It is also true in many states, including New York, that insurance companies will only cover acupuncture administered by a certified acupuncturist. That is to say, the Western doctor with 300 hours of training is eligible to bill an insurance company for acupuncture services while the licensed acupuncturist is ineligible. This is where the issue of insurance parity comes in.

It is absolutely impossible to begin to comprehend the depth of the scope of acupuncture and Oriental medicine in a 300-hour course. Yet, in many instances, the patient with limited financial resources has no option but to accept treatment from the less educated provider.

This is due to archaic insurance company reimbursement policies. Parity is not mandate. Mandate forces an insurance company to cover acupuncture services. Parity insures that if an insurance company chooses to provide reimbursement coverage for acupuncture and Oriental medicine, that all providers legally eligible to provide that service under the laws of an individual state be included in the reimbursement of that

service. It is also imperative that all providers be given fair and equitable financial remuneration for their services.

There are many patients in America who can benefit from acupuncture and Oriental medicine. It is important that this medicine be available to all who seek its benefits and that the patient seeking care under insurance coverage be in a position to choose who will provide that care.

A patient should not be locked into settling for a provider with 300 hours of training or less, when a provider with three years of training is a possibility. It is unacceptable that due to limited resources and/or limits in provider entre that Americans be denied choice in deciding access and delivery as concerns acupuncture and Oriental medicine.

I have recommendations and all, so pass this around to the Commission for supporting materials.

Thank you.

DR. GORDON: Thank you.

Natalia Egorov.

DR. EGOROV: Thank you.

Members of the Commission, good afternoon. My name is Natalia Egorov. I am a Pharm D., a CAM patient, a CAM provider, student of Oriental medicine, clinical and consultant pharmacist as a Pharm D., and chair of the Education and Research Committee and Executive Board Member of CSOMA which is California State Oriental Medical Association.

My interest is in facilitating infrastructure development for the appropriate and ethical integration of CAM and conventional medicine.

As such, I am in a unique position in California with CSOMA to witness and speculate on the multiple layers of challenges and opportunities in providing greater access and delivery of safe and effective CAM in general, and Oriental medicine specifically, to our patient populations. Many of these layers are as rich in their need for further integrated scientific inquiry as inquiry into their anthropologic humanistic and cultural aspects.

The primary concern of everyone that I have spoken with, interviewing them in preparation for this testimony is that these two different paradigms of

healing in medicine, by their very nature, if one is attempted to be integrated into another, the paradigm is lost, and that is the greatest concern of all CAM providers that I have spoken with, and this is the greatest caveat of integrated medicine.

Indeed, I believe one would be courting abject failure of optimized access and delivery of CAM without also embracing soft, qualitative, evaluations of real-world CAM systems of access and delivery, as these tools are also evidence-based, as basic scientists have expounded on.

An example of this failure to meet the demands and needs of the People of America for CAM is the current inadvertent loss of the holistic paradigm through fragmentation during validation studies and during attempted integration as with managed care.

It is also clear to me that true, sustained gains in integrative infrastructure development necessitate a change in management paradigm similar to TQM and CQI principles. I would be happy to go into that a bit more.

Being customer-focused, the consumer, and

empowering "front-line process owners," for example, Oriental medicine practitioners, in a non-threatening, multidisciplinary learning system nurtures a health care system where true meeting of the minds, teamwork, and innovation is powerful enough to overcome the current unhealthy health system riddled with its ego-based destructive inertia of turfing and distrust.

It follows, then, that the greatest incentive to increasing the probability of successful access and delivery of Oriental medicine, for example, is to include and empower full-scoped, independently licensed Oriental medicine practitioners in key processes.

Another is to support a Professional Doctorate in Oriental medicine, which includes acupuncture. I have details on how that can be done and what our profession has done to increase access and delivery in California.

Thank you.

DR. GORDON: David Edgar Molony.

DR. MOLONY: Good afternoon.

My name is David Molony. I am a professional acupuncturist and the Executive Director of the American Association of Oriental Medicine. The AAOM was founded

in 1981 and is the oldest and largest national organization of acupuncture and Oriental medicine professionals.

We were instrumental in creating the national certification and accreditation commissions for acupuncture and Oriental medicine in the early eighties, and for passing licensing statutes in many of the 39-plus states where acupuncture is licensed.

Over one billion people in China have ready access to surgical and pharmaceutical medicine of European origin, as well as to acupuncture, herbal, and manual medicine of Chinese origins.

The providers of these primary care services include nearly three-quarters of a million doctors of conventional medicine and over a half million doctors of traditional Chinese medicine. These two different systems of medicine co-exist harmoniously because Chinese citizens have equal access to, and a basic understanding of, both systems.

Their medical doctors were raised in a country familiar with its own traditions, and their doctors of traditional Chinese medicine have training that is an

evolving system of medicine that is balanced with a year or more of conventional diagnostic and therapeutic principles and procedures.

Both professions are thus reasonably well prepared to help patients make informed decisions about their health care options. We highly recommend looking at the Chinese model for the harmonious co-existence of traditional and modern, CAM and non-CAM therapies and professions.

The AAOM supports similar direct access to Oriental medicine professionals in this country who are well trained and licensed as primary health care providers, as professional acupuncturists are in a growing number of states.

We also support direct access to Oriental bodywork therapists, whose standards of practice leave little potential for confusion of their services as a substitute for comprehensive medical diagnosis and treatment. This could also expand into other aspects, as well.

We suggest the Commission can reduce the cost of health care on a national level by recommending direct

access to qualified Oriental medicine professionals through federal programs and by suggesting to State Governors and Secretaries of State on its use in public benefit programs, such as Worker's Compensation and Medicare, as well as private clinics, hospitals, and through state regulated health plans.

Oriental medicine has historically had a strong tradition of preventative wellness and self-care, and we are taught to serve as "guides" or "navigators." We communicate from a functional and energetic perspective, as well as from the conventional mechanical and biochemical perspective.

We have found that open and direct communication increases patients' confidence in our care, improves patient compliance, empowers patients to take more responsibility for their own health, speeds recovery, and often reduces the need for access to costly and possibly more dangerous interventions.

If prevention is to be recognized for its cost savings, and its more obvious health benefits, then Oriental medicine has a lot to offer.

Unfortunately, our profession faces constant

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

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

DR. GORDON: Thank you.

So, we have some time for questions from the commissioners.

Tieraona, Ming, George, David. We will just come around like this.

Panel Discussion

DR. LOW DOG: I like the whole concept in China where traditional Chinese practitioner and also medical doctors, they spend time actually learning from each other, so that there is an understanding and there is less animosity then, but would you agree that in some ways it is more difficult here because there, they are not studying homeopathy, anthroposophical medicine, Reiki, polarity, and massage therapy, Western herbal medicine, Ayurvedic medicine, biofeedback -- do you see

what I am saying? Here, because this country has so many modalities, not to even discuss the [quidendesmo] or the traditional healing practices of all the indigenous populations of this country.

It is just this vast, vast pool of healing modalities that makes, I think, it more difficult in some ways in this country, because it wasn't just one tradition that we are asking people to look at, it is many, as has been represented by so many people.

I guess my question is how do you think we can best help fix this problem between Western physicians and CAM therapists when it is so vast and it is so big, and the paradigms are so at odds with one another often?

DR. MOLONY: I imagine you are asking me. I think it has a lot to do with patient education more than anything else and patient choice, because I do think that if the patients are educated as to their choices, the people who are familiar with the [Kodenderos] will choose the [Kodenderos], and as long as those particular people have an awareness of their limitations, which I think is an important aspect of any CAM therapy, and should be in the education of any CAM therapy, that that would be able

to expand in that way, but it all starts with people education and making it so that they are aware of their choices in the matter.

I mean you ask almost any patient before they are exposed to acupuncture, which luckily for us is one of the first alternative things people choose because of the pain aspect of it, and they are totally unfamiliar with any aspect of CAM, and also they believe they worship at the altar of God of Science.

We have to recognize that science is not a god, and science, although we need to look at fact, doesn't have truth with a capital T.

DR. LOW DOG: So, basically, not to focus on education of physicians, which is what I thought at the beginning was about trying to cross, almost cross-training, but your recommendation is primarily to education of consumers, so that consumers can make educated choices, which then comes to access, that any practitioner should be available to provide any type of therapy?

DR. MOLONY: It is difficult for practitioners to recognize their limitations especially in the Western

medical conundrum that they are stuck in, and I think that it is important that we all recognize our limitations, and that there is just so much information out there that we have to really work at grasping where we stand with what we are working with.

I worship conventional medicine, like I was a month premature, and I am really happy I am alive, but I think that the understanding has to work on understanding limitations, as well as patient education I guess would it would be.

DR. GORDON: One thing I want to remind everybody is we only have a very few minutes for questions, so if we are going to get the most questions from the most people, we have to move it along, questions should be brief, and answers as brief as possible.

DR. BLALWAS: I just wanted to add one thing to David's statement, and I think it has to do with education of consumers, but also education of medical professionals in the sense of establishing a certain degree of equality for people from CAM modalities who are licensed and fully trained to be able to perform those services and to really complement each other in terms of

taking the strength of one particular medicine and applying that to another medicine which may not have that particular strength.

In the case of acupuncture and Western medicine, the sort of preventive/restorative maintenance benefits that acupuncture has been shown to have for 3,000 years, combining that with the acute care and trauma specialties that Western medicine does so well, really provides an environment that serves the patients equally well, but I think the lack of sort of the barriers and the turf battles that have existed in this country so far are keeping that education exchange from happening.

DR. GORDON: Ming, I think you are next in line.

DR. TIAN: The question is, what is Oriental medicine, the definition, and if you can make a definition because they are talking about acupuncture, which as I understand we need a national standard for, non-physician acupuncture plus the training requirements, and also it is what is Oriental medical doctors, what is qualification for that, what is training program, because

the issue I brought up this morning is we have so many herbal remedies or herbal medicine we are using for medical professionals, do patients need to ask Oriental medical doctors or medical professionals who have the knowledge to instruct patients to use that, because they have no idea which works and how much, what is dosage.

Thank you.

DR. BLALWAS: Well, it is funny that you ask this question. This is a question that is a very hot topic among the acupuncture and Asian medicine community right now. Several weeks ago, there was a task force convened by the National Commission for the Certification of Acupuncturists in Oriental medicine, and they brought a group of us together from the world of acupuncture, from the world of herbs, from the world of Qigong, Tai Chi, Asian bodywork, and a number of other disciplines to actually try to began to tackle this issue of what is Oriental medicine.

We weren't able to do that, not in that one setting, but because of the wide range and diversity of what is being called Oriental medicine now, this particular organization felt it was necessary in order to

address this question now to serve the American public in terms of them knowing which practitioners are qualified and who they are going to.

DR. MOLONY: Simply put, Oriental medicine is a way of looking at health and healing in the human body, and it needs definition, a succinct definition within our community, but at the same time, as opposed to conventional medicine, it is a different field of medicine.

DR. GORDON: George.

DR. BERNIER: A question for Dr. Molony. It is really great to hear that the Western and Oriental medicines and disciplines have lived in such great harmony. Has it been a coexistence status totally or has there been intermingling of modalities with time?

DR. MOLONY: Well, as with any group of people, there is always ego battles, but in traditional Chinese medicine hospitals, one has access to conventional medicine, testing processes. There is referral out to the conventional medicine if indicated.

Conventional medicine hospitals also refer to in-patient Chinese medicine hospitals and also usually

have outpatient acupuncture and herbal medicine programs in their hospitals.

DR. BERNIER: So, you wouldn't be seeing people who were sort of certified in both areas.

DR. MOLONY: Well, there always are people certified in both areas either due to interest or to an illness or to other reasons. I think Dr. Xiao Ming Tian is certified in both.

DR. GORDON: David.

DR. BRESLER: This is for Kathleen Golden. Over the years, traditional Chinese medical practitioners have an abhorrence for what they call cookbook acupuncture. Yet, we are here to talk about access and delivery.

For about 30 years I have been teaching anesthesia residents at UCLA how to suppress the gag reflex just by putting pressure on the large intestine 4 point. It works better than 30 milligrams of diazepam. It is strictly a cookbook approach, but I would much rather have them, if they are having trouble intubating a patient, use a little acupuncture than push more medications.

Do the acupuncturists see the possibility of there being a level of acupuncture that is not TCM, that can increase access and delivery, that we could train American physicians to do?

MS. GOLDEN: Well, I do see that that is very relevant and very helpful. I think my suggestion was that in that setting, you wouldn't bring in a licensed acupuncturist just to do large intestine 4, but what my fear is that there will be this subsuming of our profession and that that will become the only way that, for example, the low income patients that we are talking about receive acupuncture is with cookbook acupuncture.

I see that happening a lot and, you know, for me in New York recently, the issue of podiatrists wanting to be certified, so that they could, quote, unquote, "treat bunions," a similar type of a situation, and I do have a problem with that, because I do believe that the patient population that they were talking mostly about, for example, were the elderly, saying they could bring them in and just treat those bunions, and our way of looking at it is if we are going to have access to the elderly population and treat them for their bunions,

bunions is not just bunions in Oriental medicine, which I use that term very broadly, we are struggling with it in our profession, but it is an umbrella term to discuss what we do.

We could work on the deeper issues that brought about the bunions in the first place, and I think that that is more relevant to access and delivery, to treat the whole patient rather than just the bunion.

So, to get back to your idea of large intestine 4 in the operating room, I think that we would be willing to work with the operating room staff and to work something like that out.

I mean, for example, you said that Mike Smith is going to testify in New York, and in New York, what we have is people that just do the 5 needle protocol. That has worked out very well for us, I believe, in my state, because if you go to school for three years, you don't necessarily want to just be doing those 5 needles all the time, but in terms of access and delivery to that patient population which needs it, which I have done a lot of that supervision, it has been very, very helpful so I could see that model working in the operating room in

terms of large intestine 4.

So, I think if we had communication and we agreed, okay, this is the setting where --

DR. GORDON: Excuse me, I am going to interrupt because we really need to move along.

MS. GOLDEN: Sure, okay. I hope I answered your question to a certain extent.

DR. MOLONY: I just wanted to mention that as long as there is ethics involved, and the development of ethical standards when people go outside of their scope, that's all.

MR. CHAPPELL: Kathleen Golden, please. Is the vision for acupuncture in Oriental medicine to be kept away from integrated systems, a stand-alone, or would you see this still as a healing --

MS. GOLDEN: I do think that the idea of integration is very relevant. I do think that, as David pointed out, you know, we each have something very special to offer to the health of the American public, and what I am concerned with is what I have seen happening is sort of this subsuming of our medicine, and it just becoming large intestine 4, liver 3, when there

is this rich complex philosophy behind it.

I do think that the way that our country can most benefit is to keep the paradigm special and for us to be able to do our work and for Western medicine to be able, as both Davids said, acute medicine, Western medicine excels at that, and certainly for all of my patients, I feel that they need to have their yearly checkups and if I can't see into the body that diagnostic tests -- if we work together, see, my issue is we are not quite working together right now, and I would like to see us have more dialogue and more flow for the benefit of our patients.

DR. GORDON: Effie. Again, time is of the essence. We are already about 10 or 15 minutes behind.

DR. CHOW: Thank you very much, my associates. I really appreciate it. There is sort of a gradation of the large intestine 4, and then the whole cultural identification, everything is valuable.

Are any of your organizations in particular, David, is there any outstanding models that you know of now in China -- I mean there is better ones and there is not so good ones -- and also here in the United States,

are you aware of or can you get models to us that you can deliver to us for using it as a model?

DR. MOLONY: Models for?

DR. CHOW: For integration.

DR. EGOROV: In California, I have come across numerous groups of multidisciplinary CAM providers. A lot of them are licensed health care professionals who also do CAM mixed with straight CAM, we may call it, and I have been very curious myself as to where is their portal of entry for these patients, how do they do differential diagnosis as a group, and do a care plan, and how does it work exactly.

So, I could provide you with some examples that I have come across and within the structure that I work myself as a CAM provider.

DR. CHOW: Those are the individual ones. What about institutional?

DR. MOLONY: I will work with Natalie and get something.

DR. CHOW: Great. That is terrific. I think that is really important.

MS. GOLDEN: Can I say something? I do work in

an AIDS day treatment program, and we have a wonderful integrative model where we have Western medical staff, as well as "holistic" medicine staff, and the way that we work is that we communicate with each other all the time about what is happening with the patients, and so that model, I think, is very effective. I could get that model to you, as well.

DR. GORDON: That would be very helpful.

DR. CHOW: That would be great.

DR. JONAS: I have a question really for the panel as a whole. In terms of the basis upon which access should be delivered, I think, Kathleen Golden, you mentioned insurance parity, and I think eventually it does come down to who is going to pay in order to get access.

My question for the panel is what would you recommend to be the basis for that insurance parity? For example, should it be state licensing in which case then the competition for the various types of professional practitioners with each of the state legislatures becomes the main focus, should it be outcomes research, such as what was described in terms of patient satisfaction, in

which case probably the majority of CAM practitioners could demonstrate that the majority of patients are satisfied with their care, or should it be other types of approaches, any suggestions or comments?

DR. MOLONY: I know in Australia, they did a study and they found that as far as safety and efficacy, the more training somebody received, the better the patient, the more safe the patient was and the more effective their treatment, and that is essentially a given.

I imagine there is a certain plateau at which you reach, that continued training doesn't really -- it starts to get more incremental, but --

DR. JONAS: So, should the basis be on the ability to be trained or to demonstrate that the training is effective, and if so, which way?

DR. MOLONY: I would imagine the development of certification programs developed through psychometrics.

DR. JONAS: So, you would offer training then, training and licensing should be the basis?

DR. MOLONY: Some CAM things don't require quite the intensive training as maybe Oriental medicine

does.

DR. JONAS: We have heard in the research panel, for example, a number of suggestions along the lines of what Dr. Blalwas suggested, that we should do more outcomes-based research, look at what practitioners' patients are, what kind of benefit they are getting and how satisfied they are.

Is this the appropriate basis you think for reimbursement or for insurance parity?

MS. BUTLER: Within biofeedback, we have taken the route that certification is the pathway to go on, and that came about for a number of reasons over a number of years.

Because it is a multidisciplinary organization and people who use this methodology come from medicine, occupational therapy, PT, et cetera, they have their own licensing requirements, and to ask a physician to go get another license in biofeedback or a psychologist to be licensed in biofeedback, it just made no sense.

But certification is even across the board, and it asks the candidate to demonstrate knowledge in that field over a course of education and training and

supervised practice and examination. That evens the playing field. There are probably other models.

DR. MOLONY: It also depends on if you are talking sickness or wellness.

DR. BLALWAS: I actually think it is both. I think the two points you make need to be complementary, to coin a phrase, in gaining this access, because the first thing is to quantify through this kind of research that the medicine works for a variety of different health care issues, and then make sure that the people who will be delivering those services are fully trained enough to be able to provide those services to patients.

DR. JONAS: Actually, I am suggesting that that type of research is not going to advance us in terms of being able to demonstrate, because all of the professions will be able to demonstrate that they are effective and that patients are satisfied.

However, you have helped, I think, a lot in terms of what this commission needs in terms of training. We can certainly address issues of training and this type of thing whereas, we cannot address issues necessarily about a licensing, which is a state-based thing, but as a

federal commission we could suggest some types of national standard of training that then the states could use if they wished to make decisions about licensing.

MS. GOLDEN: For our particular profession, those are in place.

DR. JONAS: I understand.

MS. GOLDEN: So, that is sort of what I was talking about, to base it on those standards.

DR. GORDON: We are going to have to end this panel. Obviously, we are all very engaged. That's the good news. Thank you very much. We really appreciate your input. We may well be coming back to you to talk with you about education and licensing, and those other issues that you raise.

Thank you very much.

Public Comment [Continued]

DR. GORDON: The next panel is Elaine Marie Wallzer, Bhavna P. Bhut, Bruce Dooley, and Salvatore D'Onofrio.

Are the other panelists here?

[No response.]

DR. GORDON: Let's begin with Bruce Dooley.

DR. DOOLEY: Hi. I am Bruce Dooley. I am an M.D. from a warm state south of here, whose name I was told not to mention in Washington.

I am here to discuss a little bit something on a different note. I have been involved with some issues that have been involved with some CAM physicians being brought before their medical boards across the United States and somewhat brutalized in a disciplinary fashion.

I went to search for this because, of course, this involves our livelihood, every M.D. and DO practicing has over their head of their license being pulled by the Medical Board.

I am here to tell you today that my investigations revealed that there is an organization called the Federation of State Medical Boards, which I think you need to be aware of.

This is a federation, it is a private corporation, private organization, formed in 1912, an interesting time. That is when Rockefeller got into the pharmaceutical industry. It is when the Flexner Report came out, and that is when the AMA's Quackery Committee went underground.

The Federation, as they call it, develops policy at their annual meetings, which is then handed down to the state medical boards to be enacted in their own states.

An example of this is the Special Committee's report, which you have been given, or summary of them, on Questionable and Deceptive Health Care Practices. This is a blueprint for state medical boards to basically identify and then crack down on complementary and alternative physicians in their state. This is definitely a disincentive for other physicians to enter this field, and therefore limiting access to patients of these people.

They delineated in their definition we can't decide whether it is complementary alternative medicine, so we are going to decide to call it questionable medicine. They also told the states to coordinate and collaborate with the FTC, the FDA, HCFA, U.S. Postal, AMA, and many other federal and state agencies to get their physicians.

They changed the definition of "harm" in 1996, interesting. The mandate of the state medical boards is

to protect the public from harm. They added on, not just "physical harm," but "economic harm" and "indirect harm," economic harm if the patients lost money on the procedure, and indirect harm if they failed to go seek appropriate therapy.

They also controlled the testing of the national medical boards and the FLEX exams and the PLAS. They instruct the state medical boards -- and I was there and heard this -- to resist state and national legislative efforts to pass freedom of medical access bills. They are actively lobbying against freedom of access medical bills both on a national and on the state level.

They also maintain a physician data bank, which is the disciplinary marks are never expunged once a physician is given a disciplinary mark.

In summary, the Federation of the State Medical Boards, one, develops strategies to curtail the expansion of CAM, two, it lobbies federal agencies, state medical boards, and legislatures on the implementation of these strategies, and, three, indirectly and powerfully influences the course the content of all new physician

training via the medical testing.

These anti-CAM activities and bias of the Federation of State Medical Boards, only a fraction of which are represented here, I believe warrant further investigation by this commission.

Clearly, it is troublesome that a private corporation should wield such influence on the members of state medical boards and the physicians' means of livelihood.

Thank you.

DR. GORDON: Thank you.

Salvatore D'Onofrio.

DR. D'ONOFRIO: Good afternoon and may God continue to shed the grace of his light upon these proceedings.

My name is Dr. Salvatore Anthony D'Onofrio. I am not a medical doctor, I am a nutrapathic doctor and a Doctor of Divinity. I am in service to humanity through natural health principles in the name of God Almighty for the last 22 years.

I do not practice disease symptom supplementology. Please do not include natural health

practitioners in alternative or complementary medicine.

Commissioners, there is nothing alternative or complementary to allopathic medicine about natural health principles. God has created and given us a maintenance responsive unit. Natural health principles are the primary methods of maintenance through spiritual, mental, emotional, and physical modalities since time immemorial.

Individually determined amounts of clean air, water, and food have been the basis of natural health principles since creation. The truth is the alternative or complement to natural health practices is allopathic medicine.

I believe that natural health principles is a God-given right, protected by the Constitution. It is not a crime. I believe that the best way for medical doctors to truly study natural health principles is to legally allow doctors to practice natural health principles without attack from misinformed medical boards.

Because people get well from what we do, medical boards assume we practice medicine. We do not practice medicine.

There is a type of bill from Minnesota that would, if we drafted it to include medical doctors, would allow medical doctors to practice and learn and experientially report from clinics on natural health principles in outcome studies that medical science could accept.

I believe that doctors should do an internship under a qualified naturopath from one of the state accredited four-year colleges like Bastyr before practicing, as I had to do.

You know, we each all have our own values, and we should honor them through intelligent understanding. This medical bill from Minnesota would be a real good model to allow doctors to practice and experientially learn what we do.

You see, natural health practices is not alternative medicine, and it is not a crime, yet we are attacked all the time. We need to have God bless us with understanding and cooperation through education.

We have natural health principles. You take a couple of things like vitamin therapy out of it, and apply it to a disease, that is alternative medicine, or

you use a drug, and that is allopathic medicine. So, we have three different modalities. Keep them separate, educate ourselves about them, and then integrate them.

Thank you.

DR. GORDON: Are there questions from the commissioners?

Panel Discussion

DR. JONAS: So, you would suggest no licensing then?

DR. D'ONOFRIO: Well, I would suggest accreditations first, and then licensing maybe by words that know about what we do, definitely not licensing from a medical board, because we don't practice medicine.

DR. GORDON: Yes.

DR. LOW DOG: What I am understanding you to say is -- and I think that many of us sort of are talking around it -- is that the fundamentals of health, I am not sure have to be given by a licensed practitioner, they should start when our children are very small, about how do you eat properly, how do you handle your anger and your stress, how do you move in ways that make you feel good, and those are the things that would probably keep

all of our patients out of all of our offices, that those are the fundamentals of health and that everything else besides that is actually practicing medicine, however health oriented it is.

DR. D'ONOFRIO: Yes. And we need medicine. I mean I am the first person to -- I refer people to medical doctors every day. They refer people to me. I tell people if you get your finger cut off, you don't want to see a chiropractor or be popping pills, you want a surgeon.

If you have raging septicemia, you go get some antibiotics, but as you were saying, as we teach our children, a doctor means teacher, I teach natural health principles to build health, not to fight disease.

It is like putting, in my mind, putting a fire out with gasoline. I try not to focus on that. We teach them to focus on health.

DR. GORDON: Any other questions?

[No response.]

DR. GORDON: I have one for Dr. Dooley. Dr. James Winn appeared before the commission the last time we had hearings, and he said very clearly to us that he

was interested in not only working with CAM research, but in helping CAM researchers to develop IRBs, and I believe that one of the areas he mentioned they had a particular interest in working collaboratively with was the area of chelation.

So, I am wondering whether your information is up to date. Have you talked with him recently?

DR. DOOLEY: I went to the April meeting, their last annual meeting, and I can tell you just an example. Larry Dixon, who is on Winn's advisory board, was a past board member of the FSMB. The Senator from Alabama is Executive Director of the Board of Medical Examiners, and he was one of the speakers.

Here is what he said. "About the chelationists, is there a Board present that has successfully prosecuted a chelationist, revoked a license and made it stick? We find that very difficult. We got the major chelationist in our state but only when he branched out into other forms of quackery."

So, everywhere I was going --

DR. GORDON: But I wonder if perhaps you might contact -- I am just curious about this -- you might

contact Dr. Winn and perhaps indicate that you appeared here and talked with us, and that we said to you that he had appeared and that he was quite interested in working collaboratively. I wonder if you would consider pursuing that as a way of working.

DR. DOOLEY: Sure, I would, but as I mentioned, I was on the board of ACAM when our president, then Terry Chappell, sent 23 letters to Winn, requesting ACAM, a 25-year-old organization, you can't get older than that, and he rejected every one.

DR. GORDON: We will be happy to supply you with Dr. Winn's testimony, and we will be interested to hear how things develop.

DR. DOOLEY: I would love to work with him if he seriously means that.

DR. D'ONOFRIO: A point on chelation. I was just at the California Medical Association's study on alternative health, and they refused to study chelation therapy because it is considered by them to be quackery because of one anecdotal incident, a friend of the chairman of the board was harmed by an improper application of chelation therapy.

So, what he is talking about is rampant. We need to avoid these people.

DR. GORDON: My comments don't reflect on the truth of what he is saying. I believe what he is saying. Also, our hope is that things are changing and perhaps changing significantly, and what we heard from Dr. Winn was pretty clear, I think, about beginning to reach out and to say we are going to do things differently.

We will be happy to give you both copies of his testimony, and we hope that things can move ahead.

DR. DOOLEY: Great.

DR. D'ONOFRIO: Thank you.

DR. DOOLEY: I do have one thing to say, though, that, you know, in a disease care industry, which is a trillion dollar, quote, unquote, disease care industry, with the major players being the hospitals and the pharmaceutical cartel, if you will, all of that money comes through disease, and it seems like if there is going to be any kind of sense of fighting a single spot, laser focus would be the M.D.'s and the DO's who actually write the prescriptions and therefore are the source of their funding.

DR. GORDON: Thank you very much. Please keep us posted. We are going to keep a five-minute break and the next panel will then come up.

Session III: Use of CAM for Selected Health Conditions

DR. GORDON: Some of the people on this panel are very good friends of mine, so I am very happy to welcome them, as well as to welcome those I am just meeting.

This is a panel on the Use of CAM for Selected Health Conditions. We have people who are offering services and people who are receiving them, and people who are both offering and receiving.

We will begin with Addiction and HIV with Howard Josepher.

Addiction and HIV/AIDS

MR. JOSEPHER: Good afternoon. Thank you for inviting us here. My name is Howard Josepher. I am the Executive Director of Exponents, Incorporated, a not-for-profit organization that functions in New York City.

The people that come to our programs are overwhelmingly inner city individuals from minority communities. They are also the people that make up the

majority of AIDS and new HIV infections both in New York and in this country. They are people who have just come out of prison or involved with the criminal justice system.

The needs that we are confronted with by our clients are all-encompassing, and we have come to understand that you cannot treat drug addiction, HIV infection, or AIDS specifically without addressing other needs that stabilize the individual and make health and healing possible.

Examples are for the people, our clients, our patients, there is a need for primary care, there is a need for food. There is a need for housing. There is a need for health education, and, of course, stress reduction, and we also feel that in looking at the individual, we also have to take that holistic view of the economic and cultural environment that our clients come from.

Conventional treatment for substance abuse or drug addiction, excluding methadone maintenance, in this country, are generally behavior modification or psychotherapeutically-oriented models that focus on

abstinence.

Because of AIDS, we created an alternative approach to engaging and working with drug addicts. This approach did not require abstinence as a requirement for participation.

This is important when you understand that one in seven addicts in this country ever get treated and that the treatment field has come to rely upon coercion and mandates to get people into treatment programs. So, the need to create models that people who have problems with drugs and AIDS, the models that they want to attend.

We created our program ARRIVE in 1988. Today, we have over 5,300 graduates, many employed in the AIDS and substance abuse field. The program runs for eight weeks, three times a week, which means 24 classes. Each class is two and a half hours.

While attending ARRIVE and some of the postgraduate ARRIVE classes, topics cover both traditional and alternative approaches to health and recovery. Topics include or experiences include risk reduction for sex and drug use, tuberculosis, the immune system, nutrition, and vitamin supplements, aromatherapy,

and environmentally soothing music.

We also cover hepatitis, especially hepatitis C, diabetes, stress management, and meditation, sound healing for immune boosting utilizing crystal bowls, cognitive psycho-education, relapse prevention.

We teach about infection control, cost mainstream HIV and AIDS medications, and also complementary and alternative treatments. We talk about and teach about syringe cleaning and harm reduction. We do make referrals to other programs.

A brief meditation is practiced before, in the beginning, and the end of every one of our ARRIVE classes. Our work demonstrates the need for complementary and alternative approaches to addiction treatment.

If the health of an individual is enhanced, and if community safety for the larger community is assured and maintained, then, health models like ARRIVE, not focusing primarily and solely on abstinence, would be a valuable expansion of the continuum of treatment for drug and alcohol addiction.

Did I get in under that? That was the first

time I have ever done that.

DR. GORDON: Good job.

Denise Drayton.

MS. DRAYTON: My name is Denise Drayton. I am a graduate of the ARRIVE training program, and I am currently a staff member at Exponents, Assistant Director of Education at the ARRIVE program, and I was asked to briefly describe why I chose unconventional approaches to treat my health condition and what health results I have experienced.

I am also HIV-positive, so alternative therapy has been especially beneficial to me in dealing with the dual disease. I was first introduced to holistic medicine when I was admitted into a detoxification center for heroin addiction.

The method that was used for inpatient treatment was conventional, but included acupuncture for stress and pain. I continued with my acupuncture treatment in an outpatient program.

My next encounter with alternative therapy was as a student in the ARRIVE program. We were taught visualization and deep breathing meditation. I

incorporate several methods in maintaining my sobriety. I have been clean for 10 years as a result of holistic treatment, faith-based therapy, and self-help programs.

I choose to use the holistic approach to dealing with HIV in the form of massage, meditation, visualization, acupuncture, and deep breathing. I also attend workshops for stress management and burnout, because as an HIV-positive person in the work force, it can be stressful at times.

I surround myself at work and home with a stress-less environment. I have a crystal fountain at work, a sound fountain at home, and a sound aromatherapy diffuser in my office. So, when people step into my office, they are all like they are in la-la land.

I also attend meditation workshops that help me deal with the stress burnout pertaining to, like I said, being positive in the work force, and I believe this has had a positive effect on my health.

HIV sometimes affects my memory, and I feel by playing meditative music in combination with aromatherapy, I have experienced a more centered feeling in focusing on my work on the job.

After testing positive, I wanted to quit smoking to clear up my lungs, and I knew that pneumonia was a possible opportunistic infection for people with HIV, so I quit smoking with acupuncture. I actually joined a contest and I figured I would cheat by taking acupuncture. I did not win the contest, but I got back my lungs, so I was very happy for that.

I had sessions, I took on sessions, and I have been smoke-free now for eight years. Although I take Western medicine for my HIV, I feel that therapies are complementary. Sometimes the side effects of HIV medication causes body aches, and massage is essential in relaxing the body, and meditation helps me focus on something other than the pain.

They asked me what barriers and obstacles I face, and still face, in trying to obtain care. I am fortunate to have a workplace that incorporates and promotes healing through alternative methods, employee activities, stress-reducing devices, and conducting free alternative medicine workshops and encouraging wellness care.

However, in my community, this type of therapy

is not readily available. The clinics don't offer other methods, and if they do, it is not well promoted. It is really not obvious to people that come into the clinic that this is going on.

There is a natural distrust of anything that is not tradition in my community. It is looked upon like voodoo or something because of the lack of education that is surrounding it.

If it is perceived as not in accord with religion, it is not well accepted. Many people have never experienced some of the alternative treatments that are available. So, my recommendation that I would like to see happen to make it easier for me to receive care is I would like to see expanded health care insurance to provide for alternative therapies.

I would recommend outreach to communities of color that provide information and education on alternative therapies and how they can work with HIV medications.

I would like to see doctors do some inner healing when it comes to HIV, maybe get into CAM, some meditative approaches that help them deal with their own

issues, so that they can attend to whatever affect before they can then get involved with the healing process.

Thanks.

DR. GORDON: Thank you very much, Denise.

Jeanne Andrews.

Cancer

MS. ANDREWS: Hi. My name is Jeanne Andrews. I am a wife, mother of four, former teacher, and presently a student for the past 21 months.

Twenty-one months ago I was diagnosed with Stage IV colon cancer. I had resection of my colon and underwent six months of chemotherapy. When I was first diagnosed, a friend of mine suggested massage therapy, and she said, Jeanne, it is not a luxury, it is really beneficial for you.

I did start massage therapy, and then another friend recommended seeing a nutritionist. I went to a nutritionist and got a lot of guidance there. But it was two months into my chemotherapy when I was first working under the guidance of Dr. Fred Smith, oncologist, that I said, you know, I don't feel in control here, what else can I be doing.

Besides, I was experiencing the effects of the toxins in my body, and I just felt that I had to be more in control. It was then that he recommended that I contact Dr. Gordon, and was given a book, Comprehensive Health Care. I read that book within two days, and I was just amazed at all of the information there that I had no knowledge of prior to my illness.

As a result, I contacted Jim's office, we met, and I investigated some of their programs including their group support system. I attended that, and as a result, I learned deep meditation, visualization, and a number of other forms of relaxation.

I believe that my cancer, well, I believe that the disease can be treated by Western medicine, but it is treating the disease, and not the source, so I really felt that I needed to treat the whole body.

Anyway, as I got into the various modalities, various things worked for me, others did not, so I adjusted along the way. Well, in April of this year, 2000, they discovered another large tumor. It was too large to operate, so they put me through a series of, well, just six weeks of an experimental drug.

It ravaged my body and I was just beside myself, so I again readjusted various nutrients and supplements, and then I discovered Qigong. I traveled up to New Jersey three weeks during the course of the summer, and went through intensive medical Qigong.

In the meantime, I was also doing massage therapy, Reiki, various other things, but the Qigong I believe really helped me. You see, during this point of time, I had completed the chemotherapy, the six weeks, and although the tumor had shrunk, I then went into the Qigong, and the cancer markers went from 31 to 15 under the Qigong.

Well, when I came back after the three weeks, they did discover several weeks later a blockage occurred. To make a long story short, they wanted to operate, perform this radical surgery that would have been eight hours long, kept me in the hospital three to five weeks.

I refused to go through that, and I went back once more for Qigong. When I came back, I went in for the operation because I had to have this obstruction cleared. As it turned out, I was in the operating room

two and half hours later, when I woke up, I asked if I had the ostomy, and the doctor said, "Jeanne, this is incredible." He said, "What should have been the worst case scenario has turned out to be the best case scenario." He said, "We didn't have to touch your colon."

Well, they also took my blood, did some bloodwork on me, and today, my markers are down to 0.6. I continue to do medical Qigong, as well as acupuncture, working with my supplements, massage therapy, and Reiki, and I truly believe that all of this, the CAM treatments have been a tremendous help to my whole system.

But again I also believe that there were obstacles that I encountered, and that was, first of all, my medical doctor not truly believing in CAMs, but yet he was willing to give me this information.

In searching out the various treatments, I did have to do a lot of footwork until I came across Dr. Gordon, and I continued to travel, though, different places, so there was no central location for me to grasp all of these modalities.

My trip up to New Jersey three and a half hours

over three different times -- actually, four different times -- you know, I wish my medical Qigong master was here in the D.C. area. It would make my life easier. With the exception of acupuncture, I discovered that this was getting to be an expensive proposition. Acupuncture was only covered by my insurance company if it is done through a licensed medical doctor.

So, I thank you very much for inviting me here and being able to share my story of hope.

DR. GORDON: Thank you very much, Jeanne. We also have some written testimony from Barry [Cassilot], who is Chief of the Integrative Medicine Service at Memorial Sloan-Kettering, and we will be coming back to the issue of integrative care for cancer probably when we deal with reimbursement issues, which we will come back to later.

The next speaker is Richard Collins, Dr. Richard Collins.

Heart Disease

DR. COLLINS: Thank you, Jim. Good afternoon. You have my bio in front of you. I don't think the audience has that, so let me just give you a little

background.

I am a cardiologist and Director of the Heart Disease Reversal and Prevention Program in Omaha, Nebraska, and nationally, maybe some of you don't know this, but I am also known as the "Cooking Cardiologist" on Live with Regis.

Let me give you some sound bytes because you have all of the information in front of you. Heart disease remains the number one killer in America and while the death rate from cardiovascular disease has dropped due to technology, the absolute number continues to rise because of new onset of disease.

The number is increasing in alarming fashion for the African-American, Native American, Hispanic, and in younger age women. It is American's most costly illness.

In this country, the approach to cardiovascular disease management has been a Mr. Fix-it-up approach to acute disease therapy. Little is spent on preventative measures until after the fact, and even after the fact, conventional therapy has not been shown to be cost effective with 30 to 50 percent re-stenosis after

angioplasty or stent placement, revascularization after bypass after seven years, and costly recurrent admissions for heart failure.

The Dr. Dean Ornish program for heart disease reversal and prevention strikes at the very root cause of the disease process, stabilizing plaques, reducing angina by greater than 60 percent, reducing costly readmissions to the hospital, and improving quality of life and well-being.

We, as cardiologists, can talk about new angioplasty, widgets, balloons, but if we do not begin to manage behavior and lifestyle in America, we will never reduce the onset of newly diagnosed heart disease in this country.

Unfortunately, we, as cardiologists, are being trained as firefighters rather than forest rangers.

The Lifestyle Residential Study, published in 1983, documented that heart disease can be managed by intensive lifestyle control, again confirmed by the Lifestyle Heart Trial in 1990 with a five-year follow-up.

The demonstration project with Mutual of Omaha in mass controls was completed in 1998. The cost savings

-- hang onto your placards, Commissioners -- it was $29,000 per patient.

The findings also have recently been noted in High Mark, Blue Cross/Blue Shield of Pennsylvania with their embracement of the Ornish program. For the insurees in Pittsburgh, a cost savings has been noted of more than $17,000 per person, improvement in SF well-being scores, outcomes, and reduction of angina.

Lifestyle behavior should be listed as a prudent, first-choice medicine. The barriers to established heart disease prevention programs are the same barriers that actually continue to perpetuate coronary heart disease in America - denial, time constraints, diet controversies, risky lifestyle behavior, unwillingness to change, and financial concerns.

Our health care system in America is crisis control and fix-up medicine. In fact, most preventive and wellness programs across the United States have been cut due to cost constraints. We are shooting our own feet.

We can't afford to treat heart disease on a

crisis basis, let alone afford to consider managing it on a chronic basis.

A new model of disease management needs to be created. I believe we are on the edge of seeing that model with the introduction by High Mark, the first insurance company to totally embrace heart disease management through lifestyle intervention.

In regard to recommended policies, carefully structured programs will need to be certified and policies created to ensure compliance before reimbursement.

The Ornish program has already met those requirements with over 20 years of experience in outcome on research data. Embracing the Ornish program by accessing this to all populations should be your next top priority.

Thank you.

DR. GORDON: Thank you very much.

Walter Czapliewicz.

MR. CZAPLIEWICZ: Good afternoon and thank you for inviting me here today. My name is Walt Czapliewicz. I am 45 years old and a resident of Pittsburgh,

Pennsylvania.

About 11 months ago, I became a participant in the Dr. Dean Ornish program for reversing heart disease offered to me by High Mark, Blue Cross/Blue Shield.

I came to the program with a medical history of hypertension and coronary heart disease. In fact, before I joined the Ornish program I had three heart attacks, the first one in December of '96, and the following year I had two more heart attacks, and in October of 1997, I had bypass surgery.

I seemed to be doing well for about two years. Then, in the fall of 1999, I started experiencing chest pain again. The bypass was clogging up again. The pain became more and more frequent, so I was taking nitroglycerin pills several times a week.

I would get pain after walking, after meals, or during times of stress. I could tell by how I felt that I was probably going to have a fourth heart attack pretty soon or need heart surgery.

As the new year approached, I saw a story in the newspaper about Dr. Ornish's program. I asked my cardiologist for his thoughts, and he recommended it. I

started the program 11 months ago, and right from the start I followed it 100 percent.

Within the first 10 days, my chest pain diminished greatly and was completely gone after six weeks. In fact, I haven't had any chest pain since then. I have lost 64 pounds in the past 11 months. Even though I am eating more food and more frequently than before, so I don't feel deprived or hungry, because the food is low in fat, it is also low in calories.

When I started the program, my stress test was abnormal. After only six weeks, it came back negative, and after just nine weeks of the program, my resting blood pressure went from 160/80 to 128/72. My cholesterol is much lower now, overall down from 196 to 114, and my triglycerides down from 311 to 116.

All four of the program's components, diet, exercise, stress management, and group support have really been a true blessing for me. The results I have experienced in the first weeks alone made me even more committed to the program.

I am fortunate to live in an area where my health insurance company had the vision to make this

program a reality. In 1997, High Mark became the first health insurer in the country to both provide and pay for the Ornish program for their customers.

My experience with the program and the High Mark staff has been nothing but positive. Many of the participants are over age 65. In fact, I was the youngest one in my group, but as we all know, heart disease can strike any of us, young and old alike.

The older participants in the program are doing as well as the younger ones. We share group meals, exercise sessions, and perhaps most importantly, our life experiences, all of which created a close-knit group working toward a common goal, good health. I also manage stress so much better than before.

The nutrition portion of the program also has contributed to my improved health status and a more positive attitude. The diet consists primarily of fruits, vegetables, grains, beans, non-fat dairy and egg whites, no added oils, which makes the diet about 10 percent fat. I also was advised to take some vitamins and fish oil supplements.

I manage a catering company, so this was a big

change in my diet at first, but I have adjusted well to it. The recipes in the program from appetizers to desserts are delicious, nutritious, and easy to prepare, and I feel so much better.

The program supervision is also very comforting. We are guided through the program sessions by some very skilled professionals including a medical director, registered dietitians, exercise physiologists, stress management instructors, behavior or health clinicians, and nurse case managers.

All participants remain under the care and control of their own physicians, who receive regular progress reports and copies of all tests.

In closing, I would like to reiterate my dramatic improvements in the Dr. Dean Ornish program. This program reflects the commitment to offering innovative solutions that truly improve one's health.

The program treats the underlying causes of heart disease, not just the symptoms, and may spare some patients surgery, and most importantly, improve the quality of life.

I think that just about everyone would benefit

from a program like this whether or not they had heart disease. I hope this commission can find ways to make programs like this more widely available.

Thanks to this program, I feel like I am 35 again. I feel better, look better, and I am healthier than I have been in years. Coming into the program, I knew I was going to have another heart attack and need bypass surgery soon, but now I don't, and now I don't have to endure that pain and fear.

I truly believe this program saved my life.

Thank you.

DR. GORDON: Thank you very much.

J. Donald Schumacher.

Hospice Care

DR. SCHUMACHER: Now you want me to talk about hospice care. You have never heard the expression "not following the fan dancer?"

I want to talk with you a little bit about the picture of hospice in the United States today and how it does relate very much to the topic of complementary and alternative medicine.

Dying in America has become a very difficult

grace. Fully 53 percent of all patients in the United States die in the hospital, 24 percent of all Americans die within nursing homes although most individuals would prefer to be at home receiving the comfort, love, support, and dignity of a competent support agency, as well as their own family members.

While I see hospice care becoming more and more necessary in our culture, unfortunately, I find us dealing with more and more complicated and late referring issues than I ever thought possible.

I think hospice care in many ways is the epitome of what really good complementary alternative medicine is. I am not talking about hospice according to the hospice Medicare benefit, which has a very difficult six-month prognosis to take a look at, but some of the basic core issues of hospice care revolving around the fact that patients and families have to have the benefit of good quality support and choice while they are going through the process of dying, whereas, most patients who are in hospital settings and nursing homes, as you will, by interview find out don't feel as though they have much choice at all.

What is the true picture of hospice right now in our country? Well, unfortunately, one-third of the patients that we take care of die within seven days. Most individuals come to us essentially as train wrecks. They have been living and dying in very difficult circumstances, many of them in unrelenting pain with very complicated symptoms that are not being able to manage by traditional medicine, and they come into our program and unfortunately, very late within our care.

We, in hospice care now, refer to what we are doing in our jobs, as opposed to end-of-life care, we are doing, in fact, brink-of-death care where patients come in and die so soon that they don't get the entire benefit of what hospice can actually provide. We are running, in fact, hospice emergency rooms.

Many are living in pain for a long period of time upon admission, and they have been in high-tech settings that do not allow for patient participation in their own choice of health care.

Self-determined life closure, one of the hallmarks of hospice care and hospice support, one of the four presented by the National Hospice organization often

comes at the very end of the patient's life.

Patients now are very used to having things done to them as opposed to being able to choose things for their own health and their own well-being.

How can complementary and alternative medicines help? Well, many of the hospice programs that you will talk with around the country right now really are searching for new ways to support the traditional medicine that they are providing to patients and families, because the traditional medicine, largely around medications, do not work for many individuals.

Our program, I can tell you as a clinical psychologist, that in addition to the alleviation of symptoms, patients who are participating in their own process of choice around death, grief, and loss, generally have a better sense of well-being, are able to face what is happening to them, around them, with much more courage and much more comfort and support, and they end up feeling stronger mentally and physically to battle whatever the outcome of the disease might bring.

What do we actually use? Our program -- I was very happy to hear several of the participants up here

talk about massage -- we use massage quite often for patients in our programs, therapeutic touch for patients in our programs.

Many of our nurses are trained in therapeutic touch, and oftentimes engage, in addition to the traditional therapy that they are providing to patients and families, with some really, really good quality stress reduction through those two methods.

We also use homeopathy quite often, good chiropractic care and acupuncture. I was so happy to hear the acupuncture discussion earlier. I think acupuncture is a huge opportunity for all of you to really significantly benefit patients and their families without having patients engaging in longer term use of narcotics and very debilitating medication.

Let me tell you right now we have a patient in our program. She is 24 years old. She has metastatic disease. She has many, many tumors that are on her spine. She has two young children, age 2 and 4. For a long period of time -- she was admitted into our program -- for a long period of time she had been living in excruciating pain, and the narcotics that she was being

given to help reduce the pain, helped to reduce the pain, but she was so out of it because of the level that was necessary, that she was not able to actively engage in the care of her children.

Through acupuncture, guided meditation and visualization, we have been able to cut her prescription medications and narcotics by half, and she is now much more engaged in the care of her children than she ever had been in a long period of time.

Remember for all of you that while we are sitting here talking about how these things can help other people, everybody in this room will die. We do not know if it will be from HIV or AIDS, cancer, or heart disease, but at some point in time, hopefully in a ripe old age, all of us around these tables are going to be needing to have the benefit of all kinds of choice in alternative therapies, and if many of you are like myself, the very pushy baby-boomer, who is going to demand a lot of things, death cappachino, death latte, and a personal death trainer, we are on the right track as health care providers trying to tailor a different model of care for individuals who are going to be very

demanding as they age and die.

DR. GORDON: Thank you very much.

[Applause.]

DR. GORDON: Thank you all, to use Jeanne's words, for these stories of hope. We are very glad that you came to share these with us.

Questions from the commissioners?

Panel Discussion

MS. LARSON: I worked in hospice for five years, and my question to you is I saw the numbers actually decreasing and decreasing in the last eight years, referrals, you know, two days before death.

Now, we have a program that we know works. We have access to the program, so we are interested here in access and delivery. What changed?

DR. SCHUMACHER: The competing streams of revenue for health care right now have become much more demanding. As an example, in our community, we have two large health care systems, both of whom own home health agencies, and pretty much own, heart, body and soul, the physicians that are supporting that hospital system.

Because of that, not to the benefit of the

patient, but to the benefit of the individual health care system, more and more patients are being kept away from external agencies, such as hospice care.

You would see an increase in some hospice programs for or with those hospital systems that do have hospice as one of their core programs, but those are few and far between around the country.

I would hope that the Commission would recommend some form of streamlined and untangling of these competitive streams of revenue. Physicians are fighting with hospitals, hospitals are fighting with physicians, there is such a dearth of understanding of what patients need as they are dying, it is absolutely unconscionable, but we have run into that very situation.

Our median length of stay has gone from about 29 days down to 14 days, and that is absolutely wrong for patients who need this care.

MS. LARSON: Let me say that briefly it is an issue of capturing the money by certain parties.

DR. SCHUMACHER: Correct.

DR. GORDON: Before we go on to David and then Effie and Bill, could you give us some documentation of

what you are talking about?

DR. SCHUMACHER: Sure, absolutely.

DR. GORDON: And give us a sense of where things are going wrong and the kinds of recommendations you would like us to make?

DR. SCHUMACHER: Be happy to, absolutely. I will get that to Michele.

DR. GORDON: Thank you very much.

David.

DR. BRESLER: Despite the hospice movement, far too many patients are still dying alone on respirators in hospitals.

DR. SCHUMACHER: Correct.

DR. BRESLER: What is the movement doing or how is it going to help get access, greater access for these patients to more humane situations in the hospital?

DR. SCHUMACHER: This morning I was at the Center to Advance Palliative Care, a project that is being funded by the Robert Wood Johnson Foundation. It is a very exciting prospect because one of the topic areas that we talked about this morning was the fact that many individuals in hospitals are not able to make

appropriate decisions about getting off of ventilators and out of ICUs and cardiac care units.

I think that through a lot of national hospice and Robert Wood Johnson-sponsored organizations, it is our attempt to work within each one of the hospital settings now, to begin to work with the inpatient staff themselves to recognize when a patient and family can make another choice.

I am not saying that this is easy. I know that when it is going to my turn to die, I am going to be kicking and screaming all the way and demanding all of those things, but I do think that people, given a choice to recognize that prior to it becoming absolutely totally unbearable, having a choice about when you decide to stop the aggressive therapy because it is no longer working, I think people, given another day of peace, are more willing to do it.

It is just that right now they are not given the choice, and some of that is because of the dollars that we talked about. It is our hope that we can remove people from those very difficult situations by working within the hospital settings.

DR. GORDON: Effie.

DR. CHOW: Thank you for the touching stories and report. In regards to hospice, if the expense is growing and there is diminishing funds, is there any way of working with home care and expanding the hospice concept to home care type, that it would be less expensive?

DR. SCHUMACHER: Eighty percent of our care is provided at home. You are talking about home health care?

DR. CHOW: Home health care.

DR. SCHUMACHER: Home health care is also one of the competitors for the federal Medicare dollar, and they have done a really nice job pitting us against each other.

I think that there are some opportunities for us to work collaboratively together, but I learned just this morning of a couple of programs around the country who don't quite see the benefit of being cooperative with other hospice programs, and they are trying to manage, as I said earlier, all of that end-of-life patient care within their home health license, and it really is not

the same kind of care.

One very important issue, and that is if you are a home health patient being cared for at home, you pay your own medications, you pay your own prescription drugs. If you are hospice patient, those drugs are paid for by the hospice program.

Most people don't recognize that until you are in hospice care despite the marketing that we do. So, that is a very large issue, home health-hospice dialogue is a very large issue.

DR. FAIR: My question deals with the two presentations on the Ornish program, and I think, Mr. Czapliewicz, what you mentioned, that this program is probably good for everybody, and I think you are probably right, we would get very little argument from that statement from physicians about that.

My question to you and also Dr. Collins, is what recommendations, if any, do you have, how do we get this to influence the lifestyles of people before they get heart attacks? I mean here is a cardiologist that sort of had this epiphany after he got his heart attack, yet, I am sure you knew all of this intellectually before

you had your heart attack.

It seems to me that that is the problem, and that is really the big payoff, because it would be much more of cost benefit than the figures Dr. Collins gave. So, through your experience, both of you, do you have any recommendations to the Commission about how we could get this before the actual event occurs?

MR. CZAPLIEWICZ: Well, for myself, I think, you know, this is kind of funny, but you have got to start advertising pork as the other white meat. It all goes back to educating people about what they are doing to their bodies.

That is what I went through in this program. They taught me what I was doing wrong, and boom, and I think that just has to be expanded somehow.

DR. FAIR: We have been doing this for a long time. We have an epidemic of obesity, an epidemic of diabetes in people in their 30s, I mean we are doing something not right.

DR. COLLINS: We have in America, which I call -- you have heard about the French paradox -- we do have an American paradox. We are the only country that drive

to exercise facilities, we are the only country that it takes one calorie to roll down a car window to get a 700-calorie breakfast, and we are the only country where we are obsessed with diets, and yet we are gaining weight at lightning speed. I call this the American paradox.

Our society is gearing it up to guarantee that you get heart disease when you put your shoes on. We have taken cultures that were here in this country well before us and are giving them heart disease at lightning speed.

It is very difficult in America to get someone's attention because heart disease happens to the other guy, not you. I think there is some technology around the corner to draw people's attention. The electron beam CT scanner, as controversial as that is, with one breath hold you can lay down and see if you are laying down plaque. That has been shown to really get your attention, when your plaque load is excessively high.

I picked up a number of patients in their 30s and 40s who thought they were immune to heart disease, they had so much calcium in their arteries they looked

like the plumbing in an old house.

So, as a cardiologist, this is the hardest thing that I have, is to get someone's attention. We need to because heart disease is occurring at a much younger age. If I were to give a cholesterol screening test today, the people that would show up would be those that were 60 and 70. We need to get the 20-year-olds and the 30-year-olds.

DR. FAIR: I guess that is the gist of my question, and maybe there is no answer, but I will share one thing with you. When I lived in Manhattan and belonged to a health club, I was amazed at the way people would stand in line to wait to take the elevator for one floor to go up and use the Stairmaster. It astonished me.

DR. COLLINS: That is the American paradox.

DR. GORDON: Joe.

DR. FINS: This is for Dr. Schumacher. Thanks so much for so eloquently telling us that hospice care really is the ultimate in integrative medicine and really blends the best of both worlds.

I want to ask you two questions about funding.

One is the Medicare hospice benefit and to follow up on my fellow commissioner's comments about decreasing access.

Could you comment on what the hospice benefit and the regulations surrounding that has done, in your opinion, to access the hospice and referral rates?

The second question is the stability of the research funding. You mentioned the Robert Wood Johnson Foundation. What percentage of funding for this integrative practice comes from philanthropic sources versus from government sources, and is there a role for increased government funding?

DR. SCHUMACHER: Oh, no, not at all.

DR. FINS: I am sort of leading the witness here.

DR. SCHUMACHER: We have seen a lot of that recently, but what kind of role do you think the Federal Government should have in funding this kind of research and outcome studies and delivery system to optimize this integrative practice?

DR. SCHUMACHER: I think about this and talk about this quite a bit. I think the largest difficulty

with hospice in this country is the six-month criteria, and no matter how healthy or unhealthy we are as individuals, just to face that as looming in your future, many individuals resist it.

One of the largest examples of where that is most easily seen and understood is with children. We have 31 children in our program today. We have a program called Essential Care, and we largely provide care to them through a largely extended home health license as opposed to a hospice license.

Kids and families will never accept hospice care until the last day or two because everybody hopes for a longitudinal life for their own child.

So, I think that is the largest issue, and as treatments have become more sophisticated, and people are more aware that more and more things can be done, there is always this true or unrealistic hope that, gee, maybe if I keep on trying this chemotherapy or this radiation, I will be able to kick this and go forward and live my life. So, I think that is the largest issue.

The Federal Government needs to develop 20 demonstration projects around the country that will do a

variety of different things. One, they will allow hospice programs to provide care without a reimbursement cap. They will allow hospice programs to provide care without a criteria or prognostic cap.

They will give people opportunities to develop different kinds of services, so that without a patient having to walk in and say, yes, that I am dying, you can be put in a care path or in a trajectory where you get the kind of support that hospice provides, and you can receive the chemotherapy and the radiation and the surgery without hospice being a horrible choice for you, because that has what we have been, I think, winnowed down to in our care model.

We are a horrible choice for people. Gosh, what a great feeling, it's awful, and people make that horrible choice very much at the end because as I probably, and so will you, you don't want to do it until you absolutely have to.

So, I think the Federal Government ought to do 20 demonstration projects and really take a new look at developing a seamless model of care from diagnosis, through the bereavement of your family, so that you can

go through that trajectory without having to make terrible choices throughout the process of your disease.

DR. GORDON: Wayne.

DR. JONAS: Thank you. I think that is excellent.

DR. SCHUMACHER: So, sign you up, right, you will participate.

DR. JONAS: Sign me up now, absolutely, how do I get in this, and where do I get reimbursed, right.

What percent of individuals enrolled in hospice get identified CAM modalities? You have mentioned a number in your program, but in my experience in taking care of patients in hospice, a lot of times it is primarily kind of pain control and this type of thing, and there isn't a lot of acupuncture, aromatherapy. If individuals happen to know something about music, they will bring that in, that type of thing.

DR. SCHUMACHER: It helps if the CEO has used all of these therapies because then you tend to promote it within your organization. I think probably 15 percent at a max I would say in hospice care would do that.

The thing that needs to be educated -- and this

is one of the things that the commission can do -- is hospice CEOs and hospice managers need to recognize that they can contract with these providers of service in their community to provide this care under the hospice Medicare benefit.

Whatever the patient or family needs to reduce painful symptoms, you can contract for those and provide them, which is how we operate in our program, but it is a low utilized piece of information right now.

DR. JONAS: One question to Dr. Collins. Is there any data on the number of individuals that are eligible and enter the Ornish program, that then do not do 100 percent compliance, as you described, and either drop out or only do 20 percent compliance, and this type of thing, and what percent that is, first of all, and any kind of effects on that?

DR. COLLINS: We have a careful screening procedure. We really know what criteria guarantees your success. That is number one. And once you go through that hoop, and the anatomy is proper, we have an adherence rate of 90 percent-plus.

DR. JONAS: I will reverse the question then.

How many individuals are screened and because of non-medical or other reasons, because there is a better therapy around or something, are not then entered into the program?

DR. COLLINS: It depends upon a chronic disease basis. We have exclusion criteria, and that roughly is about 1 in 10, that they might be excluded because they continue to smoke or haven't really taken care of some lifestyle problems, that really a lifestyle program of this nature would not be ideal.

The anatomy, we are learning a lot more about the anatomy. There is an element of the catheter-ocular reflex in America, that if you see it, you want to balloon it or stent it.

We have realized that once an artery is touched, lifestyle cannot control it. What you need to do is leave an artery untouched and let lifestyle then take over and reverse the process.

DR. JONAS: So, complementary with conventional therapy may be problematic in this case.

DR. COLLINS: Well, what happens is not necessarily so, because those arteries that need to be

taken care of, are taken care of, but the fact is that in the next event, the next event that will happen to you will not be on the one that was stented or angioplastied, but it was that 30 or 40 percent lesion that is just sitting there ready to happen again.

DR. JONAS: And that will not be then susceptible or remediable?

DR. COLLINS: It is if it is untouched, yes, it cuts down second events.

DR. JONAS: So, it is about 1 in 10 that get into the program that are --

DR. COLLINS: No, no, no.

DR. JONAS: One in 10 are excluded.

DR. COLLINS: One in 10 are excluded.

DR. JONAS: Okay.

DR. GORDON: A couple of things that I think that the program ARRIVE could shed some light on, that might be really useful. One is in the area of prevention, and the other is in the area of creating a healing community.

I wonder if you could talk a little bit about your efforts to reach out into the jails and prisons, and

how you feel that works, and how that may help prevent recidivism, as well as prevent increasing illness from HIV.

MR. JOSEPHER: We do a substantial amount of outreach in the institutions in New York, primarily that you want to engage them actually even before they come out into the street, so a whole new area that is being developed in addiction work with the criminal justice population is transitional planning, where the idea is to engage people in the institution and inform them of the various kinds of services that are available out in the communities, so that you can provide some kind of a safety net upon release, and they don't just fall in the cracks, and then the whole cycle of recidivism happens.

But it must be said that most of the innovation and inroads that are happening in addiction treatment now are happening because of HIV and AIDS, and that AIDS in the drug-using community has required us to engage these individuals sooner rather than later, to present alternative models to work with them to stop the spread of AIDS and help care for people who are already living, and that whole school is something we call "harm

reduction," but we have so many barriers to any kind of innovation in the drug field because it is completely surrounded with political messages, and any other complementary or alternative approach is looked at as radical and sends out the wrong message that drugs are being tolerated.

But we are seeing again, because of HIV, that we can get people, we can engage them while they are still active, even though they are not even ready to get off of drugs, we can bring them along at a different pace, at a pace maybe that they are ready to work with, and I think this widens our net substantially.

DR. GORDON: As a White House Commission, do you see also recommendations that we could make that would make it easier to create this kind of integrative treatment for people who are positive or people who are coming out of prison who are addicted?

MS. DRAYTON: What I wanted to say about alternative treatments or alternative methods, I was noticing that women are the highest population now being incarcerated, and because the holistic approach deals with mind, body, spirit, emotional health, mental health,

as well as physical help, I would like to see some inroads for women incarcerated to have maybe alternative therapies, meditation, positive affirmation, something that tells them that they are not boxed into this life for the rest of their life, that there is a way out or some sort of change happens, some sort of relaxation, some sort of efforts made, outreach to women, so that when they do get on the outside, they have a little more positive attitude and can maybe deal with life stress situations in a better way instead of going back to some of the same stressors, and then reacting in the same way using drugs or working the streets, or whatever it was that made them feel those things.

MR. JOSEPHER: Just to quickly answer that question, Jim, is that as Denise spoke about them, her personal experience, that the utilization of auricular acupuncture helped her substantially, not only in reducing stress, so that she could deal with her HIV, but also with dealing with her withdrawal from nicotine and cocaine. But this is not a reimbursable function, auricular acupuncture, in the substance abuse field.

You know, it all does come down to money, and

if there is money, there is going to be programs, and in that way more people are going to be helped. In drug treatment, it used to be you went into a treatment center for 28 days to get your treatment. Because the HMOs have squeezed that to such an extent now, you can only get seven days if you are lucky that will be reimbursed.

So, basically, the treatment now for most of these places is to teach people about 12-step programs, which are certainly extremely valuable, but there is very little treatment going on in these places for the people who do not have private funds or even insurance for the people that we work with.

DR. GORDON: Thank you.

George.

DR. BERNIER: I wanted to ask a related question, and that is, are there good studies that indicate there is a real positive value of including the CAM medications in individuals that are withdrawing or individuals who then withdraw for a while?

I ask that not to question what happened in your situation, but just has anyone tried to put that together in an organized way?

MR. JOSEPHER: I heard in the previous session here of Mike Smith, Dr. Mike Smith from New York City, who developed auricular acupuncture. He has a substantial documentation to the effectiveness of it.

Again, effectiveness of treatment doesn't mean very much in the substance abuse field. We have had studies galore showing the effectiveness, the reduction of crime, reduction of recidivism, and we still do not invest, so I don't know what will move that, but I do believe the documentation is there both for complementary and alternative methods and for traditional methods, but it is a field that still prefers to treat drug use primarily through incarceration.

DR. BERNIER: I would guess incarceration is a very, very expensive way of trying to deal with a habit.

MR. JOSEPHER: Yes, but the expense is, that really determines it, is where are we spending those expensive programs, and they are, in New York State, it is an industry to build institutions in rural areas which generate employment in Upstate economies, when seven out of eight people come from the inner city themselves, but these institutions are upstate.

Many years ago, I think it was Eisenhower who warned about the military industrial complex, well, we have now a substance abuse institutional complex, and the documentation is out there, the political will is not there.

DR. GORDON: Charlotte.

SISTER KERR: Denise, you really did some hard things, in my opinion, to heal. I wanted to ask you, if you had to say, if it is possible to say, what one thing most helped you to heal yourself, what would you say, of all the things?

MS. DRAYTON: Immediately, I can point to acupuncture. Actually, one thing led to another. Spiritually, I was bankrupt, so when I came in to go into detoxification, the first thing somebody said to me was you are an African queen, you are a child of God, you are a beautiful woman, you don't deserve this life.

So, right then I was swept in, you know, I bought right into it because I hadn't heard that. So, there was that spirit thing, and then right after they swung me right into this fantastic acupuncture where my back was in tremendous screaming pain from the

detoxification, because they take you gradually through methadone and then they ease off the methadone, and then what - acupuncture.

So, it was like one blended into the other, and the total experience was what helped me.

SISTER KERR: Did you have your acupuncture in a group or did you meet in a group with other people having treatment?

MS. DRAYTON: Yes, it was in a group setting, in a very comfortable chair with a very wonderful person, and when the acupuncture needed assistance, it was with Tiger balm and heated peat moss, massage therapy. It was wonderful.

SISTER KERR: What I understand from that data and particularly acupuncture is that when the community embraces the whole process, that is when it is most effective.

What I had thought you might say was that someone touched you at the level of the spirit, which is what you said, and I don't hear us saying too much about that, you know, and I would invite you to speak about that if you speak again, because you spoke it even though

you didn't name it to me.

I thank you for bringing that up because it is something we have to be looking at as a commission, I think, and I would appreciate any other input on that. That you.

MS. DRAYTON: Thank you.

DR. FINS: This is also for Ms. Drayton. I was struck by something that you said at the very end of your testimony, that the people in the African-American community have a distrust I think of things that are not traditional.

I would like you to say more about that, and what does that really mean? Is there a perception that if it is not traditional, it is somehow second rate, and yet what this did for you was extraordinary.

MS. DRAYTON: Yes.

DR. FINS: It saved your life whereas traditional therapies may not have been as successful.

MS. DRAYTON: Right.

DR. FINS: So, how do we get the message out, through public education, the Public Health Service, and the like, what kind of concrete recommendations can be do

at a national level that that individual practitioner did for you when he or she was so complimentary and said you were a child of God?

What can we do at a national level to bring others in?

MS. DRAYTON: I think what is influential to people in my community is peer education. If it is coming from someone who has experienced it and has a working knowledge of it through first-hand experience, they tend to believe it.

Usually, if there is any kind of holistic healing going on, it is in the little bodegas or the little tearooms or whatever, and it is immediately kind of associated with cult, voodoo, or something not quite in line with traditional religious beliefs, Baptists, whatever, and so it is looked upon not with -- it is distrusted.

So, I think if it was brought more out into the light, not in the little backrooms, and more in the clinic settings, if you had peer educators, while you are waiting to see the doctors in the clinic, do a little talk on holistic medicine and some of the benefits of it,

that would be helpful.

MR. JOSEPHER: May I add to that, that while I think race is sometimes a barrier, if teachers had information and have conviction, they transcend those barriers. We have had the good fortune for the last 10 years to have an alternative expert come to our ARRIVE program, teach five times a year. The guy lives in Washington, D.C., and pays his own way up five times a year. He is the chairman of this commission. He has brought alternative medicine to the minority communities in New York City. We are thankful for him.

DR. GORDON: Thank you.

I wanted to ask Jeanne one question before we closed. Thank you very much, Howard. The other thing I want to say to all of you is I love going there. It is a spiritual uplift for me to go there. I feel so well used and so happy to be there.

So, I think part of what we need to do from my perspective is encourage all the young people who are in health care to go out and serve, and to really serve where they are being heard and they are being most useful. So, thank you, too.

Jeanne, you began to say something, and I just want you to say a little bit about it, about the whole question of finances, and you said a little bit earlier at lunchtime, too, that in your situation you had the resources, but you started to point out, and I would like you to underscore it a little bit, the things that were not paid for and the things that you would like, even though you had extremely good experience, all the things that were not paid for and your effort to try to create integrative cancer care.

MS. ANDREWS: Well, I have done Reiki, massage therapy, support groups, Chinese herbs, various vitamin supplements, acupuncture, art therapy, and I believe that all of those, the only thing -- well, I know -- the only thing that has been covered has been acupuncture only when done under a medical doctor, done by a medical doctor.

My Chinese herbs alone cost me, on a monthly basis, $110 a month, and I take on an average of six to eight supplements, two to three times a day, and many of them are very expensive. So, it is a costly treatment, but for me it has been working.

If I can just address that lady down, one very important aspect that I forgot to mention is that prayer has been a very important part of my healing, my own prayer, as well as prayer from many individuals throughout the country.

In talking to Denise over lunch, again, if you don't have hope or a faith, I think it is so hard to beat something like this, and encouraging other people to consider the prayer, the spirit is so much a part of the whole healing process.

DR. GORDON: Thank you very much. Thank you all very much.

We are going to have a break for about 10 minutes.

[Recess.]

Session IV: Issues in Integrating CAM in Service Delivery

DR. GORDON: This panel is going to be beginning in Tab O, and this is Session IV, Issues in Integrating CAM in Service Delivery.

We will begin with Richard Miles.

MR. MILES: I will start out by saying I am not

a practitioner. I dropped out of the business world about 30 years ago and met several of the people in the room when I was the organizer and manager of major conferences in the early seventies including the first national symposium on acupuncture at Stanford in June of '72.

We designed that event for 250 docs. We were going to hold it in the Student Union, Nixon went to China, James Reston wrote an editorial in the New York Times, and 1,400 doctors came to this conference, and away we went with what has now become holistic health complementary medicine, whatever we want to call it.

My interest in the whole arena, living in the Bay area, the San Francisco Bay area, at that time in the late sixties, early seventies, the San Francisco area was the fountain of social change, shall we call it, and I was interested in what was driving that and came to the conclusion that what was happening was a major shift in belief about how the world operated.

The management expert, Peter Drucker, wrote a book in '67, called "Managing in the Age of Discontinuity," in which he pointed out that all of the

institutions of Western culture were reexamining the assumptions upon which they were based.

I think that is happening throughout the culture, and I think medicine and health care are a major part of that, and this shift of how we view the world is a major driver of the development and interest in CAM.

When I talk to physician groups I say, or to other health care professionals, I say that the focus that you have talked about mostly is about what you do. The new trend in what is happening is who you are while you are doing it. The attitude of the past has been that we are separate observers of the world, not participants in it.

My friend, Brendan O'Regan, who used to be the Director of Research at the Institute of Noetic Science, referred to that as the infinitely extrapolated mistaken notion. We cannot be objective and separate observers of the world, we are participants in a living system.

So, my particular interest in health and in this whole arena, has been looking at it from the point of view of living systems. In your handout materials, toward the back of the report that I wrote for the

Institute for Noetic Sciences, you will see a list of 12 factors in a person's life that can affect their capacity for self-regulation and self-healing.

The kind of general attitude of our medical system has been that when you present disease, you are essentially ill and need to be made well. The interventions will cure you.

The emerging perspective is that you are essentially well and need to be made ill, and if you can get the illness out of the way, if you can get the factors that are contributing to this illness out of the way, the system will heal itself.

The living system that we live in, including the whole planet and the life system that we are part of, is a self-regulating, self-healing system. That is my view of it.

What I do now as a business consultant is work with organizations and programs that are trying to develop this particular kind of concept. The one that I probably spent the most time with, that some of you may be familiar was, was the work of Arthur Kaslow in Santa Barbara, in the late seventies and early eighties, wrote

a book about his practice called "Freedom from Chronic Disease."

Arthur said all of these chronic disorders that are presented to me are the same problem, it is just the weakest link in the system that is going down.

So, his whole practice was based on reestablishing the function of the system, not on treating the disease, and he would work with nutrition. He had a staff of five people. He had an acupuncturist, he had a yoga teacher, he had a nutrition counselor, and he had a psychotherapist, and himself, and he was essentially a nutritionally-based physician.

His whole point was that what we need to do is turn this person's life around, not fix their disease, and he had a very successful clinical practice in Santa Barbara and in Denton Beach in San Diego.

I was on a panel about two months ago at a conference in the Bay area on industrial ecology, which in itself is kind of an oxymoron, but this conference, the panel that we were asked to participate in was called "Managing Living Systems," and the four of us who were on the panel got in touch with the conference people and

said you cannot manage a living system.

So, the point that I would make here is that we should listen rather than do to, we should be with, we should care for people, and reestablish connections with other people, with nature, and with the living systems, and allow the diseases of this culture to heal themselves rather than try to fix them.

Thank you.

DR. GORDON: Thank you, Dick.

Berkley Bedell.

MR. BEDELL: Michele, I requested that my testimony together with copies of information on my foundation be passed out.

My time has started, so I don't want to wait here while she does that.

First of all, though, I want to thank you folks for taking the time to be on this panel. This isn't in my testimony, but I just appreciate this tremendously because I think you have got a real opportunity. I don't know how much the government is going to listen to what you are going to have to say, but I have a feeling the press will, and the people will, and it is my belief that

the change is going to come from the people rather from the press.

Some of you served with me on the advisory committee to the Office of Alternative Medicine. The report language establishing that office declared that it was to "investigate and validate" alternative treatments for disease.

Time after time our advisory committee passed resolutions calling upon the Office to conduct what we called "field trials," where we asked them to go out and conduct scientific trials to "investigate and validate" the treatments being administered at alternative medical facilities around the world.

I believe the Director of the Office of Alternative Medicine was supportive of those efforts. Unfortunately, the Director and top bureaucracy at NIH would not permit us to "investigate and validate" any alternative treatments.

Three years ago my wife and I decided since the government would not investigate these treatments we would try to do it ourselves. We formed the National Foundation for Alternative Medicine to "investigate and

validate" alternative medical treatments. We are starting with cancer.

We are sending teams with a medical doctor on the team to visit alternative cancer clinics and go over their patient records. We are finding clinics in Europe administering low-cost, non-toxic cancer treatments with success that would not be expected at major cancer clinics here in the United States.

These treatments are based upon a completely different concept of how to treat cancer. They treat the whole body, rather than concentrate all efforts on destruction of the tumor. The tragedy is that some of the non-toxic medications used in these treatments cannot be administered here in this country.

In most areas of our society if one develops a better product, the product grows in popularity, and the inventor benefits. This is simply not true in medicine in our country. It is no secret that employees of the FDA leave their posts to take high-paying jobs with the pharmaceutical industry and conventional medical community.

The Director of NIH, that was a party to

preventing the Office of Alternative Medicine from "investigating and validating" alternative treatments, is now President and CEO of Memorial Sloan-Kettering Cancer Center.

The former Commissioner of FDA is now Dean of the Yale Medical School. His deputy director took a job with a pharmaceutical company.

I have a friend who was selling Deprenyl as a supplement. He made the mistake of claiming that it could help Parkinson's disease, which it does. He has a wife and young son. He just been sentenced to 13 years in prison. The government asked that he be sentenced to life. He has hurt no one, only helped people.

As you know, I served 12 years in the Congress. Most of the members of Congress are dedicated to doing what they think is in the best interest of the people. Some of them are fearless in that regard. However, they cannot be completely informed on all matters.

Like most of our society, they are not aware of the restrictions imposed by our government on anyone who would develop a medication or treatment that might challenge conventional medicine and the pharmaceutical