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WHITE HOUSE COMMISSION
on
COMPLEMENTARY and ALTERNATIVE MEDICINE POLICY

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

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Volume II

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Tuesday, December 5, 2000

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

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C O N T E N T S

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P R O C E E D I N G S [8:00 a.m.]

[Moment of silence observed.]

Session V: Meeting Public Needs/Systems of Delivery

MS. CHANG: Good morning, everyone. We are going to get started, so if the first panelists could please come to the table. The first panelists are Dr. Robert Atkins and Dr. Charlotte Eliopoulos, and Mort Rosenthal.

DR. GORDON: Thank you very much. I want to thank all of you for a long day, a long attentive day yesterday, and for being here bright and early this morning, ready to roll. And thank you, too, for coming early this morning, those of you on the panel.

So we will move down. The panel will begin with Dr. Robert Atkins.

Good morning, Bob.

Session V: Meeting Public Needs/Systems of Delivery

DR. ATKINS: Good morning. We are going to speak from the vantage point of a doctor who practiced a different kind of medicine, just with the idea of getting better outcomes, and this began in 1972 when he got a little disillusioned with statements made by the American

Medical Association, when they basically said that the work that I had already observed with the regard to the effect of changing one's diet was not supported by the scientific literature.

I would have to tell you that the idea for my diet came from The AMA Journals, and it was the teaching at the time, 1963. So I vowed that the best thing that I could do would be to just try to practice medicine more effectively than mainstream medicine was doing.

After about 15 years of that, I came to the conclusion that we had succeeded in many areas in getting better outcomes certainly than I had gotten when I was practicing mainstream internal medicine and cardiology. So I wrote a book and the purpose was to describe the new medicine. I hit upon the title of "Complementary Medicine," and the book was called "Dr. Atkins' Health Revolution: How Complementary Medicine Can Extend Your Life."

The reason I say this is because I do believe that the term complementary medicine very much applies to a practicing physician and is, in fact, what I think should be the future of mainstream medication, because if

we define complementary medicine as I have defined it, and the way my colleagues and the groups that I belong to, the Foundation for the Advancement of Innovative Medicine, AKM, and so on, it is not that we are adding complementary therapies to mainstream medicine, but rather it is an entire system of patient care, a different system, a system which is based on a working knowledge of all of the healing arts.

I say "working knowledge" because I think when we make our decisions, we select therapies from all of the healing arts based primarily on the highest benefit-to-risk ratios and on their ability to synergize with other therapies.

Now it turns out that when we use the benefit-to-risk ratio, you end up using an awful lot of nontoxic nutritional therapies and a lot less of the pharmaceuticals, mainly because of the risk involved with pharmaceuticals.

It incorporates mainstream thinking, though it incorporates mainstream thinking when it applies, but not when it excludes, safe and alternative therapies. It recognizes the multifaceted aspects of illness and

expects all aspects to be considered in patient care. The term holistic really applies here.

It feels that in enhancing the host's resistance to illness is often more important than destroying the illness itself. The most striking example of that is in cancer therapy, where host resistance or host strengthening is not a part of mainstream teaching. Its therapies, which are very often nutritional, work synergistically, and optimal results will not be achieved with single therapies.

I say all of this became complementary medicine's effectiveness needs to be proven, and for many reasons, it is the lack of proof and the need for proof which is at the top of the list of things that would have to be done. In order to convince the other practitioners of mainstream medicine that they should expand their horizons to include alternatives, to include safe, nontoxic alternatives, and consider them perhaps as better alternatives than pharmaceuticals and surgery.

The first order of business is to have it proven that it works, and that it gets better outcomes, at least equivalent outcomes, or that it helps cut down

the cost of medical care, which is another important point, but in some way, something has to be proven.

Now, complementary medicine offers the government an opportunity to solve its most pressing health problem, and how best to solve the problem of increasing health care costs. The American Ministry of Medicine has been allowed to develop protocols involving optional surgery, described as mandatory. People are not told that their heart blockages are reversible, is a perfect example, or expense, risky therapies that are given unnecessarily, such as giving adjutant cancer therapy to people when the surgeon has already removed the cancer, and also the use of drugs with side effects when vita-nutrients can do the same job.

The result is the U.S. has the greatest per capita health care expenses in the world. Complementary medicine, by providing inexpensive, nutritional and non-surgical options, can go a long way towards cutting these expenses, and if the results that I have gotten, and my associates and the organizations that I belong to hold up to scrutiny, the number of hospital stays will plummet dramatically and, therefore, I think we can do some

research that I think will point in these directions.

Thank you.

DR. GORDON: Thank you very much, Bob.

One of the things, before we move on to Dr. Eliopoulos, that I want to say to remind the Commissioners of, and also inform all of you about, is that these panels, these first couple of panels today, are opportunities for us to see how people are doing integrative, alternative, complementary, holistic practice in the community in various different kinds of settings. In fact, that is going to be the focus of much of the day.

I am hoping that what we will do with each panel, is, after they give their brief statement, we have a lot of time for discussion, or a significant amount of time for discussion, and it will be asking them the questions about service delivery that will focus on ways of delivering services: what is effective; what is not; what is cost-effective; how is it working in their community; how is it working in their particular setting.

We will have plenty of time in subsequent sessions to come back to issues of licensure, education,

and research, but these are the folks we brought in specifically because of their expertise in service delivery. So I want to remind us all of that so we can focus on and get the most out of the sessions.

Okay, next will Dr. Charlotte Eliopoulos.

DR. ELIOPOULOS: I am here representing the American Holistic Nurses Association, an organization of RNs that is committed to mind, body, spirit healing.

The nursing profession has a long history, and perhaps the longest of any health care profession, at providing care in a holistic manner. We believe that a holistic approach to care is essential to the healing process.

We are enthusiastic supporters of the integration of CAM as part of a holistic comprehensive plan of care. Providing a CAM product or therapy without assessing and addressing the total needs of the person really risks perpetuating a system of fragmented care and really dilutes the beneficial outcomes that are potentially available.

To nurses, it is not a matter of CAM or conventional care, but really using the best of both

worlds to achieve optimal results for clients.

We believe that nurses must have a significant role in this integration of CAM into the health care system at large, and there are several reasons for this.

First of all, being that nurses represent the largest group of health care professionals, over 2 million of us out there, in a wide range of clinical settings as diverse HMOs, emergency departments, hospice programs, home health, and on and on and on.

Our education prepares us to coordinate care, and responsibilities that nurses have assumed for probably as long as our existence has been one of coordinating, and it seems reasonable to think that we could also coordinate the integration of CAM with conventional practice.

Nurses are uniquely educated, I believe, in first of all recognizing abnormality from normality in their assessment process, to be able to identify needs that fall within the realm of biological, spiritual, socio-economic and so on, and finding the right resources to meet them.

Coordinating the efforts of a multi-

disciplinary team, I think, has been a unique nursing function, and using a wide range of services to provide care, and also to evaluate outcomes.

Nursing standards really emphasize advocacy of the client, so protecting them in their use of CAM, in their integration of that into the health care system, seems reasonable.

Nurses also recognize the cultural and the psychological and the spiritual needs that affect health care choices and practices.

Nurses are ethically, professionally and legally responsible for protecting clients and advocating for their well being, and also nurses enjoy a high degree of consumer confidence.

We believe there are a number of actions that nurses can take to facilitate the access and delivery of CAM products and practices, first of all, being to increase our own knowledge base through continuing education for the existing work force, as well as the integration of this within the undergraduate nursing programs, also to stimulate the development of systems to help with the access and delivery of these services.

I am speaking of things such as assuring policies and procedures are in place within the existing health care system to assure that services are being safely utilized, and so on.

Advocating and demonstrating a holistic approach to the delivery of these services is also important, and also for nurses to derive private practices where they can utilize some of these therapies themselves, which many of them already are. They are doing it in terms of helping people with developing healthy lifestyle practices, managing chronic conditions in a natural manner, and coordinating the services of both conventional and CAM practitioners.

The AHNA supports an integrative approach to the delivery of CAM products and services, and we recommend that reimbursement and policy decisions be made to facilitate that, and that part of those decisions need to consider some reimbursement for nurses to facilitate the assessment, the coordination, the monitoring of the utilization of these services.

Also, that nurses be looked at as well prepared, cost-effective coordinators and monitors in,

using a catch term, gatekeepers of these services. They have got a history of demonstrating they can do this with conventional care and it certainly would make sense to utilize that expertise.

We thank you for this opportunity to present a voice for nursing on this commission. Thank you.

DR. GORDON: Thank you.

Mort Rosenthal is next.

We have a couple of corrections here. The testimony should be behind Section V, Tab C, and we need to replace page 8 and 10 of Mr. Rosenthal's testimony. I think Joe gave you those sheets.

MR. ROSENTHAL: I don't know what is on page 8 and 10, but I deny it.

I am the chairman and founder of Well Space. Well Space is attempting to consolidate and brand the CAM market, making it safer and more accessible. We believe we are creating a consumer benefit, a practitioner benefit, and we believe that there is a business opportunity created by that consolidation.

Brand will mean safety and quality in the consumers' mind, which will help create access.

We opened a prototype center in Cambridge 27 months ago. We have 21 treatment rooms. Since then we have seen 10,000 patients, excluding our classes. We have had about 40,000 visits. To give you a sense, we are open 90 hours a week, seven days a week. We employ 70 practitioners. This year we will do about $2 million and we will make some money on that, not enough, but some money. Not enough to justify their role.

We offer many modalities of massage, acupuncture, Chinese herbs, chiropractic, naturopathic medicine and nutritional classes. We see about 100 new patients a week. We get 60 percent of those from referral, from ear-to-mouth referral. Twenty percent drive by, or walk by, and about 10 percent from medical referral.

We treat a whole range of conditions. About 45 percent of our visits are related to stress, or relaxation, and the rest are specific medical conditions like pain, headaches, back and neck pain, sleep disorders, fibromyalgia, fatigue, everything to cancer.

We are complementary, not integrated. We are attempting to create an idealized delivery system for

health care, and have concluded that that necessitates a system that is neither modeled after nor dependent on the existing health care system. When you do something in CAM, there are not barriers and legacies that you would have to deal with in more conventional care.

To be successful, and I think we are pretty successful, it requires a real business focus. I think to be sustainable, whether you are for-profit or not-for-profit, you require that business focus which is on operational excellence, quality service, and cost control.

A lot of that is driven by the fundamental economics of the CAM industry. A successful CAM practitioner, with the exception of certain acupuncturists and chiropractors, probably will make between $30,000 and $60,000 a year.

The margins that we get in our business are about 33 percent, which means that we charge 1-1/2 times what the practitioner takes home. If you look at traditional health care, conventional health care, the multiples are between three and seven times. That means there is a whole lot more margin to play with in the

delivery system. If you look at any service business, the multiples are typically three to seven times for accountants, lawyers, et cetera. So the margins are tight, and that means we have to focus on expenses that are focused on quality service and affordability. We have a heavy investment in systems and processes that allow us to deliver consistent quality from visit to visit.

Another key aspect is simply the attention to our customer, to the patient. Patients are making a choice to come to Well Space. They needed to be treated like a customer, with the single overriding principle being that every touch is an opportunity to deliver care and create loyalty.

For example, patients never, never, never wait for an appointment. The money transactions are done easily and simply. Appointments are available when a patient wants them. If education is needed, it is done in a nonthreatening, informative and sensitive environment, and the physical environment supports the mission in terms of appearance and all of the other senses that are fed by walking in by walking in the door

at Well Space.

The other key part of what we do well is attention to the practitioner. In CAM, perhaps more than other forms of health care, the practitioner-patient relationship is really critical, the best practitioners definitely have the best outcomes. So we need to attract the best practitioners in order to be successful, and we need to focus on them from an economic perspective, from a policy perspective, and from a cultural perspective.

So our practitioners are attracted to a community which is both within their modality as well as the cross-multiple modalities, so they can practice with other professionals. It is a very professional working environment, and notes are filled out on every visit, for example. Their practices are managed so that all they have to do is deliver the care. They don't have to worry about anything else. Their compensation is probably better, but it is certainly more reliable than it would be in private practice, and they get benefits that are otherwise not available.

We have a heavy investment in systems, as I mentioned. There are three key systems: resource

planning, which drives utilization; appointments and point of sale; and finally, medical records. Whereas, I said we developed a system that allows for a point-and-click creation of a sub note based on our modalities.

Briefly, I want to talk about our relationships to physicians. We have excellent relationships with local physicians. We do get, I would say, referral, but I put that in quotes. It is more you should try Well Space, or you should try acupuncture, as opposed to a traditional referral.

Importantly, our patients are simply not interested in integrative care. We have the capability to create progress notes. Literally nobody has asked for information to go back to their physician in 40,000 visits.

Finally, a bit about managed care. We did a pilot study with 2000 lives that were given essentially free access to CAM without medical referral, without any pre-existing condition. In a six-month period, about 70 people took advantage of that. Of the 70 people, when we completed the pilot, of the 70, about 50 continued to come and pay out of pocket. I think what that says is

that there is not a lot of price sensitivity in this market. If you are in pain, the cost of the pain far exceeds the cost of the acupuncture treatments to address the pain or something like it.

From a policy perspective, very briefly, I think the delivery system for CAM will continue to be largely stand-alone. Of the $20-odd billion, I would say 99 percent of it is delivered by individual entrepreneurs who are practitioners, whose success is a function of their outcomes, because otherwise their clients will not come back. I think any policy needs to not necessarily have a bias in favor of integration, because otherwise I don't think it will work.

DR. GORDON: Thank you very much, all three. I am sure there are a lot of issues that we would like to discuss with you.

Who would like to begin?

Let me start then.

Bob Atkins, I want to ask you what your sense is, both of the economics of your practice, the economics and sort of economic and social aspects of your practice? And also given the fact that you are an extraordinarily

well-known author, what are the implications for other people who are not so well known, although they may be reasonably well known in their communities?

DR. ATKINS: Well, it is a tough question because being well-known has really changed the demographics of our patient population. Some 40 percent of the people now come from so far away that their follow-up has to be done through telephone counsels very often, and only an occasional visit. But most of my career, practicing that way wasn't like that.

Basically we started off just being part of the system. In other words, when they had insurance, we applied for insurance, and they got reimbursed that way. Every once in a while there would be problems. There are certain areas of care that we are very happy with that are being suppressed, and one of them, the first one that comes to mind is the high resolution microscopy that is very much a part of our diagnostic system.

With this microscope, which was an expensive investment, we can see the material between the red blood cells. We can make diagnoses of various bacteria, yeast parasites, because we actually see them in their

characteristic way of clustering under the microscope.

Now we were told by CLIO that we can't do that, that we have to basically close that down. This is going to be a very painful part because so much of our understanding of patient care was based on that.

Then various states, of course, have --

DR. GORDON: Do you want to explain what CLIO is and what that means?

DR. ATKINS: Well, that is a laboratory surveillance, so to speak, group. And they said yes, we love your lab, you get 100 percent success, but high resolution microscopy doesn't have any codes for it, so you can't use it. So that is typical of many of the obstacles.

In treating cancer patients, of course, it is a disaster because the treatments that we read about or that I learn about when I go to international conferences, and I see that they are the most successful treatments that are alternative to chemotherapy and radiation, such as hyperthermia, which I am very pleased with. But there are no legal hyperthermia devices that will provide whole-body hyperthermia legal in the United

States so we have to go to Europe or Mexico, and send our people there.

There are an awful lot of other therapies that have not been approved. Treating multiple sclerosis, we found a very effective treatment, AEP, calcium AEP injections. Legal in Europe, but not in the United States, and they are not even allowed to bring into the country, and yet it is a perfectly safe and innocuous nutritional treatment which has, in my own experience, caused neurologic improvement in about 200 of my MS patients.

So there is a very long list of obstacles that we have to face, and now, of course, we have got the HMOs and things of that nature which mean that the people aren't going to be reimbursed. Not reimbursing for chelation therapy, which has been really the mainstream of cardio prevention for thousands of physicians who practice CAM, and so this is not reimbursed by Medicare, and therefore the major insurance carriers don't want to carry that reimbursement.

Many states, of course, have different laws. New York State, we finally got a law passed which

acknowledges a physician's right to practice alternative medicine, and in so doing, they no longer can just take our license away just because we do things differently.

I think the important thing is that having a right to do things differently is very important. You asked me what the problem is. I want to talk about the solution because the solution would be to get the kind of research done that would allow people, the government and other people of interest, to see the two systems compared with a matched group of subjects to see whether or not our assertion that we get better results and at a lower cost than mainstream medicine has been getting.

DR. GORDON: Thank you very much.

Tony, Bill, and Tom.

DR. LOW DOG: Part of what we are trying to do is to determine access and delivery, and I just want to commend everybody, and I thank you also for bringing the nursing perspective which we had not really heard, and who, by the nature of their profession, are very holistic.

But my question is really directed at Well Springs. It sounds very exciting, what you are doing

over there. One of the things about access is who can afford it, who can pay for it. We have already discussed reimbursement, and that is going to be a separate session, really, but do you make attempt in your services for sliding scale fees? Do you have a day a month where there is a reduced fee schedule? How have you worked to address providing to the community for those who cannot afford $60 for an hour of service?

MR. ROSENTHAL: Couple of things.

First of all, there are discounts available that a practitioner can offer to someone in need at any time.

Secondly, we certainly encourage our practitioners, who generally work exclusively with us, to also work in some sort of giving back to the community environment. Obviously reimbursement is potentially the solution.

You know, our prices are not that high, and I think the point about the cost of the payment exceeds the cost of the treatment, and even though people have an expectation to not pay for their health care, you know, spending $200 or $300 for a course of acupuncture that

addresses a migraine issue you have had for years is pretty trivial. And, in fact, we don't have a great sense of household income, but we have done surveys of our customers. It is surprisingly low. This is not only an affluent community that comes to Well Space.

DR. LOW DOG: Could you give us an example, of like an hour of acupuncture treatment?

MR. ROSENTHAL: Acupuncture treatment is $60. You know, the intake is $85, and the treatment is $60. But you can go down to $40 if the need arises.

DR. LOW DOG: Thank you.

DR. GORDON: Bill?

DR. FAIR: I have several questions for Mr. Rosenthal.

First of all, you addressed a couple of times that Well Space is not going to represent integrative practice, but rather complementary, and since we are talking about access, I had questions relative to this.

Since your clients really didn't their physician to be involved, first of all, how does that make it complementary? It would seem to me almost separate.

Secondly, when you had that pilot project, 2000 people with the HMO, and only 70 took advantage of it. What recommendations do we have? What did you learn out of that? In 70 out of 2000, when it was a free benefit wasn't really impressive.

MR. ROSENTHAL: No, it wasn't impressive. I would say let's answer the second first.

Right now, as I said, reimbursement is not something that -- obviously the costs go dramatically up, particularly when an HMO is trying to do something unusual, the costs are even higher. So you can imagine what the costs are. And the discounting is relative to a retail price. So literally for every visit, we lost money. But it was still worth trying.

I think the message is that not that many people know about CAM or believe in it. The people who do will pay for it. But the people who don't, don't know about it. So there is certainly a policy goal of more education which would then make it not 70, but 700.

It was disappointing. We expected an increased demand to at least be something we would learn from it. But I think education is the key thing.

On the issue of complementary versus alternative, I mean we certainly established the company with the goal of it being complementary. As I said, we have full sub notes which is a pretty substantial cost. We can generate progress notes. We expected a lot of exchange on our initial intake forms. You would fill out your physician, there would be a check box, we will send the physician the note, and literally I think was zero people checked that box.

So my point was not a matter of opinion, it was just a matter that the patients simply do not view them as connected. Maybe they don't view them as connected because they go to their doctor when they are sick, and they go to Well Space, at least to some degree, when they are healthy, or when they are sick of going to their doctor.

DR. FAIR: We heard a number of presentations yesterday that heart disease and so forth, the theme was always there throughout all these presentations, or for cancer, if only I had known about this before I got sick, before the defining event, I would have changed my life. I guess it comes back to education, but I wondered, it

seems to me, and I said this yesterday, we are not doing a very good job in education. We have this epidemic of obesity and increasing risk of diabetes in people in their 30s, and it has been estimated that probably at least a third of cancers are diet-related, and another third are probably related to other lifestyles, and it seems like we are not getting the point across.

So have you learned anything that this condition could say this would increase accessibility or acceptance of CAM, from your experience?

MR. ROSENTHAL: Certainly, again, it is not like we have an easy task of getting people to come from a preventive perspective. Generally speaking, people come when they have some issue they are going to address. We have tried to put programs together that are oriented to that, and they have not been wildly successful. So we don't have any real experience of that. I think education is a key part. There is an awful lot of preventive CAM and non-CAM treatments that are not reimbursed. Certainly that would help.

DR. FAIR: The last question. I commend you for the idea of the sub notes because that is so foreign

to many of the modalities that are represented by CAM, and it seems to me a tremendous resource for outcomes down the road, although you say you are not sure what to do with them.

But was that a system that you had to develop within Well Space, or was there a commercial system that you went to, to do that? Because that really is essential if we are going to get the information. That would improve not only research, but accessibility.

MR. ROSENTHAL: We did develop it based on an existing system. We created our own vocabulary and so you point-and-click with a TCM diagnosis and you point-and-click on the points, et cetera, as an example acupuncture being sort of the most different kind of system.

We have 40,000 records that have got to be useful to somebody. But because there is not an ITD-9 code from a diagnostic perspective, because there is not a CPT code for the treatment, nobody knows what to do with it. And that may be because we are in Cambridge, you know, and Harvard is certainly the bastion of something in traditional medicine. But you would think

that someone would be able to figure out something to do with our 40,000 records.

DR. FAIR: And these are all computerized, aren't they?

MR. ROSENTHAL: They are all computerized, and they are all reasonably structured. It is not free text.

DR. GORDON: Tom.

MR. CHAPPELL: Mort, my question for you, I would like to understand better the decision that you made about complementary, not integrative, and then I would like to understand the compensation arrangements a little bit better for the practitioners. What were the driving factors for you to choose to select out MDs from the services?

MR. ROSENTHAL: There are basically three reasons.

One was that we were concerned about hierarchy. You know, if you put a physician in, and it would be an exceptional physician who could practice literally alongside a CAM practitioner on an equal footing. But the physician would want to control the care, and we were dubious about whether any physician could really do that

effectively. So we didn't want to create the hierarchy, point one.

Point two, competition. If we had physicians, then conceivably we would get referral from other physicians and other practices. In Bottener, there are several clinics that do have physicians, and they have generally not done well.

The third issue is we are an entrepreneurial organization, and we are trying to be successful. Sort of messing with reimbursement, messing with the traditional health care system is just not a good way of being successful. So we just decided to avoid it from that perspective.

MR. CHAPPELL: Do you revisit it?

MR. ROSENTHAL: With some regularity. And we have lots of physicians who would like to practice in Well Space, and we have a number of efforts or discussions to essentially put a Well Space inside of a health care system, but still sort of a separate box, with a door.

On the compensation issue, practitioners are compensated about a third with salary and two-thirds with

incentives. The incentives are largely based on number of visits, but there are also bonuses for utilization and for retention. So essentially we try to incent them to do a good job.

MR. CHAPPELL: I assume these practitioners are on the payroll and not on a referral?

MR. ROSENTHAL: Most of them are full time, but not all of them.

DR. GORDON: Okay, I have Don, Charlotte, Effie. Anyone else? And then David.

DR. WARREN: On that question about access, the access problem is that we can advertise alternatives and complementaries, but unless we have the practitioners to take care of those people, what do we do, to the nurse? I see a big chance for nursing to educate the physicians and make it their idea. Many times you go in and you try to beat somebody up with this, they go up the wall. But if you can slowly integrate it, and I see the nursing as the fastest way to integrate complementary alternatives into medicine, it could make it the physicians' idea through the back door, kind of. What do you think about that?

DR. ELIOPOULOS: Well, I think nurses have educated physicians for a long time very tactfully. I would like to not put it in the framework of a manipulative, that we are helping the boys understand this is their idea. I really think we are in a partnership. And I think part of our education is to educate about a new model of care delivery where the leader of the team does not necessarily have to be a physician with this integrative model. I think that takes perhaps a bit more than education to make that happen.

What I am hearing about in some of these other models, I have to question if maybe people don't want or haven't asked for records to be transferred because of the lack of education, because nobody sat down and helped them understand that there has to be a marriage of these therapies, and I think nursing does have a crucial role with that.

DR. WARREN: Well, I see patients not wanting records because they don't want to be insulted at their doctor's office. You know, to take those records and say I am using this nutrition, and all of a sudden they are

lambasted because they just make expensive urine.

DR. ELIOPOULOS: And I think that is why it is important, and I think this is where nursing can play a vital role, because nurses are in these private practices with the physicians, and they are in the hospital settings and elsewhere, to be able to buffer some of that, to provide some of the education, to be able to sift out what is a fantasy here versus what is a real therapy that can be effective.

DR. WARREN: So we are dealing with a lot of frail egos.

DR. ELIOPOULOS: We are dealing with some of that, yes.

[Laughter.]

DR. WARREN: Thank you.

DR. GORDON: Okay. Charlotte.

SISTER KERR: This is specifically to Charlotte. Thank you for your presentation.

Aspects of CAM are integral to nursing, touch, listening, time. The nurses were the first to know that self-care was primary care, or at least equally with the others.

I also notice that historically, and it continues to be, and I still don't understand why, nursing is even being in many ways still marginalized today. There is a crisis in nursing. And just as I was listening to you, I thought, you know, as nursing is seemingly getting to be more of a crisis and being diminished, CAM is rising. Historically it seems like the nourishing functions, the yin functions, the affective functions, the listening functions, is what we have refused to pay for in health care, at least in the experience in nursing.

So having said all that, I wondered what could you offer, what could you envision, what coaching do you have to give to us, both in the area of CAM and even policy, based on your experience in nursing? And if not now, later. And very specifically. Because you have been there and we got this.

DR. ELIOPOULOS: And it may be that I will need to come back with some recommendations to offer some specifics.

You know, I do think that some ongoing advocacy for the fact that it is a healing process, it is not just

really throwing modalities into the pot. Now those modalities are important, and the reimbursement for them is important. But there is a process, a healing process, that needs to take place, and at some point we have got to put the rubber to the road and say we are going to commit to this and reimburse for this, or we are not. Or are we, as I say, just have additional fragmented care, using a different set of modalities in the pot?

You are right with what you say about nursing. We are having a crisis, and I think it is because we cannot function in the healing arts as many of us have been nurtured into a profession to believe that is unique to us. I think our association manages to attract people who are frustrated with the conventional health care practices, and want a different path, want a different practice, and are carving out some unique practices to make that happen. But unfortunately we are tied into systems where our paychecks come from some pretty conventional sources and dictate what our practice modalities look like.

SISTER KERR: Thank you.

Dr. Atkins, when you spoke, you actually gave a

preface, in my opinion. You were talking about paradigm shift. And you said there was a new definition of system of health care.

Charlotte, what you are saying is talking about the need, as I often say, acupuncture is a process, not a procedure, and you were speaking to that in terms of what we are about, not just adding on new modalities.

My listening at the moment is speaking to the fact that we need to, perhaps, as Dr. Atkins said, is continue to have a conversation, and we are talking about what we are about here, is to talk about are we talking about a change in the system, or are we talking about -- do you think that that is important, that before we talk about the reimbursement of this or that, that we need to actually speak to that in our education to the public about what we are about here? Would you agree with that? Or Dr. Atkins, you are shaking your head?

DR. ATKINS: Absolutely. I see no reason why the practitioners of mainstream medicine don't begin to add more and more complementary therapies into their thinking. I really think that there has to be a whole movement away from specialists to the ultimate idea of a

generalist, a person who knows everything. I think that is a noble ambition for a doctor to try to achieve, and I don't think it is difficult to do. I think it is quite possible that a doctor begins to learn if he can't do acupuncture, he knows the role that it plays, he knows the role of all the herbal therapies, he knows the role of the nutritional therapies, and he makes decisions on the basis of what will be the best choice for this particular patient.

That seems to me to be the only direction which will change the way medicine is practiced for the better in the future. If we keep them separate, if we keep the alternate treatments separate from mainstream medicine and allow mainstream medicine to proceed in its direction of making us the nation with the highest health care costs in the world, and they are doing that because of financial considerations, I do believe. When surgery is being offered before you give a person a chance to reverse the heart disease, to give an example, that is money.

Complementary physicians specialize in reversing heart disease once people have been told that

they need a bypass, but to do the bypass before they get out of the hospital is the problem.

I think we have to confront the mistakes that are being made by my colleagues in mainstream medicine, and complementary techniques are the answer. They are the potential answer, the potential way to prove to everyone that this is the way medicine should change over the next few decades. I think when that happens, we are going to be very surprised at how health care costs go down, how hospitalization statistics go down, and how we will be able to handle all the Medicare problems that we are so concerned with, because they won't be quite nearly as expensive.

SISTER KERR: Thank you.

One last follow-up questions. You said -- I'm sorry, I forgot your name for a moment. You said, of course, reimbursement is the solution and will enter into reimbursement, although in your paper on policy recommendations you mention that the best practitioners with the best outcomes don't necessarily choose reimbursement.

I want to suggest that maybe reimbursement is

not the solution. What do you think about that? My experience is it is such a botch-up, and --

MR. ROSENTHAL: The existing model of reimbursement is clearly not the solution, and some sort of subsidy, conceivably, for people who cannot afford care may be the solution, or medical savings accounts with the subsidy at the low end. Again, a range of things.

Certainly for existing models of reimbursement, from an administrative perspective, do not work for CAM, period. They really, really don't, and the idea of negotiating a fee, again, remember, traditional medicine before managed care was say seven times what a doctor took time. They were billed out at seven times. There is a lot of room for administrative cuts, there is a lot of room to negotiate the fees down. When you are billing out at one and a half times what is a not very high salary and you want to discount that, where are you going to go? You can't take costs out of the operations, so therefore an acupuncturist with five years of experience, instead of making $45,000, if they are still doing it, is going to make 30? That doesn't seem right. So I don't

think reimbursement is the right answer.

SISTER KERR: Thank you.

DR. GORDON: Effie, and then David.

DR. CHOW: I also want to thank you for the report, and my question is directed towards the nursing. I appreciate the role of nursing and the role that we can play as mother, father, and companion, and overall role. One of the aspects of nursing is that we are also facilitators, and networking, really creating the ambience for healing and caring to take place. I wonder if the American Nurses Holistic Nursing Association, what is your role at working with other organizations, like the American Holistic Medical Association, or even American Nursing Association, to facilitate better in terms of eligibility and even education and so forth?

DR. ELIOPOULOS: We have just started. It has actually been a week past in terms of our networking with some of the other organizations. We do network with other nursing organizations, and there is the umbrella of the NOF and the VASNO umbrella, nursing organizations, especially organizations that do meet regularly and exchange, and we actively participate in that. We share

our views with those organizations and exchange programs and thoughts with them. We are developing a position paper. We have a draft of a position paper on the nurse's role in complementary and alternative medicine that will be shared, and hopefully endorsed by all these nursing associations by this time next year. So that networking within nursing is stronger, I think, than with the AHMA and some of the other associations. We have started conversations with them about doing some joint educational conferences and exchanging materials, but that is about it. We have not taken a stand together for positions. It has just not been the way our associations have functioned. Not out of a lack of desire. I think it is been out of a lack of organizational, administrative strength.

DR. CHOW: I hope that would be something you would consider.

DR. ELIOPOULOS: It is a goal now. It is certainly something that is important to us.

DR. GORDON: David.

DR. BRESLER: This is for Dr. Atkins. We are talking about access, and it seems to me no matter how

large your facility is, there are still just a finite number of people that can come through your program. However, you have leveraged your program by writing books that takes at least part of your program out to huge numbers of people. However, you have no interaction with those people in terms of being able to do lab testing and the other things that you do in your facility. How comfortable are you with using books and print media as a way of getting greater access to the information you use in your program?

DR. ATKINS: Well, I don't consider the books a way to get access. I hope they will get people to make a phone call, and then we work out a system. Sometimes we have quite a system of nutritionists who can do a lot of telephone consultations, but that is inadequate.

I think our greatest contribution are seminars we hold for physicians who would like to learn our kind of medicine. We expect that each year when we hold one, we expect to get a much larger group. We are pretty certain that there are more and more physicians who are going to practice this way. All we have to do is remove the fear that their license will be revoked, and once we

do that, the doctors want to do it. It is absolutely amazing. When we put out an ad for staff physicians, more and more people respond, and these are people who really don't have training in alternative or complementary medicine. They just want to learn it. And then more and more people attend our seminars, and we are not the only ones to have seminars. Quite a few other seminars are held, and more and more people join. More and more people seek membership in a group like ACAM, the American College of Advancement in Medicine who are over 1000 members now.

So I think the access is going to be through more and more physicians who emulate the people at our center, only practice in their own towns, their own cities, their own states, and I think that will be the answer.

DR. BRESLER: Thank you.

DR. GORDON: Wayne will be the last questioner for this panel.

DR. JONAS: I had a question really to Mr. Rosenthal and to Ms. Eliopoulos. There are a number of models of nurse management in conventional care,

especially oncology where nurses kind of become patient advocates and are the communicators between the radiologist and the oncologist and the primary care physician, and looking for clinical trials type of thing.

I am wondering, that type of a model as a health educator or coordinator of patient care, is that something that either of you have talked about in your organizations or considered? Is there a need for it? Is there something that patients would like, or only a certain percentage? Does that look like a way of kind of at least bridging a link between these what appear to be two fairly parallel systems that don't communicate very often?

MR. ROSENTHAL: We have a function that we call Well Space Guide, where again when we were setting up the company, the assumption was the guide would be sort of the gatekeeper for a lot of clients who were coming in and didn't know what to do.

In reality, the guide is requested or used maybe by less than 5 percent of our visits, and really only when we force it, like we have a back and neck pain

program where you have to see the guide as a sort of starting point. And so that is surprising that it was so little.

In other words, it is mostly people who know that they want acupuncture or know that they want to see a naturopath or whatever.

We considered and interviewed some holistic nurses for that, and certainly the idea of a nurse playing that sort of bridging role would make a lot of sense. Again, it has not been utilized very well. We ended up hiring someone who is an acupuncturist/massage therapist/occupational therapist, basically has a range of skills. But mostly it is around, you know, connecting to a patient in a very sort of easy way. But certainly that would make some sense, but it is not a huge demand.

DR. JONAS: In your population, people kind of know what they want and they come in, and they seek it out individually. I imagine, though, in other groups, for example, oncology patients, patients with cancer, or if there were to be an effort to make this more proactive to provide access to a wider population that did not have kind of this knowledge, that perhaps that might be more

important in those circumstances.

DR. ELIOPOULOS: That is what I would like to respond to, because there are some nurses who are developing that kind of practice, both as a private practice as well as within some conventional settings.

I know I have a limited private practice myself where I perform that kind of service for people with chronic conditions. And what I find is that I am working with a lot of people who don't know what they don't know, in terms of what options are out there, both within conventional medicine as well as some of the CAM modalities. So my role is to help educate them and refer them to practitioners, and to monitor what is going on, and to make sure that one hand knows what the other one is doing. I think it is a very viable role for nursing.

MR. ROSENTHAL: It is not like people coming in knowing exactly what they want. We have a relationship, for example, with a large cancer support group in Boston. We speak there regularly, so they come in through that door, and they are referred to a practitioner who may be particularly good at a condition.

DR. JONAS: Thank you.

DR. GORDON: Thank you very much.

I want to take just a couple of things. One is that I really appreciate the questions the Commissioners are asking, as well as responses. I feel like we are really getting to some of the issues.

I would encourage the panelists, and all the panelists who come today, that out of the questions and out of the dialogue we have, to really think on as large and ambitious and hopeful a scale as possible about some of the issues that we are all discussing, and to make recommendations to us based on what is coming out of this experience, as I think especially these last few questions were pointing out. We are really looking to see how this health care system can be responsive to people's needs and far more effective, and our task in a sense goes way beyond attention to CAM.

The other thing that I want to mention is that we have an hour at the end of the day, Charlotte, to address some of the questions that you are raising. I think it is really important that we be thinking about these as well.

Tom and Joe.

MR. CHAPPELL: May I ask one question of the panel?

DR. GORDON: Okay. But we really have to move on because we are already a little behind.

MR. CHAPPELL: Mort, are you finding branding to be successful, or a successful way of economic sustainability, as opposed to reimbursement?

MR. ROSENTHAL: That is say a consumer coming in of their own choice. Yes, I would say our problems are not in creating consumer demand. We have a good brand in the Boston area, and it generates a fair amount of visits. So I would say that in our case, branding is sufficient.

I also wanted to invite any of you who happen to pass through Cambridge to come to Well Space, because we are a delivery system which is bricks and mortar, and actually seeing it is interesting.

DR. GORDON: Joe, did you want to say something?

DR. FINS: Just a question for Dr. Atkins.

In your statement that was supplied to the Commission, you talked about informed consent, that you

wanted to follow the recommendations of the New Jersey Supreme Court, saying that conventional practitioners have to provide patients with information about alternative therapies.

Let me really turn it on its head and just ask you about access and safe access, and the safety issues.

What happens in your program when a patient fails your modality? I am sure that there failures in allopathic medicine, and there are failures in complementary modalities. What kind of safeguards are there that that person has access to the conventional modalities and is quickly and appropriately referred to a cardiologist, perhaps for bypass? What kind of mechanisms have you guys used to ensure the safety of patients in that situation?

DR. ATKINS: Well, basically, all of us are trained as physicians, and whenever we see a problem that we think requires the need of someone whose specialty allows them to handle it, we make the referral right then and there. So we have never gotten into that kind of trouble because we refer things out whenever there is the need to do a referral. So it is something we haven't had

to deal with.

Remember, you have to understand that, yes, we add complementary therapies to our program, but we are basically very well trained internists, and our instincts are those of a well trained internist.

DR. GORDON: Great. Thank you again.

We will take a five-minute break and then we will have the next panel.

[Recess.]

DR. GORDON: Will the panelists please come to the table.

Thank you very much.

Again, as you will see when you look at the schedule, this group of panelists will be focusing on clinic situations in which they play a leadership role, and they will be presenting the models of CAM or integrative care that they are offering.

First will be Tom Trompeter. Good morning, Tom.

MR. TROMPETER: Morning. Thanks for this opportunity to speak with you once again.

Before we get started, I know that when we were

in Seattle, a number of you asked me some questions that I said I would get back to you on. November is usually a rather busy month. We have got a couple of major grants that we do in the early part of December, so that was really kind of occupying our time. But I will provide you with answers to those questions, either on kind of an ad hoc basis today, or in writing, in a more formal way, some time between now and the middle of December.

You all posed four questions, and I would like to just kind of run through them, not quite verbatim as it is in your book, but as a way of sort of starting the conversation.

My name is Thomas Trompeter. I am the executive director of Community Health Centers of King County. We are a private non-profit, tax-exempt organization, with a consumer majority board of directors. What that means is 51 percent of my board of directors is comprised of patients of our health centers. We have six medical and four dental clinics in suburban Seattle, probably comprising about 50 miles between the two furthest ones.

Each year we provide about 90,000 visits for

people who are all poor and primarily uninsured. About 95 percent of our patients have family incomes that are below 200 percent of the federal poverty guidelines. About 75 percent are below 100 percent of federal poverty guidelines. A little over 40 percent of our patients have no insurance at all. Those that do have insurance are generally insured either by Medicaid or by what in Washington is known as the Washington Basic Health Plan, which is a managed care product designed for people primarily with incomes below 200 percent of poverty, who pay premiums on a sliding scale.

When you all asked why and how did we decide to provide CAM products and services, I think context is also key. The Puget Sound area, I think, has for a long time been a rather fertile ground for integrative medicine and, in fact, not just our corporation, but the other community health centers in the area have had intermittent experiments, I guess is one way to say it, in providing integrative care.

At various points in time over the last 25 years, various health centers have tried to employ naturopathic physicians, for example, although

economically it has not always worked out.

In 1995, due to some advocacy work that was being done throughout the community, an opportunity was created for us to compete for a grant that would help us establish an integrative medicine clinic, and in that process we developed a partnership with Bastyr University which is, I think, well known to most of you, to begin an integrative clinic.

What we did was we basically proposed a response to a request for proposals that had three components.

One was that it include conventional primary care, another is that it include at least some elements of complementary and alternative medicine, and the third component was that it include an evaluation component.

We successfully competed for that grant, and that is what really got us off the ground financially to start this clinic. We opened our doors on October 21st, 1996.

Secondly, you all asked -- and actually, I would like to back up a bit. There was a fairly firm commitment from our board and from our administrative

leadership to pursue integrative medicine, and I think that really helped set some organizational context for us to move forward on this. We don't move in policy directions like this without the approval of our board of directors, and it was very critical for us to have a consumer board interested, supportive, and actively involved in this process, and they were.

In asking how do we determine which products and practices to make available and for which conditions, on the which conditions side, I would just like to say we are a primary care operation, and the conditions for which we offer CAM services are the conditions for which people normally seek primary care.

We have referral relationships with specialists and hospitals, and we do use those for folks who present us with conditions that are beyond our scope of practice.

When we responded to the RFP for the King County Natural Medicine Clinic, the clinical leadership from both Bastyr community health centers, with input from our administrative staff at both organizations, identified four disciplines that we would include in the initial organizations.

Those disciplines are naturopath medicine, acupuncture, chiropractic, and therapeutic massage.

In addition, we decided initially to offer naturopathy and acupuncture on site and to offer chiropractic and massage via referral.

The decision to offer some services on site and some via referral was driven by two main concerns: the need to use limited resources wisely; and the need to offer in-house those services for which we all felt that we possessed sufficient expertise to be able to provide appropriate quality assurance.

That is, we could not afford to offer all four on-site, and we wanted to be able to do on-site that which we could do best.

For chiropractic and massage, we would then establish contractual relationships with community providers, whom we trusted, to be able to provide not only high quality care, but who would also have the necessary non-clinical skills to provide care to the particular patient populations that we serve.

Just as a sideline, a little over 30 percent of the visits that we provide require the presence of an

interpreter. This is not the norm in the private practice.

We had hoped that over time we would gain the necessary skills and necessary funding to provide both chiropractic and massage on site, and in one small step, in May of this year, we hired a licensed massage practitioner to provide on-site therapeutic massage via referral from providers throughout our system.

DR. GORDON: Tom, I think what we are going to have to do is, we have read the testimony, and we will have a lot of questions during the question period. Sorry to cut you off.

MR. TROMPETER: That is fine.

DR. GORDON: Next will be Sylver Quevedo.

DR. QUEVEDO: Thank you. My thanks to you all for this opportunity and to you for your pioneering efforts in this area.

My name is Sylver Quevedo. I am a physician and nephrologist and the director of the Center for Integrative Medicine at the O'Connor Hospital in San Jose, California.

I come to you very much from the perspective of

a conventional physician in practice and also involved with the teaching of medical students, residents, and fellows.

I have five points, and I will be brief.

Integrative medicine is the medicine of the future. Any hospital not looking at it will be seen as obsolete within 10 years from now.

The second point, conventional bio-medicine needs the broader perspective of integrative medicine to thrive. These are bad times for hospitals and academic medical centers, as many of you know, and the broader perspective of integrative medicine will be revitalizing for the conventional ranks, and it is necessary.

Integration is essential, and it is largely occurring even by virtue of the process we are engaged in today. However, programs which look at it up front and take it seriously will have an advantage in the years to come.

Culturally appropriate care is predicated on a respect for the life, world and culture of a given patient, and integrative medicine takes this perspective seriously, not relegating it to the realm of psycho-

social factors, as often happens in the narrow bio-medical model.

Belief matters, and this perspective, I think, is honored in the integrative medicine vision.

Lastly, credentialing strategies are essential for hospitals and academic medical centers, and they must be led by physicians with standing on the medical staff in order to be successful.

Let me elaborate on a couple of these points in the time remaining, but again, I will leave most of this to the questioning period.

The first point, that integrative medicine is the medicine of the future, in the materials that I have provided for you, I took some pains to spell out what we mean or what we meant in our efforts by integrative medicine, and they were not limited to a discussion of a given modality, but attempted to reach the deeper traditions of medicine and the healing traditions around the world.

We drew on the work of Dr. Gordon and others, and worked hard in our discussions to make it our own, to understand it and articulate it for our own groups. This

is what I mean by integrative medicine being the medicine of the future. It is, I think, incumbent upon us to look deeply at what we are doing in conventional medicine, asking questions about why it is no longer seen as effective, why is there such great dissatisfaction both among practitioners and patients alike.

Regarding conventional bio-medicine, as powerful as new technologies and scientific advancements have been, the broader perspective of integrative medicine brings us back in conventional bio-medicine to the larger cultural process of which we are a part. We can no longer simply be about the business of medicine or science without paying attention to the larger cultural forces and, indeed, the perspective that many consumers have, that there is something much greater than science when it comes to healing.

Lastly, culturally appropriate care in our increasingly pluralistic society is a necessity, something that we need to look at very hard, something that, without taking it seriously, will simply make what we do in conventional medicine less and less effective. And in order to do that, we need to think in terms of the

broader culture and the healing traditions from the cultures that patients come from, and to realize that belief matters very much. We are no longer regarding it as an afterthought. It needs to be brought into the main stream of conventional bio-medicine. This should be part of what occurs in medical schools and medical training programs.

Lastly, regarding the credentialing issue, it has been important for us to work actively with members of the medical staff to develop a strategy that they could feel comfortable with, and I will simply conclude by saying that initially much of the resistance that we encountered from the medical staff was simply based on the fact that they had very little familiarity in these matters, and as we began this dialogue, that resistance has largely melted away, and they are now asking us to organize a department of integrative medicine in the hospital and to bring these therapies into the in-patient setting.

Thank you.

DR. GORDON: Thank you very much.

Woodson Merrell. Good morning.

DR. MERRELL: Thank you, Dr. Gordon and other members of the Commission, for the chance to be here today. I was actually told that I would not be presenting any remarks at the beginning, so my remarks will be fairly brief. I would say that with Dr. Quevedo, I feel like we must have been separated from the hip in terms of many things we have to say about the philosophy and background of medicine are very similar, particularly the aspect of integrative medicine being the future of medical care.

I am just going to mention a few things in terms of the direction of my questions that I was given about the Academic Centers incorporated integrative medicine. In terms of that background, I am the executive director in New York City of the Beth Israel Medical Center's Continuing Center for Health and Healing. This is an integrative medical center that was in planning for about two and a half years, and just opened in June of this year.

It comprises 16 clinicians, nine physicians, and seven allied health and CAM providers, covering most aspects of integrative medicine in a hospital-based

practice.

The hospital held a think tank about two years ago, and they actually got it, they understood that this is the future of medicine, and the patients are increasingly using it, that they don't know really what to do for many of the therapies that they are using, very few reliable information sources. Someone is going to do it, and it might as well be them.

So they put together a team of people to set up an integrative medical center that would be academically based and that would combine the best of the traditional healing practices that have been around for centuries or millennia, look to them to be increasingly evidence-based, and combine that with the best of conventional western bio-science.

There are many complementary medical centers in academic settings around the U.S. The majority of them are primarily research and education, or they have clinical programs there that are very small ones, primarily focusing on mind-body. Not that that is not important, and of course it is the most important aspect of the field, but I think there is a lot of trepidation

in terms of incorporating any of the other aspects of CAM into traditional academic settings.

At Beth Israel Center, we actually have all aspects of research, education and clinical care on an equal sway, and we provide the patients access to most all treatment modalities and approaches within CAM.

We are part of an academic hospital setting. Beth Israel Medical Center is a teaching hospital of the Albert Einstein College of Medicine, and it is actually very, very focused now integrating integrative medicine into all aspects of training.

The medical school itself just had its first working group with the Dean of Education and the Dean of the Medical School committing to integrating integrative medicine teaching into every course of all four years of medical education at Einstein, and we so far have been able to do that for about half of the courses, and after our first meeting.

We are incorporating the medical students in all four years being able to rotate through our center and the residency programs. At Beth Israel, we actually have the nation's first required residency rotation in

integrative medicine, which is a one-month rotation in the family medicine department as a template for trying to train not only medical students, but physicians right now in training, because of course a big part of the problem is that even if you wanted to deliver these services, who are the practitioners that should be delivering them. There are very few people who are trained in aspects of complementary medicine in any kind of an organized fashion.

So the third part of this, besides medical student and residency education, is fellowship training, and we just received the funds to set up a two-year fellowship in integrative medicine at our institution, and we will be working with Andrew Wyles Fellowship to really try to set, through fellowship training, what are the standards of what an integrative physician actually does in practice.

One of the things that the focus of this group here today is about is access. We are primarily a private practice model, and we may not have time in this session to get into it, and I know the next people will be talking about it more. But it is very difficult, in

terms of the current managed care system, when you are reimbursed 30 cents on the dollar, when your overhead is 50 and 60 cents, to make a go of it. So our clinic is primarily fee-for-service based, with prevailing rates for faculty-based practice.

We do have a number, though, of access points for people who are uninsured, or underinsured, including what we call a Helping Hands Fund. Right now we have raised $50,000 to provide free care for people who don't have medical insurance.

We have a number of other clinics, they are Title 28 clinics, within the medical institution. Fortunately, Beth Israel who for the last decade had been providing CAM services to the underserved and minority populations, and although through the fellowship and research programs, we will be able to provide access to patients at a reduced fee. Our fellows will actually be paid a small stipend for the patients that they actually see, and these are board-certified physicians in primary care who will be able to see patients at a reduced rate.

The last point I would like to make before I close is the role of CAM providers, the integrative

knowledge of the physicians being knowledgeable in integrative medicine in terms of practitioners working together. We see it as critically important that most licensed fields of CAM be, if not all licensed fields of CAM, be incorporated in these centers, particularly an example being chiropractic.

I personally feel that chiropractic has an important role to play in integrative medical systems, not only because of the services that they provide, increasingly. Over the last decade, as patients are becoming disenchanted with the medical care system and their physicians, they turn to CAM providers.

I can't tell you how many patients that the chiropractors, as their primary care doctors -- bringing chiropractors into the primary medical care system -- actually allows those patients to come back into the traditional medical care model.

The role of nursing I will discuss a little bit later.

DR. GORDON: Great. Thank you very much, Woody. And for somebody who wasn't prepared, you did a great job. Thank you all three. It is a tremendously

fertile field for us to explore.

Who would like to begin with questions? Conchita, and then Joe, and then George, and then George.

DR. PAZ: Dr. Quevedo, I would like to find out what some of your specifics are as far as the culturally appropriate medical care that you use in your clinic.

DR. QUEVEDO: One of the most important things to address in this issue, I think, is language. Now our particular program at this point in time is in a community hospital, it is a private hospital, and we have seen many new patients with limited resources, but it is not the same, for example, as the hospital I was at just before, which is the County Hospital in San Jose, where we did see many patients that are indigent, et cetera.

But having said that, I think one of the most important things is language, but it is not only language, but also belief systems. I think the important point I would like to make to you today is that we used to think in terms of culturally appropriate care as a problem for a given ethnic group or racial group, et cetera, and I would simply like to suggest to you that all of us operate in a given belief system, and that

belief matters. This is a perspective, I think, that has been forward by integrative medicine, understanding, for example, mind-body connections, et cetera. It is revitalizing because it takes us out of a narrow sectarian dialogue and into a much broader dialogue which is more fundamental, and I think more compelling for the future.

DR. GORDON: Joe.

DR. FINS: I just think it is interesting to note a paradox here, that the for-profit entities that we heard of this morning that are outside of the mainstream reimbursements mechanisms are more viable than you guys who are trying to do it within the appropriate back-up and physician interaction.

For example, Dr. Quevedo, you have a screening by an internal medicine doctor before any referral occurs, which seems to be very prudential.

I would just like to ask you and Dr. Merrell about this paradox and the similarity that mainstream academic medicine has, that the cost of providing care in those settings is more expensive.

So what kind of funding strategies would you

recommend to allow the integration, which I think provides added value and ensures safety? Either one of you, or both of you.

DR. MERRELL: I think it is very difficult for these centers at the moment to exist without private funding, and I think certainly governmental grants are good, but it takes a long time to get them, whether it is for research or other programs. Private funding sources are really the white angels of this field. We wouldn't have been able to do it without being funded privately for start-up and operating for the first year. You can't possibly make money for a minimum of three years in most business plans, and increasingly medical centers are no longer able to foot the bill for this. So I think looking to private funding and developing those sources in the community is a critically important area.

One thing that our institution did that I am surprised, but it apparently is unique to most institutions, is have the hospital recognize the importance of what we are doing to the existence of the medical center, and to the medical care system. They actually made this a part of the mission of the hospital,

to develop integrative medicine services, and thereby they threw open the doors of the development department, so that the trustees and donors lists were given to us and they were actually courted by the development office with us, to bring additional funds in. Seeing it really lessens turf battle between the departments, because this is coming into one big pot for the institution of the whole. It is going to help it as it makes its transition from hospital-based to more ambulatory-based care in the future.

DR. QUEVEDO: I would just mention a couple things. It is certainly true that we are doing more than just taking of patients and developing programs. We are working on the institution, and we don't get paid for that, and that is a lot of work.

There is another perspective, and that is that we have argued with the hospital that there is a value added to what we are doing, that it is changing their image in the community, et cetera, and that has worked to some degree. But admittedly it is hard to do this kind of work in these institutions with so much institutional inertia, heavy overhead requirements, and cost burdens,

et cetera.

DR. FINS: Do you guys feel that there is an uneven playing field, that you are providing more and yet you have to compete with people who are not providing all these services, and yet in the marketplace you are competing against some of these other venues?

DR. MERRELL: I wouldn't put that in a proprietary model because it is based on whatever the funding source, venture capital, whatever. I often wanted to open a center, franchise it, et cetera, not that proprietary centers don't have a place, but certainly when you don't make the bottom line, usually the first things to go will be research and education, and then shortly after that all of a sudden you are going from your average 22 minutes per visit to let's ratchet that down to seven minutes a visit, pump up the volume, we need to make some money here. And I think that academic centers provide a little bit more cushion in terms of looking at the mission to be a global mission. Of course, the bottom line is important, but it is on equal footing with other aspects.

DR. QUEVEDO: We actually deliberated three

scenarios that included a venture model, a joint venture with the hospital and a private group, and as part of the hospital. And for many of the reasons similar, we decided not to go in a proprietary mode.

DR. FINS: What about the budget for your commitment to furthering the research and educational needs of this developing area?

Thank you both.

DR. GORDON: George.

DR. DeVRIES: Thank you.

Dr. Merrell, most academic medical centers are not including chiropractic at this time, and yet that has been somewhat unique in including chiropractic in its integrative clinic. And not only that, you indicated that it is critical, that chiropractic is playing a critical role in your clinic. Can you expound on that, especially if there are issues of access, like what patients you are attracting because you offer chiropractic, or other variations that you see?

DR. MERRELL: I wouldn't say critical is the right word. I think it is very helpful to have chiropractic involved. I mean similar care could be

administered by osteopaths, for example, but chiropractors do have a unique role to play, and they are often as team members of the community. So I think incorporating them into the system provides an important modality.

There is no doubt about the fact that there is an incredible entrenched opposition to including chiropractic. It used to be the same way with acupuncture, but that is considered almost more mainstream now. It seems to be a no-brainer, where five years ago I thought if I even mentioned it at my medical school, I would have been booted out. It has been quite a change.

I think that it is institution by institution. It is really the luck. I mean what you are able to depends upon which people in key places have had personal experiences that have transformed them, or understand, for whatever reason, the importance of this field.

At our institution it happened that the Chairman of Physical Medicine and Rehabilitation thought chiropractic was an important modality to look at, and to have the services available, and so therefore helped

champion it through the credentialing committee. We have actually developed credentialing guidelines you have in your packet that I provide you, the first guidelines in Academic Center in New York, to have a credentialed chiropractor, acupuncture, massage group within an academic setting that was developed by a committee that consisted of the Chairmans of Medicine, Surgery, and the resident curmudgeon skeptic who would, if he signed off on it, everyone felt that this was something that would be acceptable. There was a lot of hammering out in terms of language and scope of practice. But some institutions just won't be ready because the orthopedists, or whomever, there are large groups that won't allow it to happen. But it is something that I think increasingly will be looked at more favorably.

DR. GORDON: George.

DR. BERNIER: I would like to ask Dr. Merrell in terms of the educational programs that you have been able to put forth, you clearly have an integrated educational program in terms of CAM practitioners and traditional residents.

Have you looked, at the same time as you have

been doing that, at integrating the educational programs for the more traditional health providers, like nursing, allied health? Is that folded into one program?

DR. MERRELL: It is beginning at the medical school, primary medical school education, but particularly at our institution, nursing plays an equal role in terms of educational access. I mentioned, in answer to one of your questions that you gave me, that really nursing plays a critical role, particularly within the hospital, and so they are the ones who are on the front lines, who will help really to transform the institution. Physicians often don't have time really to do this, and partnering with nursing is very important.

Medical schools are realistically more difficult to develop joint programs with, with nursing, with dentistry, or physical therapy or other allied health programs. I think within the hospital or the medical center, it will happen first before it actually becomes capable of being integrated in the medical school setting.

DR. BERNIER: If I could ask Dr. Quevedo, do you have educational programs built into your enterprise?

DR. QUEVEDO: Not to the extent that Dr. Merrell does. We do have medical students who have rotated with us, and we do have a relationship with the family medicine residency that is part of the Stanford Medical School. But that has been informal.

We are actually involved in discussions with the department, actually the Division of Family and Community Medicine, about the possibility of a fellowship that would be after family medicine residency training, a fellowship in integrative medicine.

At Stanford, the family medicine activity is a division in the Department of Medicine, and so what we are talking about is a fellowship which would be a training program in that division.

DR. MERRELL: I just have one quick thing to add about our nursing. In our center, we have a nurse practitioner who is a solo practitioner, who also works beside being family medicine and Ayurvedic medicine, but we also have a clinical nurse specialist who actually is a person who provides what I would call holistic consultation. So when patients come in, if it is unclear whether they should be in our system, she is kind of the

point person for doing a consultation to decide where they should access which care, if they are going right to the physician or, in our system, a patient does not have to see a physician first, they can go directly to a CAM provider if they so choose, and it is often the nurse who helps them figure out, based on their history, where they might need to go.

So we see that as a kind of focal point of information for patients in triage.

DR. BERNIER: Thank you very much.

DR. GORDON: Tom.

MR. CHAPPELL: With regard to access, could I ask the gentlemen who have the medical hospital model, can you assess competitively in any way, or have you assessed competitively in any way what were the consumers' interest in coming to the hospital versus a private entrepreneurial option, or other options? Another option, the community model? Do you have any idea how appealing your model is?

DR. QUEVEDO: Well, I would say we haven't done a formal study on that, but I can give you some impressions.

One thing that we have found is that many patients who are already in the hospital community, whose physicians are at the hospital, et cetera, have been quite happy to be able to explore issues in complementary medicine, et cetera, with us since they regard us as part of the same community.

Having said that, some patients are still nervous about talking to their physicians a lot about it, but they at least feel that they can address it with us and have us act as an intermediary, to some degree.

But we also have many patients that are self-referred. When we initially designed the program, we had, largely because of considerations with the medical staff, had planned to have internal medicine evaluation pretty much for everybody. But there were many patients who simply wanted to come for massage therapy or more specific reasons, and who already had physicians who were very actively involved as their primary care physician. So we relaxed that, and we have patients who are self-referred as well.

Whether they have chosen us because we are hospital-based or not, at this point it is hard to tell.

Our impression is that it is important for us to encounter patients where they find themselves, and that is often in the conventional mainstream of medical care, and that is why we did it in the hospital.

But I want to emphasize one other side to this, and that is that as much as we have done it from that point of view, the hospital and the medical community has been enriched by the activity, immeasurably. It has been revitalizing for us.

Many of you know hospital committees that are really pretty sleepy activities. Our committee was one of the few committees where people were calling in advance to find out when the next meeting was, et cetera. So it was an experience in professional renewal for me, and I was really impressed by it, because I hadn't seen that for years in a hospital.

MR. CHAPPELL: Thank you.

MR. TROMPETER: I would like to respond a little bit. I think from the communities that we are in and our patients' standpoint, there is really no difference between what we are and what a private entrepreneurial practice might be, I think from an

operational standpoint, and what motivates us. But, frankly, when we opened, there was a fair amount of outreach and publicity that was conducted both by us and others who were excited that this was happening. We had people coming directly to us that were coming to us because we had both modalities under one roof. It has been a very popular service with our patients, both those who have no money and no insurance, and those who do. And actually the economic mix of the folks who come strictly for the natural medicine clinic is a little bit different than the economic mix of the folks who come to us for other services. Not enough to make it a go on that alone, but kind of an interesting switch.

The other thing that I think our experience and Dr. Quevedo's experience is very similar, we developed this rather elaborate protocol for informing patients of their options and their choices and ways of making sure that people knew what they wanted. We were open a month before we gave it up, because people absolutely knew what they wanted to choose. I think that that in itself was a bit of a bellwether.

MR. CHAPPELL: Dr. Merrell, do you find this

much the same as your colleagues?

DR. MERRELL: Yes. I think that we decided to open in a facility actually outside the medical center physically, so we felt that patients would not exactly want to be streaming into a hospital in New York City to be getting CAM services.

Also the quality of the practitioners, I think, is key, because unless you have high quality practitioners, preferably who are known in the community, you open a clinic in a hospital where no one really knows the practitioners in the community, it is very hard to get much volume of patients coming in. So we strove to find people who were very well respected in the community to bring into the center.

MR. TROMPETER: We have also found other corporations in the area have come to us and asked us to come and talk to them about how we have done what we have done, so that they can do similar things.

DR. GORDON: We have Linea, Bill, Charlotte, Wayne, and Julia. We have three minutes left.

MR. LARSON: Thank you. I will speak very quickly.

This is probably a little bit of a conundrum, it is a conundrum for me.

Mr. Rosenthal stated that they did not allow physicians to practice because of the reason of inability to not work without hierarchy, an inability to not be able to work alongside with other practitioners at equal levels. You, Dr. Quevedo, stated that it was important that a physician in good standing within the community be the director of this integrative clinic.

Does that have to do with access to physicians who would be approving and supportive of the services, rather than the patients coming in and valuing a physician as the director?

DR. QUEVEDO: Let me understand. What I said is that for credentialing strategies to work, they need to be managed as an inside job, essentially, by physicians who are in good standing.

Now let me preface this by saying that much of what we have done in contradistinction to Mort is that we have been working in a hospital environment, and that has mattered in terms of our strategy and our approaches.

Let me also say that physicians certainly do

need to change many of their sort of habits, but personally I have not seen them as resistant as it sort of appears from the outside, once you open this door. Practically clinicians and the people that are in practice, they are dealing with uncertainties and widespread consumer dissatisfaction, and they are really unhappy with managed care every day. I mean the time is right for them to begin thinking outside their box.

So I think there is fertile ground there, but that dialogue needs to be marshalled by people to some degree that they feel safe with, and that is, I think, the role.

Now admittedly, this is not necessarily what patients are concerned about. This is work for doctors with doctors. But my own belief if that they are an important resource, and if we have learned anything from this entire movement, it is that self-care, including healing the healer, is an important activity and professional renewal matters, and all of those things need to be managed as well. This is the part that I think has been good for us.

DR. GORDON: Before we go on to Bill's

question, could you just give us a few words of description of what it has been like within a hospital environment? And even more importantly, what lessons you would have us learn from your experience working in a hospital.

DR. QUEVEDO: Again, for me, it has been enormously revitalizing. I have been around hospitals for most of my 25 years in medicine, and the last period has been enormously difficult, as all of you know. So personally it has been great.

What has it been like the institution? The culture of hospital management right now is sick. It is a difficult culture to deal with. It is a culture that came out largely of the non-profit sector and is focused on expense and cost management, and is trying to deal with the new business culture that really doesn't understand. It is a culture that is searching for a new mission, and many people who are really doing the best they can, working very hard, but frankly, pretty burned out about a lot of things. So it is a difficult environment.

But as I mentioned to another physician who

asked me the same question, why do you want to bother with this, and I said the thing that is important to me about this is that physicians and hospital workers, et cetera, are an enormous resource. Amazing things go on every day, and they do amazing things and give unselfishly every day. If we can find some way to articulate a vision which gives hope and resurrects the feeling of joy in this work, reminds them of the sacred nature of our work, et cetera, that revitalization will result in an enormous outpouring of effort and work and creativity which I think will be sustaining in the future years. Beyond that, it is essential right now. These institutions are literally dying without it.

So having said all that, there are some hard things. I was talking with someone earlier about the difference with what Mort Rosenthal is doing with Well Space, we are investing effort in dealing with the hospital and the academic medical center and nursing and physicians.

I might mention one last thing, and that is that I think that holistic nursing is a profession which already has contributed, in fact, was pioneering in this

effort, but in hospitals. If it takes its rightful place in hospitals
it can be enormously important in the future, and we have tried to develop a model where we use holistic nurses as case managers to contribute to the effort to integrate and coordinate care.

DR. GORDON: Thank you very much.

Bill.

DR. FAIR: Woody, thank you for your presentation, and I think you deserve congratulations for pulling this off, if you will.

We are talking about access and delivery, but clearly underlying that is credibility. Unless the medical schools, the teaching hospitals, accept this as an integral part of medicine, I don't think -- I think the battle for credibility will be uphill, so I think that what you are doing is extremely important.

Along that line I had a question. In the New York area, the Columbia Center opened and closed within a short period of time, and that is my entire knowledge of the mechanisms or the factors behind that, and I think the downstate program is sort of hanging on. So my

question to you is from the apparent failures of those two academic programs, have you learned something, or is there something you could share with the Commission that would maybe influence our recommendations for stimulating the delivery of CAM services within academic programs, which I think is so important?

DR. MERRELL: I think there are two main reasons for the failure, and one was political, and that means relationships, and the other was funding. Each one had problems in one or the other or both, and there are other centers that have opened with great plans in academic settings that have also had difficulties. I think it is very important for relationships to be nurtured, the kinds of things Dr. Quevedo was talking about, in the institution. If you don't really nurture the relationship with the thought leaders in the medical center, to have them understand that you are really doing a responsible medical practice that is going to enrich patient care and focusing in on as much evidence basis as you can, that you are going to be fighting an uphill battle. You may have one or two key people, but with another eight or 10 prominent people backstabbing, it is

going to be difficult to make a success of it. So I think that is one aspect.

The other is funding, and it is very difficult within the hospital. In the hospital it is difficult to deliver the services because in terms of DRGs, how do you carve out, out of a surgeon's cell, getting massage or yoga? And that was an area of contention particularly at Columbia. And the other is just in terms of if you are going to accept managed care, how you actually can be financially viable, and that is a very difficult issue that I think if I get into that, we will be here all day. So I will just say that was a main issue, and that we are primarily fee-for-service at the moment, but trying to develop a relationship with insurance companies to have them recognize the value of what we are doing, and by the data that we are capable of accumulating to look at the cost-benefits.

Not being a big fan of the managed care system, I will say, though, in their defense, they aren't a lot of cost analyses to show what works and what is cost-effective, and we have an ability at these centers, particularly the academic ones, to be able to begin

tracking that for them and being in partnership with the insurance companies.

But it was primarily underfunding, managed care, reimbursement difficulties, and particularly bad politics within relationships between the CAM centers and the institution.

DR. GORDON: Thank you for the answer. And since we will be coming back to reimbursement, maybe you can help us with what you are learning about fee-for-service and managed care and what some of the difficulties are, and then help shape our recommendations for that as well.

Charlotte.

SISTER KERR: Dr. Quevedo, when you gave your presentation, I heard several times belief matters, that people understood that there was more than sciences related to healing. And then you again said language and belief matters, and then you said belief matters. So I wonder specifically --

DR. QUEVEDO: Just believe it.

[Laughter.]

SISTER KERR: -- how is that essential to your

work? And does or can this have implications for policy?

DR. QUEVEDO: Good question.

Is it essential to my work, and how do I incorporate it, is that a fair restatement of the question?

My own culture, my own experience, has led me to know many different experiences with healing. But I was one of these folks that loved science. I mean I loved Western science, and I think when I was less aware of my own spiritual development, I think a lot of what drew me to science was not so much what was known, but what was not known. In fact, I was attracted to the mystery of life, and the mysteries of nature.

Now as I understood over time that there was a part of me that was much broader simply than a given empirical representation that the natural world would describe, I realized that this is also occurring for patients.

Now when I was in medical school in my early years of training, this was largely represented as in the category of psycho-social factors, somehow outside the realm of the hard sciences, and not nearly so important

as biochemistry, et cetera, et cetera.

Yet, as every clinician knows, these factors are enormously important in the case of patients, and sometimes are more powerful than a given drug, et cetera, and determine behavior.

What I have learned in my own explorations of this newer view of medicine, this newer vision that I call integrative medicine, is that there is a biology of belief, as Herb Bensen has called it, that we know from studies of the placebo response, et cetera, from much of the work that many members of the Commission have done in the area of mind-body medicine, that this is not only about culture and philosophy, but it is also about biology.

So I would simply say to you that once I had incorporated that into my own thinking, my own belief system, I have taken quite seriously the act of being with patients and listening to them, practicing presence, as well as trying to work with their conceptions of reality and translate across cultures. And very often that is with people who are educated in America, et cetera, et cetera. We are still working across cultures.

DR. GORDON: Thank you.

Wayne, and then Julia, and then we will close it down.

DR. JONAS: Well, Charlotte, as usual, you have stolen the most profound question.

[Laughter.]

DR. JONAS: So I am going to have to backtrack to the more mundane issues. I think if anything comes out of this Commission, if we can get our money and our minds together, or perhaps more appropriately our health care and our heart, we will have succeeded, regardless of what else happens.

I am specifically interested in how much activity CAM practices are actually going on in-patient, because this is an area that I haven't really seen touched very much, and is an avenue that perhaps has some rich potential. Could you comment a little bit on that? Are there practitioners in the CAM area making rounds, seeing patients in the hospital, making suggestions, working with physicians under those conditions?

DR. QUEVEDO: I can tell you what we are doing. The Center for Integrative Medicine at our particular

hospital is now about 18 months old. The credentialing strategy, which was largely to set up an ad hoc credentialing committee that reports to the medical executive and also to the credentialing committee of the medical staff, we report quarterly to the medical-executive body, et cetera. That strategy has been largely seen as successful, as acceptable, and where there have been issues raised regarding process, we have had a structure in place to deliberate them.

Out of that, an interesting thing happened. There were a couple of patients in the ICU who requested acupuncture. One was an Asian patient who had head trauma and who had sensorium changes, and the neurosurgeon and internist taking care of the patient did not want to use sedating drugs because they were watching neurologic signs, et cetera. The family of the patient requested that his headaches be treated with acupuncture. The internist and the neurosurgeon, because they knew of the center, asked for it as a consultation.

Our agreement with the medical executive body had been that we would limit the scope of practice and our credentialing to the out-patient setting until we

gained enough experience to make recommendations to go beyond that. So we declined the opportunity to provide acupuncture in the in-patient setting, and the ICU nurses and the nursing director were really disappointed.

The chief of staff asked me to represent the case at the NAC meeting following that, and as I was getting ready to do it, the chairman of anesthesiology and critical care did it for me. She said that it was really a tragedy that we couldn't provide this, since we have gained all this experience in the out-patient setting. That led to a unanimous resolution by the chiefs of departments to create a credentialing strategy to bring selected therapies into the in-patient setting.

At the same time the hospital was cited by the Joint Commission for having too narrow an approach to pain management, being excessively pharmacologic in orientation. So the anesthesiology chair and the surgery chair also came to us and said would we participate in designing a CAM strategy to be incorporated and make their JACO response look a little better. And so we did that, and that is targeted to start in January 2001, and we will be bringing massage therapy and acupuncture into