the average person on the street. In my own medical training here at the George Washington University, nutrition teaching was so limited, we really had no tools applicable to our patients.

So let me recommend the following three-point plan. First, we ask that the White House sponsor initiatives to integrate nutrition into the core curricula at American medical schools. This means (a) working with the Association of American Medical Colleges; (b) working with textbook publishers; and (c) providing grant support for curriculum changes through the Public Health Service.

It also means teaching nutrition that actually works. Heart disease and cancer are the leading causes of death. So doctors need a good grounding in the vegetarian and plant-based diets that have been shown to help prevent them or to be useful in treating them. Vague notions about eating right are useless, and not much better are the weak diets that are based on the presumption that Americans won't really change.

For example, the National Cholesterol Education Program Step II Diet lowers cholesterol only a pathetic 5

percent, and the Dash Diet reduces blood pressure modestly as well. These diets focus on minor changes, such as switching from red meat to white meat.

Americans now consume about a million chickens per hour, and we are in the worst shape than we have ever been in our nation's history. Much more effective are diets that eliminate animal products, along with the saturated fat and cholesterol they harbor. These diets work, and if they are offered, patients often accept them, in most cases, in our research, do accept them.

Secondly, we suggest that White House direct the Public Health Service to issue a request for application for research on the use of vegetarian and vegan diets for the following applications: breast, prostate, and colon cancer; macular degeneration; inflammatory and non-inflammatory intestinal disease; and diseases of children, particularly Type I diabetes.

Third, we suggest a Department of Agriculture review of federal policies that conflict with nutritional goals. A generation ago, the U.S. Department of Agriculture was concerned about tobacco but was also promoting it. Today, we have the same problem with the

meat and dairy industries. A thorough review could ferret out these conflicts. Thank you.

DR. GORDON: Thank you. Doreen Chen.

DR. CHEN: My name is Doreen Chen. As the chair of the Chinese Medicine Advisory Council of the American Association of Oriental Medicine, and the vice chair of the National Association of Chinese Medicine, and also the honorary chair of the United Alliance of the New York Licensed Acupuncturist.

I would like to take this opportunity to present my view on Oriental medicine. I myself have received eight years Western medical education in the United States as in China and earned an MD degree. I also received training in traditional Chinese medicine in China, and have been integrating Eastern and Western medicine in the treatment of all kinds of health problems, clinically as well as doing research and teaching for more than 40 years.

My personal experience taught me that integrative medicine would be the future development of medicine so as to serve the people in full capacity. Let me just illustrate to you a few cases of my own practice

in the United States, and -- a movement leader in Rome, Dr. McKeedy [ph]. He has a condition of co-crisis, in Western medicine identified as thermal regulation problem, but cannot address the problem.

Six years ago, he came to see me in the summer. He had to wear two layers of heavy sweater and pants, and also two pairs of very heavy socks. He still felt cold inside and was very prone to catch a cold. His condition, in Chinese medicine, is a typical pattern of yang deficiency and qi deficiency. So I offered him Chinese herbal tea to replenish his kidney yang and chi. After taking herbal tea, he definitely experienced the difference of his body.

Every three to four months, we communicated through email and phone, and I adjust my tea and sent it to Rome. Following is his testimony:

"Since I started following your herbal therapy, the main result has been a reduction of my work impairment from 50 to 60 days per year to five to six days per year. At present, I consider my co-crisis practically disappeared. Dear Dr. Chen, in summary, this is my medical history and benefits from the treatment you

gave me. For this, I would like to express to you once again my gratitude."

My second case is a young man in his 40s that has suffered with ulcerative colitis for 20 years and has to be on cortisone all his life. His diet is so restricted, even a touch of tomato sauce would cause him diarrhea. He started to lose weight and became weak, and lost a job.

He then turned to seek help from Chinese medicine. According to the TCM diagnosis, he has yin-yang deficiency. So I rendered him acupuncture and accupressure with herbal tea. I will make it short, that by six months, he leveled off the cortisone and solely taking TCM treatments, and he is leading a very happy life. His testimony says:

"Chinese medicine has displayed --

[Alarm.]

DR. CHEN: Oh, my. Oh, my god. I will just make my conclusion, then. All right?

So in brief, I would like to conclude in words as follows: Oriental medicine has come to the immediate health of the people in the world. Oriental medicine has

its own identity and unity. It follows the philosophical laws of nature and develops its own principle and theory to balance the body.

The modality of Oriental medicine includes Chinese herbal tea, acupuncture, touch, massage, qigong, tai chi, and many other ancient techniques. In our country we need really good Oriental medical physicians to serve our people. To train a good Oriental medicine requires five years education, including internship.

This service rendered by an OM physician should be covered by any health insurance, federal or private. This is the kind of policy that our country should establish which will serve the people well.

DR. GORDON: Thank you. Gary Sandman.

MR. SANDMAN: Thank you, Jim. Thank you for allowing me to address this commission.

I have been involved in the field of alternative medicine for almost 30 years, since 1972 when I founded a community-based alternative medicine referral service in the Washington, D.C. area. Our network contains approximately 180 holistic and alternative practitioners who are fully credentialed, and where

approximate, licensed.

Callers are counseled by us to provide them with information so they can make educated choices to use the most appropriate modality of alternative care they need. Then we provide them with references to the credentialed practitioners.

We have expanded our company also to develop local educational programs. We hold two large conferences every year, one on alternative medicine and natural health in general, another on integrative approaches to cancer therapies here in the Washington area.

We are also in the process of publishing a CAM credentialing reference guidebook on the top 50 fields of alternative medicine. We have developed, with our team of practitioners, integrative approaches to chronic illnesses and helped cross the lines and the barriers between different modalities of health care.

We developed the Hospital Massage Therapy Network in Baltimore through the MedStar Health Plan, and we are developing and getting ready to launch a natural product certification program. We have also just

finished shooting a pilot for a television series on alternative medicine and cancer survivors.

In counseling over 10,000 individuals who have called our service, we have noticed that patients tend to fall in a continuum from feeling victimized by their health to being empowered. CAM tends to teach empowerment, and individuals that are empowered tend to heal.

We have seen also that illness has a spiritual aspect, as has been mentioned here before. A majority of our practitioners as well as the survivors of cancer and other kinds of illnesses look at their illness as a wake-up call that gives them the opportunity to reevaluate their life purpose and live their life more in alignment with that purpose.

It seems like our practitioners, as they start to bridge that conversation with individuals, that people want to hear that and know that that is one of the major keys to healing. People also want safety of care delivered in a holistic attitude. When people call us, they want Andy Weild. They want Andy to do things that Andy doesn't even know how to do. So we try to counsel

them to work with the MD as well as alternative practitioners that are fully qualified.

Research in general indicates that most individuals don't feel responsible for their health, even though our health is affected their emotions, our thoughts, and our environment. We need to have an education program outside the CAM practitioner's office to verify and validate that people directly have an effect on their own health, and to learn, possibly with the Genome Project, to determine what each individual's Achilles heel is so that we can strengthen that weakness and not be a victim to it.

I would propose to the Council that we develop a 20-year plan to integrate conventional medicine into patient-centered whole person health care. This was the length of time needed for doctors to comply with washing their hands before surgery. I have other suggestions that I would like to offer.

DR. GORDON: Thank you. Danny Freund.

MR. FREUND: Thank you. My name is Danny Freund. I am coming from a different perspective, but first I wanted to say timing is perfect because you

touched on a few of the issues that I want to address.

I am coming to you from the perspective as a cancer survivor. I have since become an honor student at Penn State University under the direction of Rustum Roy who spoke yesterday. I am really nervous right now. I want to share with you how I gained access to alternative medicine. I was sick with cancer four years ago, and about two weeks after I heard that I had cancer, I was given a paper that says, will you sign this paper that says we can amputate your right leg.

So that really woke me up to a lot of the issues, but I wouldn't have heard about it if my mom didn't tell me about it. So I think that is a really important aspect.

The doctors kept telling me to take aspirin and that would get rid of the pain that was being caused by the tumor in my leg, but my mom kept saying, go to acupuncture and try some of these alternative therapies because they might work, too.

Since then, I have tried numerous things from applied kinesiology to hypnosis to get rid of pain, and also living in a holistic community at the Omega

Institute in Rhinebeck, New York. I also went to a spiritual camp for Jewish kids that had cancer, which was phenomenally helpful in my recovery. It really got me in touch of aspects of spirituality that I had no idea about before. I always rejected them as a younger person when all of my friends were kind of anti-religion. I learned that there were important issues for me, too.

Since then, I have gone on to Penn State and I have organized a number of things. I have given a number of presentations on my experiences with alternative medicine, and I have tremendous feedback from those and a great turnout. I have also organized a course on alternative medicine. It is not called that, but it is relating to the sociopolitical issues relating to CAM, and that will be offered next semester. That class was filled up within a few days. So I was excited about that.

I think that this course should be offered as a general education course at the undergraduate level, because that is one of the ways that people find out about it. One of the problems I encountered is that there aren't any of these great journals that I have

encountered at Penn State. There are a number of journals that you probably are familiar with. I wish we had them.

Also, and I will make it really brief, I did a search on Amazon.com the other day about alternative medicine, and there are 250 books about alternative medicine, but who knows which of these to use. A lot of my friends are interested, but they are not knowledgeable about it. So I think we should have a peer review of which are the better books.

One last thing, and I know I have three seconds, but I want to say that I have also gotten involved in Dr. Gary Nall comes to speak. He has been doing a whole year-long program in northern New Jersey where he comes twice a month, or his associate comes. That has been really helpful because instead of just saying, this is what I believe, he is actually helping to make a difference in our community. He has had tremendous support, too. So thank you.

DR. GORDON: Thank you. We have some time now for questions from the Commissioners.

Yes. Veronica.

DR. GUTIERREZ: My question is for Dr. Nordstrom. The Association of Chiropractic Colleges' Position Paper goes on to say that chiropractic is concerned with the preservation and restoration of health, and focuses particular attention on the subluxation. Yet, I noticed subluxation is not mentioned anywhere in your presentation.

I have a bit of a concern about chiropractic, the patients accessing appropriately, because neck and low back pain seems to be the niche that they want to put us in.

And then, I am wondering if you would address the relationship between subluxation, health, wellness, and quality of life.

DR. NORDSTROM: I don't think I have enough time to answer that to the depth that you would like, but certainly the nexus of chiropractic care is spinal manipulation. The term that we call the spinal manipulative entity is subluxation. It has been described by a variety of different people, different terms, and in and of itself, needs more research. I think Veronica is asking a philosophical question that is

a debate within my professional itself.

But in general terms, clearly, what we do, Veronica, is adjust the spinal lesion we call the subluxation. That is the primary goal of chiropractic care.

The effect of that care, as I think has been talked about Drs. Meeker and Rosner earlier, has some research in the area of low back pain, some fairly good research. Its effect on other kinds of conditions, be it asthma or other health-related conditions, obviously needs more research, and we are 100 percent behind good science. We need it, a lot more of it.

DR. GORDON: Tom, then Tieraona.

MR. CHAPPELL: Gary, could you explain more about the Natural Product Certification Program.

MR. SANDMAN: It is a five-point program where our practitioners have gotten together and are concerned about the quality of natural products, because issues arise that tell a patient to take saw palmetto, and it may not be saw palmetto that they are purchasing at the store.

So we are developing a criteria where it

involves assaying the raw material. It is a validation verification. It is not setting standards, it is just disclosing. So that, is it a standardized extract or is a raw material. If it is a raw material, is it organic. Where is the source of it.

Then the manufacturing procedures for the FDA, are there quality controls in place. The aspect of assaying the product when it comes off the line as well as off the shelf to determine what is in the jars, on the label, and vice versa.

A label review to make sure that what is said is proper and within the law as well as within the scope of the product. Then having a review board to be able to publish research that connects the ingredients with scientific evidence as well as tradition to show that there is a benefit to it.

MR. CHAPPELL: That is a lot.

MR. SANDMAN: Yes.

MR. CHAPPELL: Congratulations to you. That is funded by fees that -- people send you their products?

MR. SANDMAN: Yes. We are about to launch that to do that as well as -- what we want to do to add

strength to it is gain acceptance amongst the various disciplines that this is a plan that they would accept as well, and then make those types of changes, so that a certain subgroup wants this to make sure that it develops even stricter codes, we are open to that. We want to gain consensus so that it holds weight to say that practitioners won't recommend a product unless the seal is on it.

So that is our process.

MR. CHAPPELL: Thank you.

DR. GORDON: Tieraona, Don, and me.

DR. LOW DOG: Yes. I do hope that you are working with other organizations since there is a number of them that are attempting this validation that have got a lot of work. Building bridges, I think, is important so everybody is not reduplicating work. There has been a thousand seals out there that nobody knows if it means anything.

Neal, again, I just want to appreciate the -- thank you for the conciseness, and your very specific recommendations, which I think are so important. One of my questions is, until we sort of get this into the

medical schools, how much do you think we can interface, or be interfacing, with registered dieticians, who actually are sort of somewhat underrepresented in this whole discussion of complimentary and alternative medicine.

The new food pyramid is based on about 70 percent plant-based material. So I mean, we are moving in the right direction. We are moving toward a much more plant-based material, but it is going to take a while to implement some of these things.

Do you interface with registered dieticians? Do you work with registered dieticians? How do you see their role in this?

DR. BARNARD: Yes. We have registered dieticians on our staff at the Physician's Committee, but diseases walk in the door of a medical office, as hypertension, as diabetes, as atherosclerosis, or whatever. The physician may not know to even refer to a dietician. When they do, they often don't know what sort of treatment to prescribe.

A doctor can send a patient to radiology, and they know what they are looking for. They know what they

are going to get back. When they send a patient to the dietician, that is a sophisticated enough move there, but they often have no clue what they are looking for. They ought to know that you can have a realistic chance of actually reversing existing atherosclerosis, and that is your goal. If you are sending the patient there, you are sending them for an Ornish type of regimen.

I am glad you raised this because we need also to work with dieticians and not assume that they are current with current treatments. The hairy hand of industry has played its role at least as aggressively in the dietetic community as it has in the medical community. I am speaking specifically of the meat industry, and the dairy industry probably the worst of all.

DR. GORDON: Don?

DR. WARREN: We talk about education and including nutrition into the curriculum of medical schools, and in my case, dental schools, but the educational system so crammed with information you have to have to pass your boards, to pass licensure.

Where do you propose putting this? Are we

going to add another year to the training to each one of these professions?

DR. BARNARD: No. I think for everything that goes in, something has to come out. We clearly have to prioritize, and there is no medical educator, I don't think, who really envisions that you are going to learn medicine with a capital M in the four years of medical school. You are going to learn the basics, and you are going to see them applied during residency, and you are still going to have an awful lot to learn when you get into practice.

But if we don't know that you can get most people off their anti-hypertensives or off their Type II diabetes drugs if you change the diet and lifestyle enough, then we haven't taught students their most important thing.

At some medical schools, they are still practicing surgery on rabbits and dogs and so forth in the first or second year of medical education; utterly pointless at that stage. You will learn your surgical technique later. You need the learn the basics about what keeps a person well.

MR. WARREN: One more question here. Chiropractic. We talk about access to services. If my figures are correct, chiropractic deals with about 7 percent of the population now, and it was 7 percent of the population 20 years ago.

How has chiropractic improved access to its services at this point, and what can be done in the future to improve access?

DR. NORDSTROM: Well, a lot of figures. I have seen figures that have gone from approximately 4 percent, I think, in the late 70s, early 80s, to maybe as much as 10 or 12 percent. So I think there is a change.

Education, research. Research has opened a lot of eyes. When the AMA was stopped from boycotting chiropractic cooperation with medical doctors, that changed a lot. I think as we see some of the data that is coming out as an example at this Illinois practice where chiropractors are seeing their patients regularly and there is a significant reduction.

We are looking at some data now that is suggesting that the average Medicare patient costs Medicare about $7,000 a year. I don't know if we have

indexed for severity yet, but it looks like maybe the average chiropractic patient is going to cost Medicare about $4,000 a year. We are doing some more research into that.

So finding good information that shows that things like diet, things like all of these things, that promoting those things, that the information is spread to the practitioners, and the insurance companies stop looking at administrative bottom lines, but looking at health outcomes, seeing those kinds of realities and looking for that information, like we are having to look for it ourselves now, but the insurance companies start looking for it, and they change their focus. I think that is going to make a big difference.

DR. GORDON: Ming, and then Charlotte.

DR. TIAN: I have a question for Neal and Gary regarding the organic food. I go with you. I think organic food is more delicious. There is no doubt about it. If we eat one million chickens every day, I guess 99 percent are not organic. We have enough data to show organic food, or organic meat, does prevent disease.

We need what kind of study to prove it?

DR. BARNARD: There are limited data on organic produce, showing two things. One, what you would expect, there are fewer residues of toxic substances, particularly organichlorines. There are also, though, which is a little bit of a surprise to people, higher levels of some nutrients, particularly minerals, which is important.

I don't think that that translates, though, into saying that organically raised animals, chickens or others, are necessarily going to be any lower in saturated fat or cholesterol and so forth. The studies really are on produce, and I think we have got still further to go in exploring that.

MR. SANDMAN: What we have seen is that if a practitioner prescribes that and educates the individual, than that is moving the patient further into using organic vegetables.

We are building a national website in conjunction with a group of organic farmers that will allow people coming from our site or their site to find the closest organic farmer to make it more accessible, and juxtaposition those two together. Also, that has a

rub-off effect, that, yes, this is a healthier way to go. And then, where do you find it that is not so expensive. What we want to do is drive people to go right to the farmer that is located near them.

MR. TIAN: My second question is for Dr. Chen.

I understand you have treated a lot of successful cases using acupuncture and Chinese herbal medicine, or herbal remedies.

Do you think it is necessary for all the patients to use both acupuncture plus herbal medicine? If the money is not an issue, then certainly the patient can have both. More CAM therapies for the same patient, if the patient is, let's say, not reimbursed, how do you handle those kinds of patients?

DR. CHEN: Well, because of my background, both in Western medicine and in Chinese medicine --

DR. GORDON: Speak into the microphone, please.

DR. CHEN: Oh, I'm sorry. Because my background is both Western medicine and Chinese medicine -- I have been practicing integrative medicine for 40 years -- my personal experience taught me is that both medicines have their own approaches, but it is very

different. And yet, both have their shortcomings and advantages and disadvantages. So the best is to integrate the two, to take advantage of both and get the best result for the patient.

Now, what is the best result? Then by practicing it, you will know some of the elements that you have to go for Western medicine, and some of the problems, maybe, Western medicine cannot address, and the Chinese Oriental medicine can take care of it. So this is what the indication is.

Now, we need experience and we need publication. We need to do research to let the public know what kind of problem to search for. This is only the first step, I think, in this country because most of the patients, they are exhausted with the Western medicine approaches, and they come to see me. Most of them are like that, my cancer patients, my infertility patients.

I have a lot of patients' testimony that I don't have time, but I would like to present for your reference. I think it is an indication.

DR. GORDON: Charlotte and Bill next.

Let me just say to the Commissioners, that obviously the panelists are interesting and interesting to us. If we continue at this rate, we will be cutting into our time for discussion at the end of the day. If people want to leave by 5:00, we really can't do that.

MS. CHANG: [Off mike.]

DR. GORDON: Okay, so we need to stop right now. Thank you. This is no reflection on the panel. In fact, just the opposite. Thank you very much.

MR. SANDMAN: Okay. Bye.

DR. GORDON: With everyone's permission, I will control the time strictly.

DR. FINS: Mr. Chairman, can I just ask that Mr. Freund's syllabus get entered into the record?

DR. GORDON: His what?

DR. FINS: His undergraduate syllabus.

DR. GORDON: Yes.

DR. FINS: That it be officially requested.

DR. GORDON: Yes.

DR. FINS: Thank you very much.

DR. GORDON: Melinna Giannini, Jane Hersey, Boyd Landry, Lawrence Auburn Plumlee, and Michael John

Rohrbacher. We will have 15 minutes. Each person will speak for three minutes, and then we will have 10 minutes for discussion, for questions, from our group. I will cut it at that 10 minutes.

The first person will be Melinna Giannini.

MS. GIANNINI: Thank you and good afternoon. I come to you from the perspective of the insurance industry. I used to design, sell, and monitor self-funded medical plans for large employer groups.

I created a company called Alternative Link. We have developed about 4,000 codes that describe what is said, done, ordered, prescribed, or distributed by alternative care practitioners, and each one of these codes has a relative value unit attached to it so that a rate can be developed for each procedure.

This is important because having this system allows comparative analysis between statistical information from conventional medicine and statistical information from CAM.

The code set has been published in the Unified Medical Language System at the National Library of Medicine in 1998. They were added to the American

National Standards Institute X(12) standard for electronic commerce in 1999. They have been recognized by the American Nurses Association, and they are currently before the Department of Health and Human Services for consideration as a standard for electronic claims processing.

I respectfully suggest that the Commission consider its influence to cause in-CAM funded research to incorporate this code set so that cost-effective CAM treatments can be identified as a solution to escalating health care expenses, especially where these procedures could have an impact on Medicare/Medicaid recipients.

A key barrier to viable CAM coverage is vast differences in state scope-of-practice laws. Alternative Link has a fully developed database to identify legal treatments in each state. I respectfully suggest that the Commission review this information as it pertains to assuring CAM compliance with state laws. This information is key to viable CAM insurance reimbursement because payment of claims outside scope of practice triggers fines as high as $10,000 per line item for payers and providers who are outside of compliance.

This code set and associated scope-of-practice database can assure that data for CAM is viable for future reimbursement. I am leaving a copy of the code set for the Committee's review, and I want to thank you for the opportunity to give this testimony.

DR. GORDON: Thank you very much. Jane Hersey.

MS. HERSEY: Thank you. I am director of the non-profit Feingold Association.

What I would like to talk about is the fact that a simple elimination diet is among the oldest and most conservative forms of medical treatment, but in the United States this is viewed as an alternative.

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

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

placebo-controlled studies published in peer review journals.

Despite the potential of this healthy option to help medical and social problems, and despite all of the supporting evidence, it is opposed, ignored, or misrepresented by the very government agencies and professional organizations that should embrace it. I would refer to Center for Science "In the Public Interest" report that verifies this.

The sad fact is that a doctor who suggests diet rather than drugs as a first option to help children risks losing his license. I am sure you are familiar with the case of the doctor in San Francisco, and I believe Karen Scott, one of his patients, will be testifying at one of these hearings.

We have lots of practical information that a family can use, understand easily, and put into practice immediately. We have our book "Why can't my child behave," and I brought along a sample of the material that we provide to parents.

They don't have to make drastic changes in their eating or shopping habits, but sometimes something

as simple as cutting out petroleum-based dyes, artificial flavors, and the petroleum-based preservatives can and does make an enormous difference in a child. Once a family understands that food really matters, that nutrition matters, then they go on to further refine and improve their diet.

If there were something that we could ask for on a wish list, one would be that the National Institutes of Health follow their own recommendations suggesting that new research is warranted. This has not happened, and that people take a close look, that the Department of Agriculture take a close look at the exciting study that was conducted in the New York State schools.

MS. CHANG: Thank you. You are out of time.

MS. HERSEY: Thank you.

DR. GORDON: We are having some mechanical difficulties.

MS. HERSEY: I was watching this, and it didn't get red yet.

DR. GORDON: Thank you. We would very much welcome those reports. I don't think you have given them to us.

MS. HERSEY: No, I haven't. I didn't have any to bring. I will provide the additional ones.

DR. GORDON: Thank you. Boyd Landry.

MR. LANDRY: Good afternoon. Thank you for having me again to provide public comment. My name is Boyd Landry, and I am executive director of the Coalition for Natural Health headquartered here in Washington, D.C. and in another office in Missoula, Montana.

After sitting for the day and a half, and the two days back in October, I too believe that you have a great opportunity to do great things. Unfortunately, as the meetings continue, I believe that the Commission is not seizing on an opportunity to look outside the box, but instead figuring out a way to fit CAM inside the box.

If our system of health care worked in this country, we wouldn't be here today. If we didn't have all the problems that precipitated this discussion, why would we be here?

So I think that is important to keep in the back of your mind as you go through this process. A way to work through that process is to bring about and encourage practitioners of modalities that don't have one

foot in the box, or even two feet in the box, to come forward and provide you information about their practices and the good things that they do.

One most important voice that is going unheard by this Commission is the voice of consumers, how they want it delivered to them, what kind of access are they looking for. That is what the fundamental purpose, I believe, that this commission should center itself around, is access and delivery, and what do consumers want, not what practitioners want, but what do consumers want.

I don't know that you can get it in a town hall meeting, or even in this setting here, unless you actively seek out their input. There are many ways to do that, from polling data to running full-page ads in the newspapers where you are going to have town hall meetings, to encourage that to be brought forward.

On the issue of who will pay, if access were opened up to the market for everybody, then the market would deliver on every level, from the low-income side to the high-income side by virtue of the fact that the market forces would work to provide that.

A recommendation by this commission to add inclusive language in the federal programs will only stifle these organizations and these practitioners with cost control measures that force the problems that we have today, by allowing inclusive language into the federal insurance roles or third-party reimbursement programs --

MS. CHANG: Thank you. I'm sorry, you are out of time. Thank you.

MR. LANDRY: Thank you. Well, can we get a 30-second warning?

MS. CHANG: Well, we do, but the thing is broken.

DR. GORDON: We will give you 30 more seconds.

MR. LANDRY: Okay. Let me just sum up real quick. Finally, Dr. Jonas, yesterday, came close when he asked Michele Forzley from the Bar Association, the relationship between harm and regulation.

Let's just suppose for a second, so you can see how the unregulated practitioners live and practice, that conventional medicine was immediately deregulated. What would happen? How would our society function? If you

close your eyes and thought about it, you can pretty much see a changed dynamic from systematic care devoted to disease to systematic devoted to wellness.

DR. GORDON: Thank you.

MR. CHAPPELL: Mr. Chairman, may we give Ms. Hersey 30 seconds? We shut her off simply without warning. She didn't get her 30 seconds.

DR. GORDON: Why don't we give her 30 seconds when everybody else is finished and let her make a statement. We are sort of wrestling with these mechanical difficulties here.

The next speaker will be Lawrence Auburn Plumlee, and for 30 seconds, Michele will rise up.

[Laughter.]

MS. CHANG: I will give you a one-minute warning. How is that, okay?

DR. PLUMLEE: I am Lawrence A. Plumlee, a physician, formerly medical science advisor at the U.S. Environmental Protection Agency, and now the president of the National Coalition for the Chemically Injured.

We are concerned that chemical pharmaceutical industries have turned toxicology into a laboratory

specialty designed to rapidly move new products to market, while asserting that many chronic manifestations of toxicity are psychogenic in origin.

Such manifestations of chronic toxicity include many cases of multiple chemical sensitivities, auto-immune diseases, fibromyalgia syndrome, and chronic fatigue syndrome. There is a great need for much research to investigate the role of toxic chemicals in these syndromes. By failing to do this, patients are subjected to dangerous and ineffective psychiatric drugs which prolong the illnesses, thus selling more drugs because the causes are not recognized and eliminated.

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

diagnoses to receive such less toxic effective treatments.

Another area requiring scientific research and better medical education is the induction of mild immunodeficiency by some toxic chemicals with resultant super infections by viruses, bacteria, parasites, and fungi. Often appropriate diagnosis and treatment of these infections will enable substantial gains in health.

MS. CHANG: One minute.

DR. PLUMLEE: Even though -- how much?

MS. CHANG: One minute.

DR. PLUMLEE: Even though the body burden of chemicals or their damage may remain uncorrected. Again, the effect use of anti-fungals for treating chronic fatigue syndrome and asthma has been shown in several double blind studies. Yet, the medical profession is not adequately educated about these studies to lead to changes in usual and customary treatments.

Government medical education is needed to balance the extraordinary influence of the pharmaceutical industry. It will be difficult to achieve this when the government itself is so heavily influence by this wealthy

industry, but idealistic persons can often make a difference by acting in the public interest when it places their own careers in jeopardy.

Persons receiving public funds owe the public nothing less than this. When satisfactory grant proposals are not forthcoming, contracts must be let to accomplish the support.

DR. GORDON: Thank you very much. Michael John Rohrbacher.

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

(1) Definition. As defined by the American Music Therapy Association, music therapy is the use of music in the accomplishment of therapeutic gains, the restoration, maintenance, and improvement of mental and physical health. Music therapists work with individuals

of all ages who require special services because of behavioral, social, learning, or physical disabilities.

Over 3,700 individuals currently hold AMTA membership. The AMTA sets standard and identifies competencies for the practice of music therapy and establishes criteria for the education and training of future music therapists. Nationwide, there are 69 undergraduate music therapy programs, 25 graduate programs, and 159 internship sites approved by AMTA.

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

(3) Accreditation. CBMT is a member of the National Organization for Competency Assurance. CBMT is accredited by the National Commission for Certifying

Agencies. The NCCA accreditation standards address areas certification boards must adhere to, including organizational structure, exam development and administration, test validity and reliability, and a number of other items.

(4) Representation. Persons holding the credential MBTC have successfully passed the CBMT certification examination, demonstrating the knowledge, skills, and abilities necessary to practice at the entry level of the profession.

To be eligible to sit for this national exam, candidates must have completed an undergraduate degree in music therapy or equivalent, including the six-month internship from a program approved by AMTA. The CBMT exam is now offered at over 100 computer-based testing sites throughout the United States. The exam itself is updated every five years to remain current with the profession.

The CBMT also offers a re-certification program where music therapists must accrue over 100 continuing music therapy education units.

(5) Use. Increasingly, MTBC is used by

consumers, employers, personnel boards, and facilities to identify competent music therapists. I will mention quickly that the States of Michigan, Wisconsin, and Virginia all turn to MTBC to identify competent music therapists.

Thank you.

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

Jane Hersey, did you want to make a final comment?

MS. HERSEY: Yes, just very quickly. I just have one copy. I will be happy to give more. There was a major study that took place in the New York City school system back in the 80s. This involved over 800 schools. By making simple changes in nutrition, they were able to bring up the test scores quite significantly. In fact, the test scores over a four-year period increased over 15 points on the California Achievement Test.

Unfortunately, after the director of Food Services retired, the schools went back to the same old stuff. So I think you might see the potential for some dramatic examples of how nutrition can affect people, if

there were ever any interest in more studies like this.

DR. GORDON: We are interested. We would very much like to receive that information, especially in the panel specifically focused on wellness. I think it would be very appropriate for us to spend a good deal more time on some of the nutritional interventions that we have heard about today, and other times as well.

So let's begin. Joe, Effie, Tom, Wayne, and David. We are going to cut it at 10 minutes.

DR. FINS: Dr. Rohrbacher, thank you for your comments. I am pleased to see somebody from my mother's hometown, Winchester, Virginia. I spent a lot of time there as a little kid, and it wasn't musical time.

I want to ask you about --

[Laughter.]

DR. FINS: It was. It was a wonderful time.

I want to ask you about the penetration access of music therapy in hospitals. What percentage of hospitals have it? What is the Joint Commission doing as far as incorporating these kinds of important therapies into the hospital mainstream? And, any problems or challenges that we might be able to help you guys with?

DR. ROHRBACHER: Sure. A study by Paul Nolan at Hahneman University identified 100 music therapists in the nation who are practicing medical hospitals. At least half of those are connected to university settings. So the number is quite low in terms of music therapists who are credentialed and engaged in hospital settings.

However, the research is very significant. For example, Jane Stanley at Florida State University has done a wonderful meta-analysis of music therapy in hospital settings. We are side by side, often, with musicians, music practitioners, persons who use music at beside, for example.

But I am pleased in terms of the progress we are making, at music therapists presenting the full range of what is possible in a hospital setting.

DR. FINS: Just quickly, who pays for the intervention? How does it get reimbursed?

DR. ROHRBACHER: It is often the case that through such programs as Therapeutic Recreation, Child Life, the money that is beyond what is collected through DRG often funds activities such music therapy. We are not a fee-for-service at this point.

DR. GORDON: Effie.

DR. CHOW: Thank you very much for all your remarks.

Neal, I want to thank you for bringing back a very important issue about bringing the consumer --

MR. LANDRY: Me?

DR. GORDON: Boyd.

MR. LANDRY: Oh, okay. You said Neal.

DR. CHOW: I'm sorry, Boyd Landry. Boyd, Hi. Thank you for bringing that aspect into it. I think that is very important. Perhaps, can you tell us how we can access better?

I mean, I know we should go out to them. Perhaps you have some thoughts on that.

MR. LANDRY: Well, I think the past year and a half, at least maybe even the last eight years, policy in this country has been driven by public opinion. Whether it is the Executive Branch or the Legislative Branch, the utilization of polls and focus groups and things of that nature have been a driving force behind policy.

One thing we know for sure is people are already voting with their feet, because over 50 percent

of the population is already utilizing these services to the tune of $60 billion a year. I think once we already stipulate to that fact, then let's take it a step further and find out how they want it, the access, the delivery, whether or not some of these issues even matter to them, because they are the ultimate consumer, for a pun on words.

MR. CHAPPELL: Jane Hersey. The Feingold Association has been helping families for over 30 years, if I remember.

MS. HERSEY: Well, actually, Dr. Feingold began in 1965, and we have been around for 25 years. So yes, you are very close.

MR. CHAPPELL: How is it funded? Is it fees?

MS. HERSEY: Yes. It is funded through membership fee, primarily, which is $69 for a family, and they receive a lot of material, constant updates through our newsletter. People they can call, et cetera, lots and lots of support. We do get donations. Unlike some ADD groups, we are not funded by the drug industry. Primarily, it is donations and membership fees. Yes, we could use a little more.

May I just point out one thing. I am delighted to see all these modalities and all things represented. I think we are unique, in that, in our program the parents handle it. The parents can do it themselves at home. We all value alternative practitioners, but this is one thing that a parent doesn't even need to go anywhere or seek out any help.

MR. CHAPPELL: Our family has used your association.

MS. HERSEY: Successfully, I hope.

MR. CHAPPELL: Yes.

MS. HERSEY: Great.

MR. CHAPPELL: You also recommend a great toothpaste.

[Laughter.]

MS. HERSEY: Okay, now I know who you are. We knew early on when one of the children ate a whole tube of it, and it was fine, that we had no problems.

[Laughter.]

DR. BRESLER: Very quickly, for Jane and for Lawrence. Are your organizations doing anything to address the PTSAs with your information, get to the

parent organizations and schools and elsewhere, and alert them if their kids are having problems, it could be chemicals, it could be food sensitivities?

MS. HERSEY: We try to. I do workshops all over the area. I am happy to go to any school or group. I just need two ears, and then I will talk. I like to focus on showing families really, really simple things that they can do. I can teach a group of people in 30 minutes how they can make dramatic changes in their grocery shopping and cut out some of the worst of the additive.

DR. BRESLER: But that is just you. Does your organization really putting energy behind that?

MS. HERSEY: We try, but it is very difficult because the drug-funded literature, the schools have been flooded with pro-Ridalin information. So it is hard for us to get in in some cases.

DR. PLUMLEE: I would have to say that we are not. We are a coalition of groups from all over the country. There are some initiatives locally, but primarily because we are coalition of patients who have been chemically injured and can oft be demonstrated as

having brain damage on SPECT scans and other sensitive measures, people are not able to be as active as they would like to be if they were healthy.

DR. GORDON: Thank you. Wayne.

DR. JONAS: I just wanted to clarify a little bit about the need for data in looking at what happens if you do not regulate medical practices. I don't want you to misinterpret my question about that. I think we need data. I don't know if any has been collected on that.

When I close my eyes and imagine a world like that, the first thing I imagine is before the Flexner Report in which there was major harm from unregulated practices, both regular and irregular, and I don't think we want to return to that.

I did have a question, both for Ms. Hersey and Dr. Plumlee, about multiple chemical sensitivity. I know there has been a large debate and many panels, official and unofficial, that have looked at this over a number of years, and it always seems to come back to the same issue. It is very difficult to identify any specific toxin or chemical associated with any particular type of damage or condition.

They re-resurrected this problem in looking at Gulf War syndrome. Certainly, a number of people are very sick, but they can't really identify why in terms of particular chemicals.

I wonder if you would want to comment on that area.

MS. HERSEY: I would very much like to comment. Our program is sometimes considered to be much too simple, and it really is very simple, but it is also very effective. We start out with a small group of chemicals to identify and remove, and it is not because we think they are the only ones, but they are very obvious, they are very easy to get rid of, and our results have been excellent.

So we take a focus on synthetic dyes, artificial flavors, and a group of preservatives, as well as aspartame. Now, we understand there are lots of toxic chemicals in the world, but a family has to start somewhere. I jokingly say that some of the people who call us are the folks who consider Taco Bell to be one of the four food groups.

Now, when you are working with people like

that, you really have to make it very simple and doable. These folks, even though their diet is far from perfect, and they may be exposed to all sorts of toxins, when they take away the Skittles and the Kool-Aide and the Jello, and their kids aren't eating petroleum-based dyes and other things like that, invariably, there is a significant change, a significant improvement, and then that gets them started.

Larry would be sort of in the graduate school area of what we are doing. We are kindergarten. You know, kindergarten isn't everything, first grade isn't everything, but it is awfully important.

DR. PLUMLEE: Well, I would like to speak to that. I think that part of it is that, as my first reference indicates, the genetic variability of sensitivity to chemicals in the population is greater than can be accounted for by homogeneous strains of rats and mice on which the toxicology studies are done before chemicals are brought to market.

Also, we know that certain pesticides alter sensitivity. That is, that repeated exposures lead to exquisite sensitivities.

[Alarm.]

DR. PLUMLEE: Is that for me?

DR. GORDON: We will go to the end of this question. Then, Don, we will have to let it go after that.

DR. PLUMLEE: But since we have been able to reproduce some of this in rats, it does seem quite clear that this is a real phenomenon and not a psychogenic one.

DR. JONAS: I was happy to see that there is a rat study, though not for the rats.

DR. PLUMLEE: Part of the difficulty, again, has been that the studies sponsored by the chemical industry have been the ones that have found psychological characteristics of the patients with chemical sensitivity.

DR. GORDON: Thank you.

Incidentally, we do welcome any suggestions that you may make as far as research, the kind of research, that we ought the be encouraging. So please forward that to us and we will certainly consider that as well.

Thank you very much. We will go on to the next

panel.

The next panel is Andrew Rubman, Marshall Sager, Diana Miller, Courtney Banks, and Richard Pavek.

We will begin with Andrew Rubman.

DR. RUBMAN: Yes. Good afternoon. The AANP and I welcome the opportunity to present observations and concerns.

In your book, Dr. Gordon, "Manifesto for New Medicine," you elegantly address many of the concerns that I would raise, and I applaud you in that.

What distinguishes traditional medicine from CAM is its reliance not only on the CAM therapeutic modalities, but the underlying principles of enhancing normal physiology to decrease the emergence of pathology. This notion is inculcated in naturopathic medical training and makes us fresh and unique in this.

We are the only physicians licensed to practice as primary care providers in the United States, and formally trained in the basic and clinical medical sciences, who are additionally trained in the science and philosophy of traditional medicine. In the State of Connecticut, where I have been licensed to practice for

18 years and had the privilege of lecturing for NIDDK and for Yale on a number of occasions, the terms "naturopath" and "naturopathic physicians" are used synonymously in state statutes where our licensing act dates back to 1930.

It is the opinion of Connecticut state senator George Gunther, himself a naturopathic physician, that naturopathic Medicare may be added to Medicare language to correct a drafting oversight, and much the same access can be granted to the military by modifying DOD revisions currently being contemplated.

In a published news release, the American Osteopathic Association stated that doctors of chiropractic care, for various reasons, should not be given a full scope of practice in their interactions with the military. Without passing judgement on that opinion, I would say that no physician in this day and age should be considered fully licensable in all arts. The present needs of our citizens and the enormous body of emerging medical information leaves us no choice but to produce a better model where no one approach to medical care is forced to stand in judgement of others.

Insufficiently trained providers may actually be a threat to public safety. The time has come for us to study and implement the model that Dr. Gordon so insightfully crafts, but to do so with the participation of the naturopathic physicians. Incorporating naturopathic medicine as a guiding principle to help shape and implement the new medicine will allow our citizens to become better, more objective consumers, limiting high-priced procedures and pharmacy by increasing their wellness and thereby avoiding disease.

The medical doctors and osteopaths have enough to do staying current within their discipline. Let's not try to produce a single specialty renaissance physician. Let us instead modify medical delivery and provide the oversight of a multi-disciplinary tribunal. It is my wish that a naturopathic physician be appointed to this commission to help make this dream of improved, responsible health care a reality.

As a professor of clinical medicine at the Naturopathic College University of Bridgeport, I certainly welcome your next topic as well, embracing education as a next focus.

Thank you very much.

DR. GORDON: Thank you. Thank you for the nice words as well. Marshall Sager's testimony, everybody here, Roman numeral VII, Tab 6.

DR. SAGER: Good afternoon, ladies and gentlemen. I am Marshall Sager, Dr. Marshall Sager, and I am pleased to speak with you today as president elect of the American Academy of Medical Acupuncture and chair of the American Board of Medical Acupuncture, which administers a comprehensive examination leading to board certification of physician acupuncturists.

My address today is an abbreviation of our complete submission, which I trust you will read in its entirety. Medical acupuncture, which is the practice of acupuncture by fully trained and licensed physicians, falls within the scope of the practice of medicine. By combining Western and Eastern medicine, the medical acupuncturist fills a unique and critical role in patient care.

In other words, the best of both worlds. The AAMA adamantly believes that the rules and regulations governing physician acupuncturists must, as in the case

of any other medical specialty, fall under the purview of the respective state medical boards. Reimbursement for medical acupuncture services in this country is sparse, and usually limited to those patients who can afford to pay out of pocket.

While physicians are routinely reimbursed by third party payers for conventional Western medical-related services, such as evaluation and management, rehabilitation, inoculations and the like, payment for and access to the ancient and effective practice of medical acupuncture is generally denied. This is illogical and disturbing, especially when we consider caring for our elderly, those who could benefit significantly from medical acupuncture therapy.

Never forget that, as physicians, we are held to a high level of accountability and responsibility. Those of us who care respectfully request -- no, insist, that this inequity be remedied. The fact that most health care plans do not reimburse for physician acupuncturists services has forced patients from their primary medical care providers and out of the health care system. This fractionalizes health care. Furthermore,

this disparagement in health care delivery borders on discrimination because poor patients with limited out-of-pocket resources are unable to participate.

Unfortunately, there is no quick fix to this problem. Medical students and physicians must be educated about the use and effectiveness of all complimentary medical modalities, especially medical acupuncture. They must understand that medical acupuncture is not a threat to their practice. It is an enhancement to their success.

We must change the sad fact that medical acupuncture is virtually non-existent in hospitals where patients would benefit enormously from medical acupuncture to alleviate pain and expedite recovery. Medical acupuncture saves money and creates win/win scenarios.

Patients benefit by speedy recovery and reduction of biopharmaceutical use; surgeons benefit because their patients heal faster; hospitals benefit because of shorter hospital stays; and the public benefits because of reduced health care costs. A win/win all around.

DR. GORDON: Thank you very much. Diana Miller.

MS. MILLER: Hello. Thank you for letting me be here to testify today as a public commentor.

I am an attorney and I am committed to legal research, education, and designing laws that take away the barriers for consumers for access to alternative health and other kinds of health care that they deem necessary for their healing.

[Alarm.]

MS. CHANG: Sorry. Sorry.

MS. MILLER: I have been involved in a lot of cases where practitioners have been prosecuted or consumers are trying to get access, child protection cases where parents want to take the child to CAM providers, licensed people who are being disciplined in front of their boards, lay people who are being prosecuted criminally for the practice of medicine without a license.

I have worked on task forces for ALINA, which is a 19-hospital system in Minnesota, trying to set up credentialing for integration in that system.

In my younger years, I was a chemist and did a lot of National Science Foundation research in organic chemistry, but I think the final thing that really made me dedicate my life to alternative health was that I was totally disabled for three years and kind of sent away to, whatever, look out the window in my rocking chair and wait to die. So I learned a lot about alternative health care in a very short period of time, and I am here to tell about it. I am very excited about it.

My goal now is to find a way for the healing energy, healing truths, healing light or path of any consumer to come to as many of us as possible in as many ways as possible. So I am quite unintimidated by the laws, and I want to encourage you to think outside the box. I will support Berkley Bedell in his request of you to take some risks.

I have been working in Minnesota for the last four years, creating a law there that would find a balance between the government's duty to provide protection to the public, and the consumer's right of privacy and to make their own decisions about their health care. The current system is disempowering

consumers. Anything that you do to disempower a consumer will make it more expensive and will not get consumers well.

Minnesota believes consumers have the right to access any person or treatment they deem helpful to bringing them to full health. Consumers are their own best resource and friend, and can make good decisions regarding healing decisions. Consumers benefit from an informed environment. Empowering consumers in their healing process is the bedrock of healing.

DR. GORDON: Thank you very much. I think you may know that we are planning to have a town hall in Minneapolis, and we would like to be in touch with you before then so you can help us discuss who would be good to have participate in that town hall.

So thank you very much.

Next is Courtney Banks.

MS. BANKS: Hi. My name is Courtney Banks and I am 33 years old. I am here to tell you how alternative medicine and therapies have changed my life, and, I believe, have saved my life.

Up until I was 26 years old, I thought I lived

a very healthy lifestyle. I exercised, I ran five days a week, I ate lots of fruits and vegetables, I took very good care of myself. I also would take antibiotics when I had an infection or a bad cold. I would take aspirin or Tylenol when I had a headache, which was normal to me.

When I was 26, three months after I gave birth to my daughter, I found a lump in my neck and found out I had Hodgkin's Disease. I had five weeks of radiation therapy, which got rid of the Hodgkin's, but I knew I had to look at my whole life and, what was I doing or not doing that enabled my body to get so sick.

So I started reading everything I could, and luckily I was introduced to Dr. Gordon who became my doctor, and he began helping me get focus and get on my path. I have done acupuncture with him, and in the last seven years I have changed my diet. I eat only organic fruits and vegetable. I eat whole foods. I don't eat foods that are filled with preservatives and other chemicals. When I get a cold or my daughter gets a cold, we use homeopathy.

I can truly say, in the last seven years, I have never felt healthier, had more energy and a more

positive outlook. I have one other testimony of how it has worked. Three years ago, I had an abnormal PAP smear that came back with cervical dysplasia. After talking to several friends of mine, five of them had all had it, and all had done what the doctor recommended, which was chirosurgery. I am not quite sure I am saying that right.

My doctor said the same thing to me. I went to Dr. Gordon and I said, I have mild to moderate dysplasia and he wants to freeze them off. And he said, Do not do this. You need to do this and this and this, and there are different alternative treatments, which I did. Six months later, the dysplasia was gone and I have had normal PAP smears ever since.

So I know that these work. It is not alternative to me, it is going back thousands of years ago, which I know many of you know, to being natural. I guess my two main wishes are that there are more Dr. Gordons that people could go to help guide them, and that people need to be educated about health and really truly healthy living because I thought I was living healthy, but not until I learned about natural living, that that

is really healthy. So I thank you, and thank you for this opportunity.

DR. GORDON: Thank you, Courtney. God bless you. Thank you very much.

Richard Pavek.

DR. PAVEK: Thank you. I am Richard Pavek from the Biofield Research Institute. I wish to raise a point that has not yet been addressed. Much of what has been presented in these conferences is focused on the integration of CAM into conventional medicine. When it is integrated, who will control its future? What will happen to the alternative practitioners who are not MDs?

DR. GORDON: Richard, come a little closer to the mike.

DR. PAVEK: Is it on?

DR. GORDON: Yes. That's it.

DR. PAVEK: Oh, okay. Sorry.

I would like to remind you that every alternative practice, teaching, method, or philosophy was developed outside of conventional medicine. What will happen to the developers of alternative therapies, the alternative thinkers?

Conventional medicine has a long history of persecuting and repressing any thinker and any system that lies outside the biochemical, soulless model of the human being upon which conventional medicine is currently grounded.

One of the earliest examples of continued persecution is that which was given to friends, Antoine Mesmer, his theories of a subtle energy field, which he called animal magnetism, and the treatment system utilizing the animal magnetism from his hands.

In 1784, he proposed, as Dr. Atkins did this morning, matched groups of patients, one group to be treated conventionally, the other by his method, the results to prove efficacy. The medical association refused and said his effects were all because of belief and suggestion.

Conventional medicine could not accept the idea of a subtle energy field, and for over the next 50 or so years, medical societies banned their members from associating with animal magnetizers. Medical journals threw papers submitted for publication into the trash, and that is recorded historically, and publicly denounced

the process as superstition.

Does this sound familiar? Mesmer's work, which has risen again in the form of therapeutic touch, healing touch, SHEN therapy, and the other forms of biofield therapeutics has been so erased from history, that his history is not even known to many current practitioners.

History teaches us that every discipline, every theory, has eventually rigidized, coalescing into a concrete icon that cannot be moved without the aid of dynamite, or in some cases semtec [ph]. This happened to conventional medicine and will happen to it again if we are not careful. What will we do in the future if we do not protect and nurture alternative medical thought?

I urge you to recommend that alternative practitioners be enfranchised with as much legal right to practice as possible, or the seed beds of future new thought and medical/health possibilities will be destroyed.

I yield back 29 seconds. That is a record for me.

DR. GORDON: Thank you very much, Richard, and for your generosity as well.

I want to make sure that all of the panelists, all the people who are speaking on these public panels, if you would just check at the desk to make sure we have all your contact information, names, address, phone, email, wherever applicable, because one of the things I want to say people is that people who have spoken at public panels and people who have spoken at town halls have given us a tremendous amount of guidance, and we are in touch with them.

A number of the people who are speaking here today are people we met first at the Town Hall in Seattle. So we regard you as ongoing partners with us in this journey we are taking.

Questions from Commissioners. Any questions? Joe.

DR. FINS: Mr. Sager, I am not a real expert in any way in acupuncture, but it strikes me there are lots of organizations that have competing names and objectives and goals.

If one of the overall objectives is to ensure access to safe and standardized care, how would one propose bringing all these groups together in a way that

would allow regulation?

DR. SAGER: Well, I speak for the physician acupuncturists, primarily, since I am a physician and I am an acupuncturist. Actually, I am an osteopathic physician, so I am a triple threat.

The American Academy of Medical Acupuncture is the primary professional organization that represents physician acupuncturists across the country, or in North America. There is no other organization that is primarily physician acupuncturist. There are other organizations that represent other physicians, non-physician acupuncturists, and there are some that represent a mixture of two, I understand.

If your question is, how do we get all of them to act in concert, I think that is a good question. I don't have the answer. They don't seem to be too friendly at times, and it becomes a problem with respect to turf, basically. I would like to see more friendly relationships, too.

DR. FINS: Because it seems like it is a generic problem for all of the practitioners because --

DR. SAGER: Well, it is; and it isn't, in the

sense that physician acupuncturists are trained in multi-paradigms of acupuncture, basically -- and that is not 100 percent thing -- and non-physicians have their own TCM approach.

DR. FINS: But what I am saying is that we have multiple practitioners with different degrees of experience and different kinds of training doing similar tasks on the same patient population. So it seems like it is a generic kind of issue that we are going to figure out how to do.

DR. SAGER: Well, yes and no, again, in the sense that when you are dealing with a physician acupuncturist, he or she is bringing in the Western medical training also. So the application of the acupuncture might be similar in the sense that it is acupuncture, but it might be taking a different as an adjunct or as a primary mode of therapy.

DR. GORDON: Joe, I think it is an issue, and I was actually talking about it earlier with several different groups of non-physician acupuncturists.

I think what we would ask is, where possible, if different groups that have interest in the same

general area could get together, and if you want to talk with us, could come together and share different perspectives simultaneously with us, and share common perspectives, that would be helpful as well.

We hope that, just as in Seattle, one of the ways our being there seemed to work, is to bring different groups of people together to talk to one another, as well as to talk to us. We really want to encourage that. We are not trying to discourage pluralism. We are trying to encourage collaboration, though.

George, and then Wayne.

MR. DeVRIES: A question for Diana Miller.

Diana, maybe you can just highlight for us. We have talked today about access to CAM services, and we have talked at a level, I think, principally about access to CAM services for adults versus access to CAM services for children. I think specifically you had mentioned issues related to Child Protective Services. I am thinking, particularly, of the Navarro case.

Maybe you can highlight, from your perspective, what you think some of the issues are in terms of

parental choice when they want to make the choice of CAM for their child, perhaps, like the Navarro family did.

MS. MILLER: I think that is a difficult issue, depending on which state you are in. I think it is an important issue. First, I will just say that state law is very specific to the culture there. So I will speak for Minnesota. How does that sound? Because child protection issues are very different from state to state, and we want to protect that pluralism. We don't want a federal standard for child protection, but we want kids to be safe.

So in the context of the culture of that state, and I can talk for Minnesota, there are child protection standards and it says necessary medical care. Then you get into a fact situation about what kind of medical care and what kind of evidence is brought forward; and if it is a divorced couple; did they bring an expert homeopath on the stand; or if they even allow a homeopath instead of a medical doctor.

So the courts are dealing with this, and part of the legal reform necessary, which we were working with, is the legal reform to give the court some

direction in terms of the expert witness testimony. But in general, it is the appropriate medical care standard. For the new legal reform in Minnesota, we just went with the basic standard and did not change the child protection laws.

So it will still be a fact case for the judge to decide. Even in a non-CAM situation, like a surgery versus an antibiotic, that is always a fact situation that is very difficult for the judge to decide, especially if it is between divorced parents.

DR. JONAS: In terms of who is going to deliver what services, which we have been touching on, I think, around here. Ms. Miller, thank you for giving us this description of the Minnesota law. A lot of what is talked about is opening up access and kind of removing licensing regulations and this type of thing.

Dr. Rubman said something that I thought was very intriguing, which is, no physician should be fully licensed for all arts, which would imply, maybe, the opposite of that, that we should go in and perhaps more precisely regulate scope of practice and what could be delivered, even to the point of saying physicians cannot

practice certain types of things, which, right now they are not restricted to, such as acupuncture, for example, without certain types of credentialing and training.

I am just wondering if any of you would like to comment on that. Is this what is going on in the states, where there is more fine-tuning of the regulation of who can deliver what types of services?

DR. SAGER: To the contrary. The move has been, specifically with your last comment about maybe physicians not practicing acupuncture or being limited in their scope, the trend is toward allowing -- there have been a handful of states that were reticent to allow physicians to do acupuncture under the scope of their license or with some training that is reflective of the World Health Organization recommendations.

It is difficult to tell a physician that he or she can't put a solid needle, which no medication is applied to, into the skin when they are using all these other drugs and these larger needles. That, I think, is a difficult example. Maybe there are some others that you wanted to use, but I have to defend that situation.

MS. MILLER: There is a difference in a

jurisdiction law and an exclusive scope-of-practice law. In Minnesota, we had to discern a lot about -- there is a lot of healing that all practitioners do that medicine, that nursing, the chiropractors, that everybody does. Then there is a lot of healing that a lot of them don't know about.

So to create models that allow rights and don't provide exclusive scopes of practice so that if someone can practice another modality they can have that opportunity, is a very different model than the licensing scope because it doesn't follow the five elements of a licensing statute. So to change the legal model of how to make that work and still keep the safety in mind is what needs to be --

DR. JONAS: Andrew, do you want to clarify?

DR. RUBMAN: Yes, okay. Thank you, Wayne.

I think there are a number of issues here that are interesting to reflect upon. I have yet to meet a renaissance physician. I have met some very gifted physicians, but the more years I spend in clinical practice, the more I realize not only what I don't know, but also what others don't know.

I think that what we need to do is, of course, first and foremost, hold public safety tantamount, do what we need to do in order to craft criteria bars to clear, ways of assessing and measuring the didactic and the practical knowledge that an individual possesses so that, first, they do no harm, and secondly, they provide a legitimate cost effective service to the population that they serve.

I think if we hold these criteria central to this investigation, then we will make very few false steps.

DR. GORDON: Thank you. We have to end the panel now. One thing I wanted to say, earlier in our informal discussion we were talking about conceptualization. I think that the whole issue that we have just been raising, with these last few questions and responses and with this panel, is partly, how do we somehow get beyond the guilt mentality at the same time that we teach an appropriate respect for what is possible, professionals as well as non-professionals, and also an appropriate respect for what all of our limitations are.

That is a kind of conceptual issue that is so clearly raised by this kind of discussion; what are we capable of, and, how do we know our limits, and, how do we encourage people to both go to their limits and understand those limits at the same time.

Thank you again. Look forward to continuing to be in touch with you.

We are going to take a 10-minute break, and then we will have the next panel. This is the last panel of today. After this panel, we will have time for questions and discussion. Then there will be a discussion among the Commissioners about some of the ideas, some of the concepts, some of the perspectives that have been generated by these two days of discussion. That discussion, of course, is open to the public. So you are welcome to listen in on us, as it were.

[Recess.]

Session VI: CAM Integration in Existing Delivery Systems

DR. GORDON: We have two people who have helped to integrate the integration of CAM approaches and therapies and research in two very significant systems. We will be having others who represent other systems in

the panel on reimbursement, but we wanted to begin this discussion now.

The first speaker will be Alan Trachtenberg. Welcome.

DR. TRACHTENBERG: Thank you. Thanks very much, Jim. It is a pleasure and an honor to be here. I want to thank all of you Commissioners and the staff for having me.

My name is Alan Trachtenberg. Some of you may remember me from the NIH Office of Alternative Medicine, which I ran from '94 to '95, or from the NIH Consensus Conference on Acupuncture, which I organized in '97.

Currently, I am the medical director for the Office of Pharmacologic and Alternative Therapies, or OPAT, at the Center for Substance Abuse Treatment, CSAT, of the Substance Abuse and Mental Health Services Administration. SAMHSA is an agency of the Public Health Service at the same level as NIH, FDA, or CDC, and is the primary public health service agency responsible for federally funded mental health and substance abuse treatment.

A vital part of our mission is the full

integration of these services with the rest of the public health and medical care system. So it is particularly appropriate we be here at this panel here on integration, for which I again thank you.

Within SAMHSA, we have three centers, the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment, or CSAT. The bulk of my activities at CSAT are currently involved with taking over from FDA in the regulation of opiate addiction treatment providers.

A group from Yale that recently published in the Archives of Internal Medicine performed their highly significant randomized trial of ear acupuncture for cocaine addiction in the kind of clinic that we are dealing with now at our office at CSAT.

Since treatment of opiate addiction with agonist medications like methadone is highly effective against heroin addiction, but has little activity against cocaine, this kind of clinic offered the perfect setting to integrate a complimentary treatment against cocaine. I will say a little more later about some acupuncture activities my office hopes to be undertaking in the near

future.

I was asked by staff to provide answers to four questions today, which I will try to do. I was asked by staff, what CAM practices does my agency support; how were they selected; where and how are they provided.

Well, we support a variety of alternative practices that maybe included as elements of comprehensive treatment programs. These include acupuncture, meditation, and culturally-specific healing practices, such as sweat lodge and traditional Hawaiian medicine.

The specific practices are chosen based on needs as determined by the local or state level. Because CSAT funds are provided directly to the states in our block grants, we are working with the National Association of State Alcohol and Drug Abuse Directors, or NASADAD, to gain a more complete picture of the alternative therapies that are being used in publicly funded drug treatment programs.

We were asked to make the delivery of CAM more culturally appropriate. Alternative therapies and traditional healing practices have been included in our

programs, primarily as culturally relevant elements of a comprehensive treatment and outreach program. The cultural and linguistic appropriateness of the specific alternative or complementary health practices for communities served by these grantees is itself the primary impetus for the inclusion of the complementary practices in the programs.

Is the delivery of CAM to our agency's target populations accomplished as a stand-alone system, or integrated with conventional care, and why?

All therapies for drug abuse treatment, be they alternative or conventional, psychodynamic or medical, should always be included in an integrated matrix of services that are as comprehensive as possible and tailored to the specific needs of the patient and the community.

In the drug abuse field, we recognize many elements of our treatment programs, just like many conventional medical practices, are based on less than perfect evidence. However, in the drug abuse treatment field, we have much evidence that our patient's outcomes do better in direct association with increasing amounts

of time spent in treatment settings.

If an alternative therapy brings patients into the treatment setting and keeps them coming longer, then it has utility over and above whatever specific efficacy it may have. This would not be the case, obviously, for a single, stand-alone therapy, be it alternative or conventional.

At this time, my office is requesting funds to assemble a consensus panel to make recommendations about how acupuncture should be incorporated into more existing drug treatment programs. This would be an obvious next-step to follow up on the 1997 consensus statement on acupuncture which said, in part, that "Acupuncture treatment for many conditions such as asthma or addiction should be part of a comprehensive management program."

My personal view is that the treatment guidelines the come out of such a process would most likely include the protocols of the National Acupuncture Detoxification Association, or NADA. This is the ear acupuncture in a group setting approach developed at Lincoln Hospital in Bronx, New York, and used by over 400 drug treatment programs, 40 percent by drug courts, and

by almost all addiction researchers studying acupuncture in the USA.

I brought copies of my complete testimony, which I have left at the back, and an accompanying of a study that was funded by the Center for Substance Abuse Treatment on Acupuncture in drug treatment programs.

Thank you.

DR. GORDON: Thank you, Alan, for coming back.

Milton Hammerly.

DR. HAMMERLY: Thanks for inviting me to share CHIs perspective on how to foster a more integrative approach to health care. As you can imagine, in a system that is in 22 states, over 100 facilities, 75,000 employees, there is a great diversity of services being offered, a great disparity in the levels of understanding, the level of sophistication.

It has been an evolutionary process. Early on, there was a steering committee, basically, that was a homogeneous group of believers trying to promote CAM integration, and that was not met with a lot of success. Since then, we have opened that up to a more heterogeneous cross-section of the organization,

including skeptics, and we have also defined a compelling philosophy of integrative health care, asked the why and how questions.

I am glad to report that now we have, basically, unanimous organizational buy-in and support of that philosophy. The difference being on what that looks like based on specific market variables, what the consumer readiness and expectations are, what the availability of services are, what the medical staff of readiness is.

We are very interested in research. So far, what we have is very limited data. It is soft. It is qualitative. In an effort to facilitate data collection, we have created a comprehensive care assessment tool, a holistic mind-body spirit evaluation intake that seamlessly imbeds the SF-36 so that it makes data extraction easier later down the road.

We have not been successful in accessing research funding which seems to be mostly finding its way to academic centers. In an effort to remedy that, we have approached pharmaceutical companies with synergistic combinations of supplements and pharmaceuticals which

are, in fact, patentable, now providing an incentive for them to want to pay for the research.

We are under no illusion about their motivations. Clearly, their motivations are profit-driven. However, I think that whatever the past history of pharmaceutical companies has been, they can be recruited as part of the solution, as part of important stakeholders to help forward integrative health care.

So we are looking to make a sustainable research funding mechanism that could potentially be far greater than actually existing government funding. In the handout, we have identified several sources of opposition, and also several sources strategies for overcoming opposition.

First, is embracing the opposition, addressing the legitimate concerns and making them part of that heterogeneous group. Second, is finding the common ground. I think cost is the lowest common denominator. I think patient advocacy, patient safety is the highest common denominator. That is something that people can get passionate about. I have heard a lot of passion about therapy advocacy. I think we need to be

dispassionate about therapy advocacy and passionate about patient advocacy.

That is the essence of our philosophy, which is to provide comprehensive mind-body spirit care which personalizes care and which has to be, of necessity, collaborative. In the handout, I spent a full 10 pages devoted to the why and the how of the CHI definition and philosophy of integrative health care, talking about evidentiary standards, talking about a risk-stratified step-care model, talking about the primary importance of safety and the overarching philosophy.

Another way of stating the philosophy of integrative health care, CHI, is to say it is about patient advocacy and not therapy advocacy. It includes CAM, but it is not about CAM. As a result, we have had a tremendous support for that.

The last barrier that I will address is the issue of finances, which is a recurrent theme. I think the only reason it is a barrier is because we are stuck in the old assumptions. I think if we can move past those, it will be very helpful. I think we are still putting the new clinical line of integrative health care

in the old reimbursement skins. Similarly, we are doing the same, I think, with the old research skins and the old regulatory skins and so on.

I think we can all be instruments of healing, whether we are chiropractors, whether we are massage therapists, naturopaths, acupuncturists. When we work together we create an orchestra, and the music that that orchestra can play is far greater than the music we can play as individuals. I think that the Commission, by helping to break down those silos, those barriers in reimbursement in clinical areas, can actually help lead that orchestra.

DR. BRESLER: This is for Dr. Trachtenberg. First, I want to congratulate you on all your extraordinary efforts in both the LAM and Consensus Conference. These are really useful, helpful activities that are going to make a real big difference, we think. Thank you very much for that.

DR. TRACHTENBERG: Thank you.

DR. BRESLER: The question comes up, it seems to me a real big issue in chemical dependence now is dealing with the compulsion aspect, not just dealing with

withdrawal issues, but looking at the compulsive nature of this problem.

Is there active research going on now looking at CAM interventions that deal with the compulsive issue?

DR. TRACHTENBERG: I am glad you raised the issue of compulsion, and with craving that goes along with that, which in fact, is the core of the problem with addictions. It is not withdrawal. I mean, we were mistaken in thinking that it was about withdrawal and that an addict would be cured once they were detoxed. We went awry with that. In the last 10 to 20 years, we have understood differently.

You know, it is very interesting, in that, addiction treatment has in this country, even in fairly conventional circles, had a spiritual dimension. Perhaps because of the lack of much else to offer, spirituality was allowed into the treatment setting. In that sense, bringing the two together in terms of the new-age complementary and alternative medicine kind of spiritual dimension coming in with the rest of medicine is, in some ways, old hat in addiction treatment.

Now, the interface of the issues of spirit,

plus the neurophysiology of craving and compulsion and a reward, I think it opens a lot of research questions which deserve a lot more attention than they have gotten, and I am hoping that perhaps the Commission will urge us on more in those areas.

DR. BRESLER: Is there any active research being done with CAM modalities on compulsion that you know about?

DR. TRACHTENBERG: I am no longer from a research agency, so perhaps your question would be better directed to some of the National Institutes of Health.

DR. CHOW: This is also for Alan. I also commend you on all that you have accomplished.

I have to turn this way. I want to also commend you on your accomplishments and all that you have done. In here, you said there were 13 million individuals being treated, and approximately 10 million are not receiving it. So this talks to accessibility and eligibility.

Can you say something about that number that we are not reaching. And, what is it you recommend that can be done, besides resources? Having money would help, but

are there other thoughts on that?

DR. TRACHTENBERG: A number of things. Probably, as Dr. Chavez commented here in the same quote where you got the 13 million who need treatment to only 3 million of whom are actually receiving it, a lot of it has to do with stigma, with our willingness as a society to cast aside people with this range of problems, to blame the people for their problem because of the vagaries of history, that we put such a moralistic judgment on this particular category of illnesses, much more so than we currently do on other aspects of health.

Four- or 500 years ago, if you got tuberculosis, that was felt to be the wrath of God. It was your own damn fault, and we still feel that way about addictive disorders in particular, and to some degree about mental health problems in general.

So that, I would say stigma, besides resources and the lack thereof, and possibly intertwined with and causing the lack thereof, has much to do with that treatment gap.

DR. CHOW: So your recommendations, then, would be education?

DR. TRACHTENBERG: More than just education. I have to be careful what I say here in Washington. I think we should encourage each other to find -- you know, complementary medicine, to some degree, has brought this message into the rest of American medicine. We should try to find the human in all of our fellows, try to find ourselves and see ourselves in our fellows.

How to implement that as a program, I couldn't tell you, various ways. We all should try to do our part.

DR. GORDON: Joe.

DR. FINS: Dr. Hammerly, thank you for your excellent submission. I just want to make an observation that will lead to a question. Dr. Quevado, who spoke earlier, I believe was from a Catholic hospital. You are from a Catholic hospital system. Their mission, their values; there is kind of a core sensibility.

What impact has that had in developing a consensus downstream? And related to that, on page 22 of your testimony, which was about taxonomy, which I thought was incredibly helpful, you talked about grouping therapies according to how we think they work.

I was wondering why you had a means versus an ends approach, because you could have also said, let's group them based on what they accomplished versus mechanism of action. So those are two related questions.

And then one request on behalf of the Commission. There is a big table of contents here of what I presume is a book or a binder, or something. If you could furnish several copies to the Commission, it would be very helpful to us if you would be willing to do that.

DR. HAMMERLY: Okay.

DR. FINS: Great.

DR. HAMMERLY: On the issue of Catholic health care systems, there is a commonality in terms of wanting to provide holistic mind-body-spirit care. The theme that Dr. Quevedo kept mentioning, that beliefs matter, I said it in a different way. I said that we can no longer afford to treat patients despite their beliefs. I think that that makes it a lot easier to get that unanimous support when we agree that providing this comprehensive care is essential to who we are and the kind of care that we want to deliver.

On the question of taxonomy, my approach is to say, if we don't have at least a theory about how it works, then how are we going to utilize it, because I think our understanding drives what we do with it. In terms of using a taxonomy that is entirely based on mechanism of action, there is the danger of becoming mechanistic and losing the totality, perhaps, of a more systematic approach.

I have heard several comments about using CAM as a term being a disservice, as a generic term. I think using a system of medicine is somewhat of a disservice because that system of medicine has several different modalities with several different mechanisms of action. So we need to, if we want to know how to apply it, have an idea of how it works.

DR. FINS: There is also an instrumental value in clumping things together, because it shows areas of overlap, how you can departmentalize it, how you can organize it, how you can have the psychotherapist working with other similar kinds of mind-body practitioners in a way that allows for organizational structure to occur.

Was that something that happened because of

this clumping?

DR. HAMMERLY: It gives us a clinical strategy. The other thing it does, in terms of a classification scheme, it helps identify similarities, differences, and where it could be applied. It also can be, actually, a diagnostic tool where we say, okay, what is going on in the biochemical category; what is going on in the structural category; what is going on in the energetic category.

So it actually can be like a pneumonic to help us remember to be thorough in our evaluation of patients. In fact, the comprehensive care assessment tool that I mentioned is based on that and addresses all those categories so that nothing is left out.

DR. GORDON: Wayne, and then Tieraona, and then Tom.

DR. JONAS: Alan, I want to also thank you for your long-term and ongoing, even now, continuing work in these areas. You have contributed, I think, to these areas in a number of ways, a number of avenues, and I really appreciate that.

I know that SAMHSA is not a research

organization. However, they do do demonstration projects. Isn't that correct?

DR. TRACHTENBERG: Correct.

DR. JONAS: I am wondering what the possibility would be. Would it be reasonable, or is there an opportunity, perhaps, in SAMHSA to do an integrated systems demonstration project that looked at a number of addiction types of treatments. It would have to, obviously, build off of the current successful practices, and look at add-ons, for example. You can incorporate in spirituality, acupuncture, biofeedback, this type of thing.

Is that something that SAMHSA, you think, a good place to do, or could do that, or would be in a position to do that?

DR. TRACHTENBERG: Well, at least CSAT, the part of SAMHSA that I work in, Center for Substance Abuse Treatment, I think would welcome the collaboration, and especially the resources to do projects like that.

DR. JONAS: Yes. They would be open and able to set up such a project, probably, if there were resources and a request for that.

DR. TRACHTENBERG: Yes.

DR. JONAS: I am always struck with the contradiction, not just in this area, but I am going to use this area as an example. If you go over to NIH and NIDA, and you say, are there any specific, effective treatments for addiction. The answer I get is no, we really haven't found any good treatments for addiction. Yet there are a number of them being delivered.

I am just wondering, is this a definitional issue in terms of looking at specific efficacy and clear demonstration in independent trials on one hand, with mechanisms, or basing it on outcomes research on the other hand, or something like this?

DR. TRACHTENBERG: I think perhaps you just haven't been talking with the right people at NIDA and NIAAA, because --

DR. JONAS: This is prior to the NIDA director, but it was the NIDA director, in any case.

DR. TRACHTENBERG: There are very efficacious pharmaceutical modalities for the treatment of heroin addiction, for the treatment of alcohol addiction.

DR. JONAS: Sure. Withdrawals, yes.

DR. TRACHTENBERG: Excuse me?

DR. JONAS: Withdrawal, right.

DR. TRACHTENBERG: Oh, no, not withdrawal. Heroin addiction is extremely well and effectively treated with opiate agonist maintenance.

DR. JONAS: With methadone.

DR. TRACHTENBERG: With methadone or LAM, or probably with bupamorphine, a new pharmacotherapy. If you have cocaine problems along with that, acupuncture added to that regimen can be highly helpful, as was demonstrated by Avants [ph] and Margolin from Yale, which, the article I referred to, and I have the reference cited from Archives of Internal Medicine a couple of months ago.

DR. JONAS: Yes, I see that. Okay. I understand there are studies out there, but it wasn't on the Consensus Conference list. It seems like there are, maybe, a few but not a lot of actual effective treatments in these areas.

DR. TRACHTENBERG: I think people generally don't recognize what effective treatments there are in this area, possibly, again, related to stigma and those

issues.

DR. JONAS: Okay. I am wondering if some kind of demonstration would be useful in this particular area.

DR. GORDON: One of the things I was thinking as you were talking, Alan, and Wayne, as you were as well, is whether we shouldn't be thinking of integrative demonstrative projects, both in the area of addiction and also in the area of mental health.

DR. JONAS: Yes.

DR. GORDON: I am sorry you weren't here yesterday when people from ARRIVE presented what is really an integrative program to dealing with addiction and HIV. It might be really interesting for you to go to New York. I can introduce you to them, and you can see what they are doing, combining a variety of different modalities.

DR. TRACHTENBERG: Yes. I was sorry to have missed that. In fact, I would have been here, but I was still chasing down clearance for my testimony, which I only got at 6:00 p.m. last night.

But if they had a handout of their testimony that you could share with me, I would much appreciate it.

I will bring it back with me to CSAT.

DR. GORDON: Yes.

DR. JONAS: Can I ask a brief question to Milton. That is, you describe in here a data collection system. I know you have been working on an ongoing data monitoring collection system.

What is the status of that? Has that been looked at? Is there any data coming out of that, at this point, related to CAM interventions?

DR. HAMMERLY: We have that comprehensive care assessment tool, which has the SF-36 embedded in it, again. So it is a tool, but so far, with the lack of research, we haven't actually started collecting data. We have it there and are starting to utilize it at some sites, but we have not yet collected the data.

DR. GORDON: Tieraona, Tom, and then Charlotte.

DR. LOW DOG: Thank you both for those presentations.

Alan, just in brief passing, you mentioned a traditional North American, Native American practice of the sweat lodge, which, as we have talked about Ayurvedic and Chinese and many other modalities, we really haven't

mentioned much of our own indigenous practices here. In New Mexico, they have introduced the sweat lodge there now in the prison systems out there, and they are being used quite extensively in addiction programs as well.

I just wanted to know if you could talk a little about how you have integrated that. Have you used indigenous peoples to run the lodges? And, how has that worked or fit in?

DR. TRACHTENBERG: Generally, those are parts of community-based treatment programs that are serving specific Native American communities. The leaders from the communities themselves being served usually provide the culturally resonant aspects of the overall treatment program, be it sweat lodge, be it vision quest.

There is a program that is funded in Hawaii that used traditional Hawaiian Huna medicine. That was under a rural, remote, and culturally distinct communities program. That was a grant program from CSAT that started in about '93. In fact, those grants were going to fund things like acupuncture in drug treatment and sweat lodge before the first grants came from the NIH Office of Alternative Medicine.

So I just wanted to point out SAMHSA does lead, even if not in research. But those are done very much in concert with the communities that they are serving. That is kind of how they get in there.

DR. GORDON: Tom.

MR. CHAPPELL: Again, Alan, you mentioned the spiritual aspects of addiction therapy. I am just wondering how intentional you have been with your group to understand that more. There are plenty of 12-step programs out there.

Is that something that you try to understand better?

DR. TRACHTENBERG: Well, in terms of how to use it to improve clinical outcomes, certainly. You know, there actually are manuals, for instance, published by the National Institute on Alcohol Abuse and Alcoholism on what is called 12-step facilitation therapy.

Twelve-step groups are not professional therapy. They are self-help, peer-counseling kinds of things. So there are manuals to help health professionals use those groups in order to improve their patients' outcomes and to support their patients' work in

the 12-step groups.

Whenever you talk about scientific research of spiritual topics, that is obviously a very touchy area. It is kind of an ambiguity in drug abuse treatment we learned to live with, and perhaps that is why many of us in drug abuse treatment are more comfortable with alternative medicine than in some other medical areas. I don't know.

MR. CHAPPELL: So even in this world of CAM, it hangs out there as something other than a CAM therapy.

DR. TRACHTENBERG: Well, we didn't think it was terribly alternative until we saw David Eisenberg count AA and other 12-step self-help groups as alternative health practices when he did the first survey. Then the addiction treatment field in general discovered that we were alternative.

DR. GORDON: Charlotte.

Tom, are you finished? Tom? Or, you want to go into it a bit?

MR. CHAPPELL: I'm finished.

SISTER KERR: Dr. Hammerly, thank you so much for the qi work, and particularly your report here, and

all the work that Sister Diana chaired and got moving, along with all of you. So I congratulate her.

One of my concerns always is -- and if you have been here all day, you would have heard it -- is that we do add-ons, and this is a going to be a shorthand conversation of adding on modalities. The conversation has gotten bigger, and we understand it so much about a new consciousness and a new paradigm shift, and all the things that have gotten trendy language.

One of my things about the hospital that concerns me at times, and I see the process and unbelievably doing great things. I will give you an example. I once worked with Tom Berry in Assisi, and the students were so into cleaning the rivers and streams, and everybody was excited for the ecological cleanup, but there was never an association between drinking 12 Coca-Colas a day and their own rivers and streams.

One of my concerns in the hospitals with an ecological paradigm is that sometimes, for example, I will talk about food in hospitals. When we get an ecological paradigm, it gets real hard to give Jello to everybody on liquid diets. This is when, as you said --