group meeting to discuss implementation of all of medical care for that department, and they look at me knowing what I am doing and say you are the guy who wants to take some of the money, this is essentially taking another primary care provider out of the office or someone off call or someone out of the ER in order to provide these other services.

The only way to answer those questions is with good evaluations that show that we have equally or more effective care that helps them and helps our member and

our patient most importantly, provide them the best health care available.

So, my policy recommendations, if I may quickly, is that we need to fund an organized systematic reviews in a coordinated fashion on specific CAM methods and by clinical conditions. This will be the basis of the evidence-based approach in forming the educational materials, and the research agenda.

We need to increase research on clinical implementation of specific CAM treatments for specific conditions involving CAM practitioners and experienced researchers, and we need to compare that to standard care that is largely nonexistent right now.

Creating and supporting public and clinical information systems out of that, and then accelerating the research focused on belief and mind-body medicine which lies at the interface of these two driving forces.

I would like to acknowledge that one of my colleagues, David Sobel, who is the Director of Health Education, was asked to come and present mind-body medicine, but was unable to attend, so his materials are in your packets. Very clear cost effective analyses are

done on mind-body approaches, and I think there is little question about the effectiveness and safety of those approaches.

DR. GORDON: Thank you very much, and we will be asking David and some of this colleagues perhaps to come back at a future session.

Questions from the commissioners.

Veronica.

Panel Discussion

DR. GUTIERREZ: I would like to ask Dr. Goldberg two questions actually. The first is which services are you providing based on guidelines versus clinical necessity, and secondly, what services require gatekeepers at the present and who fills the role of the gatekeeper?

DR. GOLDBERG: Guidelines versus clinical necessity? I am sorry, I don't understand. We developed these recommendations. You could call those guidelines. Those are driven initially to be looked at by clinical necessity, but to answer your question about which services, specifically, we provide acupuncture services in the context of chronic pain programs.

There is actually multiple answers here because there are answers around what we do as an integrated base coverage in our entire system versus other methods of delivering systems as supplemental riders by self-referral and/or access through affinity programs, if you appreciate what I am talking about.

Those are just health care delivery systems issues, but I will presume your question is about base and then I will say that right now we are integrating acupuncture as one component of our chronic pain delivery systems, and that is a multidisciplinary program that is one aspect of it.

In addition, manual therapies are provided through our Physical Therapy Departments. Health education programs have a whole array of choices of mind-body approaches. That will be where I would stop for now.

Is that answering the question you are asking?

DR. GUTIERREZ: Yes.

DR. GOLDBERG: I think there was a second half, but I am not sure I got it.

DR. GUTIERREZ: I was asking who plays the role

of gatekeeper?

DR. GOLDBERG: Oh, right. That is the differentiation between if a service requires physician referral and if a service is available on self or patient referral. Basically, if it is a specific treatment for a clinical condition, it requires a physician referral, and the primary care provider, if you will, is the gatekeeper although referrals can come from any specialist or any provider in the system.

DR. FINS: This is a related question for Dr. Goldberg. What kind of consensus was generated, tell us a little bit about the process, were consumers participating in this process, was there disagreement, where were the fault lines, where do people sort of disagree, and how did you read those bright line distinctions which look good on paper, but were probably difficult to achieve?

DR. GOLDBERG: Right. I appreciate your sensitivity to that. Basically, we selected, as I said, the areas that we would evaluate based on the surveys, which were done of tens of thousands of members, and the summaries of those surveys, which is actually in that

article I referenced in the Western Journal of Medicine, September of 1998, Nancy Gordon and David Sobel, lead authors, basically, we used that as our guide to start with, and then we used multidisciplinary clinicians, so depending on the thing we were evaluating, clinicians involved in that service, as well as some clinicians experienced in epidemiologic systematic review process to evaluate the data.

So, we didn't actually have members involved in reviewing the evidence because we didn't feel that was where they could be most helpful, but they were involved in selecting what we chose to review first.

So, actually, my request of this panel is that the Commission provides funding and support for systematic reviews that would be done to help Christopher and to pay Christopher to review herbs for us, and so then I don't have to repeat what he is doing.

Obviously, he is doing a much more thorough job perhaps than we did on the beginning of our herbs. It is scattered throughout and it is the same evidence data, and if we had respected people doing that work for us as a whole, the whole country and world would benefit.

DR. GORDON: Let me say who I have. I have George Bernier, George DeVries, Bill, Tieraona, Ming, and Wayne. Anyone else? Okay. David afterwards.

Go ahead, George, and then George.

DR. BERNIER: I would like to ask you about the educational process. Since that is one of the areas that we have been asked to really comment on, you have had the opportunity to develop educational processes for people at various levels.

What would your idealized system be? How could you best educate the population --

DR. GOLDBERG: When I asked that question to our director of Physician Education, her answer was eight times, eight different ways repetitively meaning to say that what we do, in fact, is provide information in written format on paper electronically, in summarized versions, in full guideline versions including the bibliography of all the work we did, the evidence tables that we created, the summaries of that clinical information.

In addition, by video conference presentations which we do on a quarterly basis for our system as a

whole, et cetera. Members also, and public, in addition, want education, and basically the answer is that it is an entire effort that must be conducted periodically and repetitively on each of the areas of interest.

Is that answering your question?

DR. BERNIER: Yes. Thank you.

DR. GORDON: George.

MR. DeVRIES: This question is directed to Dr. Awang, Dr. Gaby, and Christopher Hobbs.

Do you have recommendations on improvements that could be made to labeling regulations for herbal and dietary supplements based on some of the concerns that were expressed?

MR. HOBBS: One recommendation I have is to talk about a traditional medicines category because again there are so many herbs out there that are being sold and being used, for instance, 5,000 herbs in the Chinese Materia Medica, probably in this country, commonly used 500 herbs or maybe at least 100 or 150 herbs in the common herbal practice, and we can't have the level of evidence that we would like in the next few years.

This is going to take years and years. It is

difficult to study herbs because they are not monosubstances, they are so complex. So, a traditional medicine category basically would look at the historical and traditional, the best evidence in historical and traditional medicine, which is vast, and it goes back several thousand years.

Hippocrates already talked about using Vitex Agnus-Castus for hormonal imbalances, Dioscorides, which is a Greek physician in the first century A.D., talked about St. John's Wort for mania.

So, this has been around for a long time, but if we have a traditional medicines category where the best evidence of traditional use and efficacy is taken and reviewed, and then manufacturers are able to put these types of recommendations on their label, to better educate consumers how to use these medicines or herbs, because they are out there on every level.

They are in the drugstores, they are sold everywhere, and multilevel marketing, and so forth, and frankly, a lot of the advertising and a lot of the information that is going out is not very good, it is not high quality, and on the web you can read anything. What

I have seen out there is just ridiculous.

So, obviously, we can't study scientifically and prove all of these herbs that are being used right now, today, in a very short time. We have to have some system, so that manufacturers and some guidelines, and American Herbal Products Association is working on this, American Herbalist Guild, some other organizations are working on recommendations to the FDA for a traditional medicines category.

DR. GABY: My answer is similar. In relation to nutritional supplements, there is a lot that is already known as far as adverse effects, other interactions, for example, with drugs or nutrients, and there is also a lot that is known on efficacy. Apparently, there is a law about what you are allowed to say for efficacy, but you can always say what the strength of the evidence is, for example, an uncontrolled trial showed that something works, or Dr. Jonas' double-blind study showed that niacinamide is effective for osteoarthritis.

If you are taking more than a certain number of milligrams, see your doctor. If you are taking so-and-so

drug, do not take this without seeing your doctor. This would greatly enhance both the effectiveness and the safety, and it would probably greatly reduce the number of visits to doctors without causing harm to people.

DR. AWANG: First of all, I would like to say that there is a lot of information that can be put on a label, and a lot of information has been put on a label. Much of the information is unreliable.

I think at this point of the state of regulation of these materials, which I think just about everybody agrees they are pharmacologic agents, not nutritional supplements, that the most useful information you can put is warnings against possible adverse effects or toxicity, and recommendations as to use, but that is a very difficult area because if you are not going to allow claims about treatment of disease, conditions, and so forth, then, you are severely limiting what you can put on the label.

In fact, the pharmacologists, in an article some time ago said -- I will read it here verbatim -- "Rather than claims to treat disease, one sees vague suggestive comments on herbal product labels and

advertising material."

For example, Saw Palmetto is supposed to promote prostate health rather than treat symptoms of benign prostatic hyperplasia, which I think everybody knows is what they are buying it for.

So, at this point, I mean you see so many labels of Saw Palmetto saying 85 to 95 percent fatty acids. Now, I have serious doubt that you can rely on that content in the vast variety of products that claim that.

What has happened is that when the original clinical research was done, and the material properly characterized, the estimation was that the fatty acids ranged between 85 and 95, so everybody else does that, as they do for 24 percent of flavonoid glycosides and 6 percent terpene lactones for just about every ginkgo product you see.

So, unless this area is better regulated, I think the usefulness of the label is severely limited.

MR. HOBBS: May I make just a quick comment?

DR. GORDON: Yes. One thing I want to say to everybody is for this panel, we have 15 minutes more and

we have to end.

MR. HOBBS: Just that the label is more than what is on the bottle. Remember that many manufacturers use magazine articles, advertising on the web, and so forth, to advertise, so really we have to consider the wider conception of the label is a lot more than just what is on the bottle.

DR. GORDON: Bill.

DR. FAIR: My question is to Dr. Brannon. First of all, thank you for this nice handout. As I look at the mosaic of nutrition, I see there is the proper eating portion, which I guess is nutritional therapy, and then I think there is a role of supplements and some diseases, vitamin E in heart disease, or Saw Palmetto, but I keep getting more and more questions from people recently about some of these approaches, what I guess you would call taking function foods and desiccating them or lyophilizing them and putting them into a capsule or a drink, I guess 2-Plus or something like that is one, and it is often sold through a multilevel marketing system.

My specific question is, is this a valid approach, is this something that should be considered as

a way of increasing access to good nutritional habits if people say they don't have the money or they don't have the time to eat the way you would tell them to eat?

DR. BRANNON: I think that we are going to see more and more functional foods, so the issue of whether it is appropriate or not is probably a lot less important than how we are going to handle it.

You are going to see more, and I think it is being driven by consumer demand, benecol-containing margarine is a good example of that. However, what we are missing -- and I think it is a thing that we are missing in all of nutrition -- is how does it fit with what the diet as a whole is.

So, some of these foods, if a consumer thinks that they are going to use benecol-containing margarine in a high fat diet that has a lot of other saturated fat without any of the rest of the aspects that we know are part of a healthy diet for an average American, that is a misconception, and it is not one that, as I looked at the literature available, the literature available addresses very well.

So, when I said I thought there was limited

data on dietary supplements -- and I would put functional foods as maybe an unusual category of a dietary supplement -- in the context of the diet as a whole, it is hard to know, looking at these studies, what the rest of the diet looks like.

I think that is part of the efficacy problem that we have in evaluating nutritional therapy.

DR. FAIR: If people are skipping adequately eating, can they make up for it by taking pills or drinks?

DR. BRANNON: Well, that gets to the fact that for many of the issues we don't know what the bioactive food components are really, and I would point to the recommendation that still holds up, which is increasing the consumption of fruits and vegetables decreases your risk of cancer.

The hypothesis that was beta carotene mediated doesn't appear to be true, and, in fact, we have some evidence that beta carotene in high levels is not safe and can actually increase the risk of cancer.

So, what it is, is that there are many things in foods, and this is, I think, an important fundamental

principle as we move forward, that small amounts of many different substances together can be more effective than large amounts of any single substance, and we frankly don't have data that evaluate that.

DR. FAIR: My question is still do you have to eat the fruits and vegetables to get this effect or can you get it in a capsule or a drink that is supposedly made from the juice of all these fruits and vegetables put together?

DR. BRANNON: I don't think we have enough data to give you a yes or no answer on that.

DR. GORDON: Tieraona.

DR. LOW DOG: It is sort of on the tail end of that. You know, listening to all of this and talking about access and delivery, there is such a big spectrum, isn't there, from just talking about food and how you prepare your food and eating a healthy diet to taking megavitamins or orthomolecular medicine, heavy nutritional supplements, and there is also the same argument with herbs, using whole herbs, which again comes back to whole foods and recognizing that there is probably lots of things in there that work together to

make it the whole more than just the sum of its parts, and then there is standardized extracts, there is this huge range, and part of what we are trying to figure out is how to make recommendations, how do you make recommendations that will enhance the access delivery in health care of people here.

I guess I would like some ideas from you all when there is such a broad spectrum, from whole herbs, whole foods to minute dietary supplements, ancient wisdom that has been around forever, and now new scientific technology with very complex kinds of things.

How do we begin to address that, how do we begin to make recommendations when it is so big and so vast? Chris.

MR. HOBBS: My feeling is we will never understand, we will never get to the bottom of the complexity and the mystery of herbs and foods. Also, to address your question, will juice powders give you the same thing as a whole food, no, they will never give you the same thing as a whole food. They can approximate it, they can help supplement if a person is not eating any fruits and vegetables, then, a juice powder is probably

better than nothing at all.

As far as herbs go, my feeling again is that go back to the traditional herbalism, there is still, even in this modern science of all the studies and all the science, there is still a place for traditional medicine, there is still a place for a traditional system of medicine like traditional Chinese medicine, Ayurveda, because it deals with whole substances, it deals with the whole herb in a context that is very, very ancient, and it also deals with people.

We are not considering so much that -- standardization just hasn't have to do with the herb and identifying the chemical constituents and the pharmacological action. It also is how does that herb or food interact with the person or the patient.

This is what traditional medicine studies, so each person is evaluated, each person is looked at in the context of that system, and then the herb and the food is applied.

So, I think, just to sum up, I think we have to go back to traditional medicine and we have to promote the study of traditional Chinese medicine, Ayurveda, some

of these systems that looks at the whole person and the whole food and the whole herb in the context of an ancient practice, and we can fragment these herbs and study them to death, but we will never get to the bottom of all the mysteries that are included in there, although I think we should try.

DR. BRANNON: I would also like to comment in the sense that I think that in the absence of knowing about effectiveness, that it is important we know about safety, and one of the guidelines for food, in particular, in diet, is that people make food choices for a lot of reasons, and as long as the food choices they are making are safe or don't have an adverse effect, then, how much should we worry about that particular food choice.

I would argue that in this context, we should probably worry about the food choices or supplement choices for which there are adverse effects.

DR. AWANG: I would just like to make a brief comment about the whole versus extract thing on the traditional versus modern usage. I feel fairly confident that you can't take enough ginkgo leaf to affect your

memory, but because the modern evidence for it is for highly concentrated extract, a 50 to 1 extract of ginkgo leaf, and that is what has been shown to be useful in Alzheimer's and memory, and so forth, but I don't think you are going to get it in corn chips or in a food drink.

Also, ginkgo itself has toxic materials in it, and you have to remove the ginkgolic acids and the ginkgo toxin, so one has to be very careful about that, as well.

DR. GABY: Just so we don't overlook what may be most important in the discussion of standardized herbs and concentrated nutrients and Juice-Plus, which probably should be called Juice-Minus, we talk about functional foods when our real policy, since the evidence is that eating whole foods or avoiding dysfunctional foods promotes health, we can create a policy which is somewhat outside the scope of medical care, but within the purview of the public health, to promote the use of whole foods in our society, and as a public policy, it is very simple to do that. That would be to tax junk food and to give a subsidy to whole food.

[Applause.]

DR. GORDON: Harley.

DR. GOLDBERG: Just in response to Dr. Low Dog's comment, we cannot do randomized clinical trials on very specific questions and get quick answers, it is a long process. However, to answer questions quickly, you can use epidemiologic data and other types of studies on populations which have been done, for example, the Chinese data on the use of soy in menopausal symptoms, et cetera, and get good, relatively quick answers to begin the process, so the short answer has to come from other types of studies than randomized clinical trials, and the spectrum of types of trials that are used and how they are weighted in terms of evidence and what that means is standard and is available, and we ought to use it.

DR. GORDON: Ming. I think we are just going to have time for Ming and for Wayne, and we are going to have to end. We need time to digest our whole food lunch.

DR. TIAN: My question is, I think that herbs are very important, easy, and also very complicated, and are we talking about the medicinal herbs or are we talking herb, because in this country, FDA regulates herb as a food supplement or a dietary supplement, so if it is

a medicinal herb, you should go to pharmacist or industry to do that.

When we do the herb, I think it will be very important to address the issue, what are the herbs commonly used, and also very safe, if you experts can list this, to submit a list or with any scientific support.

Number two, if the herbs with any health claim, as FDA requires, any label, you have to put that on it, but you can't say that is a cure or prevention or treat any disease, but again, what kind of a health claim would be reasonable to put on the label to guide the American public, and the medical profession, and to tell people which one is useful and what is dosage, or you want to use serving size, whatever you want to use, but that is very important.

I think American public and also medical professionals are a little bit confused, a lot of them are confused. They don't know which herbs you should take, so that is very important.

Number three, you know, WHO already has the guideline for herbal medicine, they call "herbal

medicine," what we call "herbal remedies," whatever you call, it is the same thing. Then, should we adopt that guideline for the United States, otherwise, how do we evaluate such a big issue? That is my question. Thank you.

DR. GORDON: All in 30 seconds or less.

MR. HOBBS: Oh. Well, first of all, there again we talked about traditional medicine and whole herbs. That generally can be thought of as being maybe a little safer than when you start purifying herbs, like Dennis mentioned, ginkgo, 50 to 1 extract.

Once you start isolating compounds and purifying them, then, you get into a whole different ballgame. I think, in that case, then, if you are using science and you are using fractionation to isolate compounds, this is closer to drugs, is it not?

Then, I think you have to have more safety data, you have to have more efficacy data, and because it is a different context now. You are getting into modern science, you are getting into more pharmacy, and so forth. Then, it requires more science, more efficacy studies, more safety data, and more very specific

labeling guidelines, whereas, with traditional medicine, then, you are working with a practitioner who understands the whole herbal medicines and applies it to a system of practice.

So, it depends. I think there is a very real division here between modern scientific herbal medicine, fractionated herbal medicine, and traditional herbal medicine, but I think both are necessary and both are applicable, and both can be effective in our country.

DR. GORDON: Wayne.

DR. JONAS: Thank you. One short question also to Mr. Hobbs. How do you know when you have a qualified herbalist?

MR. HOBBS: At this point, there are about five schools of herbal medicine in this country, also naturopathic physicians, which there are three approved schools, also study herbal medicine. Nowadays, chiropractors have some herbal training.

But really anybody can call themselves a herbalist. There are no guidelines. In fact, I believe that herbal medicine is not a real career choice in this country. There are no real guidelines for it. There is

no official terminology or definition for what an herbalist is. So, we are trying to do that now.

The American Herbalist Guild is the only national organization in this country, and we currently are working on registration. So, we are developing educational standards, we are talking about registration, that you take a test and you put your name on a registration roll, so at least a person knows that if you are a registered herbalist in the American Herbalist Guild, you have a certain modicum of training.

But other than that, it is going to take time, because there are so many different traditions, are there not? There is traditional Chinese medicine, Ayurveda, Western herbalism, and so forth.

So, this is going to take time to integrate it, but it is a very exciting time in herbal medicine today because all of these influences are coming to this country, Ayurveda, Chinese medicine, so we are working all this out right now as we speak, but I certainly agree with you it is not easy.

DR. GORDON: Thank you very much. I apologize to Charlotte and Tom.

DR. JONAS: This is a yes or no answer. Dr. Goldberg, I really appreciate what is going on there. I am a little skeptical about systematic reviews, having done many of them, sort of like counting chad, it depends on who is doing the counting and whether it has been poked all the way through or not.

[Laughter.]

DR. JONAS: I have a very specific question. Does your system provide acupuncture, does it make it available, acupuncture, for the treatment of chemotherapy-associated nausea and vomiting?

DR. GOLDBERG: At this moment we don't. We recognize that we need to move in that direction, and it is a matter of developing access and delivery systems, and we are working on that right now.

DR. JONAS: Related to access and delivery, which is what we are talking about, in the area of nutritional therapy, for example, for hypertension, how much time and how many visits are allowed for the nutritional treatment of hypertension?

DR. GOLDBERG: There isn't a limit.

DR. JONAS: There is no limit.

DR. GOLDBERG: Just like how much time and how many treatments are available to the physician for the treatment of hypertension. They come in, they get a diagnosis, they get a treatment plan, they get followed up, but they may not move to the same level of nutritional therapy that Dr. Gaby is talking.

DR. JONAS: I am sorry?

DR. GOLDBERG: They may or may not depending on the nutritionist's treatment program. It may or may not be the same level of treatment that Dr. Gaby is talking.

DR. JONAS: So, it will be kind of an individual consultation with a nutritionist.

DR. GOLDBERG: Yes.

DR. JONAS: And it will depend on those skills and that type of thing.

DR. GOLDBERG: Right.

DR. GORDON: Thank you, Wayne.

One thing I would like to mention to the commissioners aside from apologizing to those of you we couldn't include in this time, we will have time to address questions of licensure, education, research, and other issues in subsequent sessions.

I think if we can focus even more, discipline ourselves to focus on access to services and service delivery, that will help us move ahead, and we can ask the people on this panel, if we want them back, to address some of these issues, for example, how do you know who an herbalist is, and how do you proceed with that. We can ask them back for the panels on education and licensure, et cetera.

So, we are going to take a break now. We will return at 1:35.

[Lunch recess taken at 12:25 p.m.]

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A F T E R N O O N S E S S I O N [1:35 p.m.]

Public Comment

DR. GORDON: This is the section for Public Comment. We are going to have three panels of four persons on each panel. I would like the first panel to come forward. It is Francine Butler, Nancy Dolores Kolenda, Diana Chambers, and Rustrum Roy.

Oh, we are going to get two panels together. This is our logistician here. We would like the second panel to come up. It will make life easier.

David Murray Blalwas, Kathleen Golden, Natalia Egorov, and David Edgar Molony, please.

What we will do is we will have the first four speakers and then we will have a time for questions from the commissioners, and then the next four speakers.

Each speaker in public comment time has three minutes, and we are going to be ruthless. So, we invite you to make full use of your three minutes.

First is Francine Butler.

MS. BUTLER: Thank you. Good afternoon, everyone. On behalf of the members of the Association for Applied Psychophysiology and Biofeedback, I want to

express thanks to the Commission for inviting us to share some thinking on access, delivery, training, and credentialing of CAM providers.

I serve as executive director of the Association representing an organization that is 32 years old, has 1,800 members in several disciplines. We are primarily psychologists, I would say about 65 percent, physicians, and nurses each represent 8 percent, social workers, physical therapists, occupational therapists, dentists, chiropractics represent another 12 percent, and the balance are students.

Biofeedback is one of the most well-established of the CAM therapies. The efficacy of biofeedback for the treatment of specific disorders compares favorably to traditional medicine. There is a large body of scientific work demonstrating treatment efficacy and absence of adverse side effects. Only a month ago, HCFA agreed to recognize biofeedback for the treatment of incontinence.

Nevertheless, biofeedback is not a household word, nor is it an accepted word in traditional medical treatment. The largest problem with access and delivery

that patients confront is denial by third-party payers because biofeedback is still branded as experimental.

Individuals should not have to be forced to turn to other procedures with high-risk factors when biofeedback has virtually no associated risk factors for treatment, nor should patients who are unable to afford services be encouraged by physicians or insurance companies to use medication or therapies that in some cases may be less effective or simply treat the symptoms.

We recognize that more research is needed. Like other CAM treatments, biofeedback has not been provided adequate clinical research funding to conduct necessary large-scale clinical outcome studies, so that treatment can be evaluated as to efficacy and risk, but biofeedback and other CAM applications should not have to be held to higher standards than other medical protocols, of bearing the proof of burden of efficacy either.

Access is more than just finding a practitioner. It means responsible delivery of, and public access to, quality information about the conditions for which the treatment has efficacy.

It implies developing guidelines for good

practice management and delivery of service. It implies developing a knowledge base and ensuring that practitioners have met at least minimal criteria to deliver treatment.

I am proud to say that biofeedback has met all of those criteria. APB, the membership association, has developed practice guidelines and standards. We have prepared white papers on efficacy, and we have developed consumer information brochures.

Most importantly, we recognize the need for identifying providers, and through the Biofeedback Certification Institute of America, we developed a procedure for credentialing practitioners.

Our goal is to see that this credential be the recognized standard of practice in this field. Hopefully, we can be a resource to the Commission and to other colleagues as they develop these areas in their practice.

Despite these efforts, our work is not done, and we are far from it. With the good officers of the Commission and the NCCAM, we will have support to complete the needed clinical research and remove the

barriers to acceptance in the third-party arena. In turn, cost effective and efficacious biofeedback will contribute to benefit our citizens' health and welfare.

Thank you.

DR. GORDON: Thank you very much.

Nancy Dolores Kolenda.

MS. KOLENDA: Good afternoon, everyone, and I thank you for allowing me to be here and express some of my ideas concerning advancing clinical research. I am the director of the Center for Frontier Sciences at Temple University, and in my 13 years there I have seen a real revolution come about and acceptance of new complementary and alternative medicine therapies.

The question that I raise today is what can be done to expand the current research environment, so that practices and interventions that lie outside conventional science are adequately and appropriately addressed.

Well, my response to this question is the fact that it is important that the major medical schools and research centers throughout the United States have access to funding to set up models to study various CAM therapies, such as herbal medicine and homeopathy and

acupuncture.

I believe it is important for the NCCAM and the firms that are related to these various therapies to make this funding available to these schools and institutions.

The idea that I really see fourth in this is that when you review the latest figures as to what is being spent on CAM therapies, you can see that there are firms benefiting from these investments, and they, in turn, must be willing to invest in furthering the research on such therapies.

I have really seen the importance in it right now because our major medical schools I may say, speaking from our own and Temple, are going through critical financial crises right now in health centers, and I am sure they would be more open now than ever to incentives to advance the research in complementary and alternative medicine therapies, and encourage that we help to find that for them and make it accessible for them, and stimulate them to do so.

I thank you.

DR. GORDON: Thank you.

Diana Chambers.

MS. CHAMBERS: Good afternoon. It is good to be with you again.

Before addressing the issues of access and delivery, I just want to pick up on the conversation that we started in October on language and philosophy of healing, because I have been thinking about it some more, and we have been discussing it at length with different leaders in the field what the options might be.

We have thought about matrix medicine or multidimensional medicine, and all sorts of things, but at this point, Friends of Health is recommending using the phrase "whole person healing" as the phrase to best describe the practices for which we are advocates.

"Whole person" moves us beyond the distinction of mind and body, and allows for inclusion of the spirit dimension, and "healing" is preferred over "medicine," the latter being so associated in many people's minds with drugs or a pill.

We are concerned to recognize that the practices for which we advocate have their own long-standing foundations, and they should not be defined over against conventional allopathic medicine.

As far as philosophy is concerned, we want to recognize that in integrative medicine we have the meeting of two vastly different philosophies, with Western high-tech medicine focused on fixing, fighting, and curing disease, while whole person healing practices focus on prevention, wellness, and health.

Probably the greatest distinguishing factor between these two philosophies can be found at the point of death. While Western allopathic medicine treats death as an event always to be opposed and avoided at all costs, whole person healing recognizes that death is part of the human experience, and it is possible, and indeed a part of healing, to die well.

So, Friends of Health wants to ask the Commission to include within its work a very careful review of these issues of language and philosophy, knowing that the ways in which we name practices define them and affect their very nature.

The language of CAM is clearly limited. Many of the people testifying in front of this commission have evidenced their frustration with the language, and these limitations need to be addressed before the practices

that we care about lose their essential nature because of the language that we apply to them.

I also want to say a couple words about access and delivery. Friends of Health has a particular commitment to the poor and underserved population, so I am delighted to have an opportunity to say a couple of things for them.

The first question you raised was do patients and health care providers have ready access to CAM practices and interventions, and clearly from the perspective of the poor, the answer is no.

The constituency with which we are concerned is the poor, both urban and rural, and other than a few notable exceptions, such as the wellness center at N Street Village here in D.C., that offers whole person healing practices to women who are in transition from drug and alcohol abuse and were formerly homeless, there are almost no targeted provision of such whole person healing services.

For those without insurance and who cannot afford to pay out of pocket, there is no access at all to these practices, and this must be addressed both for

issues of equity and also that this constituency places a significant burden on the public purse, which could be alleviated through preventive whole person healing practices. I have some ideas as to what we might do about that.

DR. GORDON: Thank you.

Rustrum Roy.

DR. ROY: Thank you, Mr. Chairman.

I bring a slightly different perspective from most of our colleagues here, that of a working scientist, a physical scientist, 50 years on the faculty at Penn State, 25 years directing its major physical science lab, and deeply in the state about science today from nano stuff to diamonds.

I am involved in the whole integrative medicine, friends of whole person healing group through my mentor, Linus Pauling, to my friendship with Norman Cousins and Yvonne [Illich] and Chopra, and that is how I have gotten into it for 25 years.

From that perspective, I am going to respond to your questions about access. Access for whom? There are three communities I want to identify, which have not been

touched on much. The first community is the half million physicians in harness -- I am not talking about new medical students -- in-harness physicians. Are they being given the appropriate knowledge about whole person healing?

The second population is academic scientists or the world of science, research scientists, and the third is the general attentive public, which, in theory, we call the attentives.

The first one, how the present approaches are much too small. You need real emergency education program for the in-harness physicians. The consumer public is going to them, and how are you going to attack him? I work with Andrew Weil at the University of Arizona. We take four fellows a year, and now we are doing CME stuff. Maybe we will get 100, but that is piddling compared to the problem.

So, you have got to think of an emergency, not making them into alternative providers, but making them into knowledgeable about and how to guide people.

The second population is the world of science. In science, we have moved beyond all this pettiness. We

are in a globalized world where we take information from China, from India, from anywhere. Here, we are stuck in a Western model. You have to get out of that. This is not the only source of truth.

So, if the Ayatollah is running around telling people what science is, and they have had the press up until now, we really have to change that attitude among the scientists with information.

We have collected a group of the highest powered world scientists, and these people will be working now for the next several years on presenting to show that science in the best sense is not opposed to alternative medicine at all. In fact, it may very well be the basis.

To the public I give you an example of a newspaper, the Pittsburgh Post Gazette, as compared to the Times or the Post or the Los Angeles Times, does a wonderful job on educating its citizens in Pittsburgh about the kind of stuff that alternatives do, a modest, balanced presentation, so that we don't hear it occasionally as some funny stuff over here, so we need that.

Now, I have got a recommendation. I worked with the President. In Reagan's administration, we had zeroing out of science education. What you need, I think what our country needs is whole person healing education, a crash program. The Congress took it from zero to 700 million now, and we can have a modestly ramped-up science education program, CAM education program.

DR. GORDON: Thank you.

Panel Discussion

MS. SCOTT: Thank you all for your presentations. I was wondering if, Ms. Chambers, you could elaborate on some of your thinking about access to those communities of people who typically don't have access, and include some of your recommendations for how you would make sure that this population is included.

MS. CHAMBERS: Yes. Thank you. The question that the Commission had asked was how can access to safe and effective CAM practices and interventions be improved. Well, for the poor, the real question is how such practices can even be introduced, let alone improved.

So, I believe that the first step is to

identify the most prevalent conditions that threaten the health of the poor, such as obesity, heart disease, diabetes, drug and alcohol abuse, and determine which whole person healing practices might be most efficacious, such as acupuncture for the treatment of recidivism in alcoholics.

Then, given the culture of poverty, which is the environment of the poor, I believe there must be a tremendous commitment of quality resources to affect even marginal change.

One basic step in this direction would be the expansion of Medicare and Medicaid to cover whole person healing practices and products with the associated financial commitment to support this expansion, and then if provision of whole person healing practices and products for the poor were taken seriously, not only is the potential for significant cost savings, and hence broader provision through the release of resource, but -- I feel very strongly about this -- is the knowledge that the poor have been treated and welcomed as whole persons, a dignity that in the field of health provision, the more privileged have been able to claim for themselves.

So, for actual delivery to the poor, speaking from my personal 10-year experience of working with inner city programs that are concerned with the poor, I can testify to the obvious, that religious institutions offer by far the most effective systems for delivery to the poor of information, encouragement, and group support practices.

These systems have been shown many times over to be substantially more cost effective than federal and local government initiatives, so I feel that a coherent strategy for involving religious institutions in the provision of whole person healing practices and products should be introduced.

Thank you.

DR. GORDON: Effie.

DR. CHOW: Dr. Rustrum Roy, your concepts for the first two was very interesting. What is your third, the general --

DR. ROY: The general public?

DR. CHOW: Yes.

DR. ROY: In the National Science Foundation where we now have $700 million for science education,

remember, it was zero, it is $700 million per year, we do science literacy. That is at the level of the general public, and we do also science education for making scientists. Now, let's address the population of the general public.

We need CAM literacy among the general public. It is the kind of thing which the League of Women Voters did a wonderful job in the seventies on educating about the nuclear threat. It was very balanced, they got the best advice from DOE, it was earlier in those days, and we can do the same thing.

We can give balanced education for the general public. We have an excellent model, and I propose that we have a joint -- maybe the Public Health Service and NSF jointly.

NSF has a lot of experience in doing this kind of getting science knowledge out to general public, which they never use, by the way, and we spent $700 million on that, and we now need CAM knowledge, so they can use it. A lot of us know that wellness is going to be the most cost effective. So, I would think that the model that we have is existing, it is funded, I don't know, a few

hundred million bucks, in the NSF and the federal agency to do exactly what I am talking about in the area of CAM.

DR. CHOW: If you have the model, is that possible for you to send it in to us?

DR. ROY: Of course, of course, sure.

DR. CHOW: We would appreciate that.

DR. ROY: I will. Thank you.

DR. GORDON: Charlotte.

DR. LOW DOG: Dr. Roy, thank you for your presentation, and all of you. I would like you to speak -- you can just go off from here because I know you can say a bunch of things -- about the new science, the world science, and the implications for research in alternative medicine.

DR. ROY: Well, it is not really new in a way. When quantum mechanics was introduced, most of the people missed the significance of it. You remember that Einstein opposed it for 27 years. I have quoted him at least 20 times when he opposed quantum mechanics.

But the real implications of quantum mechanics opened the door for many of the phenomena which we see. I have come back on the red eye from Honolulu to get here

in time for this, and we had a whole groups of presenters in Honolulu on this kind of topic about saying what is the model of science which permits the interaction of humans with so-called dead matter, and what are the models in which we can see many of the phenomena manifest in Qigong practice, that we used to say, well, this is all nonsense from China.

Well, you know, acupuncture was also labeled that way. Within science, there is nothing to say then. Science from Aristotle to all the great, we have said, science is based on fact, not on explanations. The facts are the first principles of science. I am quoting [Nicho] Mccann Ethics from Aristotle.

So, in a very real sense, science permits us to go where man has never been before, women had never been before. We can go to some of these new, well-established scientifically validated and empirical data in China and India, and so on. We should look at them. We don't stamp them and say this is okay, but we should look at them.

DR. GORDON: Thank you.

Yes, Conchita.

DR. PAZ: This is for Francine Butler. I was wondering if there is other areas besides the incontinence issue that biofeedback would be real helpful for.

MS. BUTLER: Yes, indeed, there is a whole panoply of applications for which biofeedback has been demonstrated effectively. Just for fun I brought our notebook on white papers with us, and this is a summary of probably 16 different applications, quick summaries with the kinds of applications and the data used to support these demonstrations.

DR. GORDON: Buford.

MR. ROLIN: This is for Ms. Chambers. You gave an example of acupuncture and how it could be used. Are there models or do you have any data for other models that you may submit to us?

MS. CHAMBERS: With regard to acupuncture specifically?

MR. ROLIN: Right, acupuncture or any of the other areas that you mentioned.

MS. CHAMBERS: I can certainly get that acupuncture materials for you. The traditional

Acupuncture Institute has been doing a study at -- I think it is called Penn North -- Penn North in Baltimore, that has shown a lot of advantages of the use of acupuncture and a lot of cost savings, working with the disadvantaged population, so, yes, we can get that to you.

DR. GORDON: Buford, there are two also at Hennepin County where Pat Culliton works. They have done work with alcoholics, and we can ask her for that, and in New York, Michael Smith will be presenting on work with addicts, that he really organized.

There are a couple hundred programs now around the United States based on his original work with addicts, that I think will be interesting. We can get those, as well.

MR. ROLIN: Thank you.

DR. GORDON: Any other questions?

DR. JONAS: I have an issue with the suggested approach, Diana, that you had for approaching the whole person healing. You took really what was a reductionistic approach to a holistic phenomena by suggesting that we look at the most common diseases and

then see which treatments would effectively alleviate them.

A whole person approach, in my perspective, would, in fact, look at chronic disease in general, and look at ways in which health can be promoted and thus a variety of conditions alleviated including improvement in function and this type of thing.

MS. CHAMBERS: Right.

DR. JONAS: It is a little bit difficult to then conceptualize how to deliver that in a disease-oriented, trained, reimbursed health care system, so I am just wondering if you had any thoughts about how that might be addressed.

MS. CHAMBERS: I agree with you, Wayne. I think I went that route because it is such an enormous field and issue and concern, and to try to break it down and to pick out a piece that might be doable was why I had gone that route.

I mean I feel like nutrition is a terribly important area for the poor and disadvantaged, and if we could work on nutritional health -- and we were talking a little bit about that this morning -- that that would

have a massive impact on all these other diseases that we are seeing.

And yet I have been then thinking, okay, so how do we do that. We have got to change the entire culture because the poor eat at McDonald's, you know, and you are not going to persuade them to go to Safeway and buy vegetables, take them home and steam them. It is not going to work.

So, that is why I had focused on a few things, but I would love to see the nutritional emphasis be a primary one, because I think it would have such a broad effect on the whole person healing.

DR. JONAS: So, in that case, not focused on a particular illness, but as general for health.

MS. CHAMBERS: Well, another way to look at it would be that those other illnesses would have been affected by the nutrition.

DR. JONAS: I had one brief question for Nancy Kolenda. That is, a number of groups are now getting into this field from the orthodox community, because there has been some money available.

How can we go about sorting through which ones

are truly going to capture the spirit of whole person health or how many are looking really at the bottom line, which is getting redder and redder by the year? Is there a way to approach those?

MS. KOLENDA: I think that there is a way to approach them. I know one thing, at our medical school now I am getting more questions asked about is there funding for different therapies. I have two doctors up at our medical school now that want to set up studies on acupuncture, and I said, well, you can apply to NCCAM, and they will give you guidelines on how to file for a grant.

Our medical students particularly, they are hungry for knowledge. They are upset that we don't have enough elective courses, and nutrition like is one thing we had a very big discussion on last month at our school that it is so important, that they get so little training in this, so I said that if they would do research on these different issues and the importance nutrition plays in overall wellness, I think we will be able to, you know, address these and get their interest in it.

I know one thing, in fact, even I have talked

to two major representatives from pharmaceutical firms who are also showing an interest to see what is out there, and the definition they ask for is what are CAM therapies, and I tell them what I know from my experience and what I have read and researched to investigate, but they are interested there, so I am hoping that funding will come about and see the importance it will play in overall health and reduce the cost of health care as a whole.

DR. GORDON: Thank you. We will move on to the next panel. David Murray Blalwas.

Public Comment [Continued]

DR. BLALWAS: Thank you. Good afternoon.

My name is David Blalwas. I am a nationally board-certified licensed acupuncturist practicing in Maryland. I would like to thank the Commission for this opportunity to testify.

I am here today representing State Associations of Licensed Acupuncturists from all across the country. My testimony concerns two important points.

One. To present the Commission with data concerning delivery of services and patient satisfaction

from a written survey of acupuncture patients conducted in the State of Maryland. I have copies of the surveys for the Commission's full consideration.

Two. In light of this evidence, to convince the Commission to recommend nationwide outcomes-based research studies on acupuncture and Oriental medicine as performed by fully trained licensed acupuncturists, and to have this research be the foundation for the formal governmental recognition of acupuncture and Oriental medicine as a medically effective, separate and distinct system of medicine in America today.

The survey was created and conducted by professional medical researchers. The written questionnaire was designed to provide journal quality outcomes-based research data on the care provided by fully trained licensed acupuncturists.

The researchers received 1,004 completed patient surveys. To our knowledge, this is the most extensive acupuncture survey of patient satisfaction conducted in the nation to date.

Here is a sample of the results from the survey. When asked to rate the effectiveness of their

acupuncture care, 55 percent reported it very effective for back pain, 49 percent reported it very effective for arthritis, 54 percent reported it very effective for allergies, 68 reported it very effective for stress and tension.

When asked, "With acupuncture, do you think you have been able to reduce your health care costs," 82 percent of patients responding said it reduced their visits to medical doctors, 73 percent said it reduced their use of prescription drugs, 56 percent said they avoided surgery, 69 percent said it reduced coverage demands from insurance companies.

When asked about a variety of lifestyle outcomes associated with acupuncture, 56 percent strongly agreed that it helped them work better, 56 percent strongly agreed they have less pain, 49 percent strong agreed they were less susceptible to illness.

When asked, "Who do you consider to be your primary health care provider," 44 percent of patients said medical doctor, 39 percent of patients said acupuncturist.

This outcomes-based format we used in this

study makes it possible to capture the full range of health benefits received by patients of acupuncture. While single variable double-blind studies can provide data on a single effect, acupuncture care has long been known to provide simultaneous multiple physical and emotional healing benefits.

We therefore strongly urge the Commission to recommend that futures studies into the effectiveness of acupuncture should take this outcome-based form. This allows for the expression and evaluation of the full range of health benefits patients receive from acupuncture treatment.

Lastly, let me stress that acupuncture and Oriental medicine is a separate medical system. It is a form of medicine whose history, philosophical approach, and treatment techniques are wholly different from allopathic care. It should not be viewed as simply a pain management technique that can be incorporated into the Western medicine system. It is a separate medicine that offers a much needed complement to the allopathic model.

Simply put, the preventive, restorative, and

health maintenance medicine people receive from acupuncture care is precisely what is missing from American's health care system today.

DR. GORDON: Thank you very much.

Kathleen Golden.

MS. GOLDEN: Good afternoon and thank you for having me here today. I am a licensed health care provider of acupuncture and Oriental medicine in New York State. I represent the Acupuncture Society of New York, which is a professional organization representing the interests of the practitioners and patients of New York.

As our focus today is access and delivery, I would like to talk about an issue that I think affects access and delivery for patients. Acupuncture and Oriental medicine is a rich complex form of health care. I feel strongly that Americans are obligated to preserve the integrity and wholeness of the medicine.

It has been an unfortunate pattern in our country to dilute the traditions of culture to suit an impatient nation. I do not wish to see acupuncture and Oriental medicine diluted to serve existing hierarchies of health care in subsuming this medicine to augment the

diminishing financial returns currently experienced or to boost professional all-controlling egos.

In this country, the acupuncture and Oriental medicine profession has established national education standards. These standards generally require graduation from an accredited three-year Master's degree program, passing a national board exam in acupuncture and/or Chinese herbs, which is administered by an impartial third party, and clean needle technique.

Completion of these standards enables a provider to be licensed in their state. In many states, allied health care providers are able to practice acupuncture with a minimal amount of training.

For example, in New York, doctors, dentists, and osteopaths can take a 300-hour training program in acupuncture and then become certified to practice acupuncture.

In many other states, this is also the case. An unfortunate consequence of this disparity in education is that the public consumer is generally unaware of the differences in education and quality of care that are possible.