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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. testimony	Yong Ming Li (partial) (1 page)	nd	b(6)
002a. cover sheet	testimony of Brian MacNamara (partial) (1 page)	01/23/2001	b(6)
002b. testimony	Brian MacNamara (partial) (1 page)	01/23/2001	b(6)
003. testimony	Tsao-Lin Moy (partial) (5 pages)	01/23/2001	b(6)
004. testimony	Janice Pingel (partial) (1 page)	01/23/2001	b(6)

COLLECTION:
Federal Records
White House Commission on Complementary and Alternative Medicine Policy [WHCCAMP]

OA/Box Number: 43238

FOLDER TITLE:
WHCCAM Testimony Given, Lighthouse International Conference Center, January 23, 2001 [3]

2011-0568-S
kc889

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
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Divider Title: _____

Members of the commission

Thank you for allowing me to speak here today.

I am here on behalf of The Coalition For Natural Health;

I am both a certified nutritionist and a cancer survivor.

I am not a doctor or a scientist.

I am also not a guinea pig or a statistic.

Being told that a blood test indicated a second bout with cancer was upon me led me to study nutrition.

Putting the information I obtained during my studies into practice saved my life.

No allopathic treatments were used to accomplish this.

I share the reason for my good fortune, the macrobiotic diet and life style, with everyone who will listen.

Macrobiotics has been used for thousands of years to successfully treat many illnesses.

The health benefits of diet are substantiated by the work of such famous Medical Doctors as Dr. Sherry Rogers, Dr. Dean Ornish, Dr. Lorraine Day, and Dr. John McDougal.

It saddens me to know that some oncologists totally disregard diet and nutritional supplements as being effective tools in the cancer battle.

For doctors to make such remarks to patients who are counting on them to have all the answers is bias arrogance, bordering on criminal behavior.

If my source of information is correct, cancer is the number two cause of death in the US.

Drug reactions are number three.

First do no harm?

I have witnessed the prescribing of prozac for an individual with extreme chemical sensitivities simply because the doctor did not know what else to do for her.

My own daughter's elementary school psychologist recommended my daughter be put on ritalin when she had a hand eye coordination problem which was cured by doing eye exercises.

No drugs were or are being taken by my daughter.

She is now a second year college student with a B average.

Though I graduated from the National Institute of Nutritional Education, I am not allowed to legally call myself a certified nutritionist in New York State, while in most other states I can.

The American Dietetic Association feels they should be the only kid on the block when it comes to nutritional information and education.

A more uniform ruling on the credibility of Certified Nutritionists is sorely needed.

The American diet is nutrient deficient, but Medical Doctors have little or no nutritional education.

The public needs more information on the benefits of a healthy diet and nutritional supplements.

In an effort to educate the public, supplements should be allowed to list on their labels, any known health benefits as well as risks.

Ideally, nutritional education should begin in elementary school.

School lunches should reflect a knowledge of healthy eating practices.

At the present time, French fries are the number one seller in school cafeterias.

What has happened up to now proves that common sense can not be legislated or drug induced.

Without question the medical profession does an excellent job when it comes to dealing with acute and emergency care.

It is also obvious that the medical profession is in need of help when it comes to dealing with degenerative diseases, and I am positive Alternative Medicine and therapies can provide what is needed.

Virginia Langley CN

Association of Chinese Herbalists
Thomas Leung 1/23/01

I would like to begin by thanking the commission for their hard work in making today possible, in particular Commissioner Tian for encouraging Traditional Chinese Medicine organizations to participate in this movement. My name is Thomas Leung, and I stand here today representing the Association of Chinese Herbalists of NY. Our organization has been in existence for over 25 years and has a membership of over 300 TCM herbal practitioners.

The Association of Chinese Herbalists would like to address the White House Commission on two areas. The first is regarding the differences in the training of herbal practitioners and acupuncturists, and second, the distinction between Traditional Chinese Medicine and Chinese Herbs.

It is important that a distinction be recognized between the practice of Acupuncture and the practice of Traditional Chinese Herbology. They are two distinct disciplines that share some common theories, but are very different in their practices and training.

The practice of acupuncture does not necessitate the knowledge of TCM herbal medicine. An acupuncturist can treat patients very successfully with acupuncture techniques alone. As a matter of fact, most academic institutions in the United States as well as mainland China do not require students of acupuncture to take any TCM herb classes in their curriculum. Further, it is not an educational or licensing requirement in the State of New York or any other state for an acupuncturist to study TCM herbology. The reverse applies to an herbalist's training, he/she does not have any training in the discipline of acupuncture. Therefore, it would not be in the public's best interest to have practitioners of either disciplines to treat patients in the modalities in which they are not trained.

Our association recommends to the commission that these two different disciplines of TCM should be of two separate licenses with different educational requirements. They should not be lumped together as one practice under Traditional Chinese Medicine.

The second subject is the importance of recognizing the roles of Chinese Herbs in Traditional Chinese Medical and Chinese culture in general. A Practitioner of TCM Herbology may use Chinese herbs in its practice. However, Chinese herbs are not limited to its role in TCM. They may also be used as a spice, as well as a food.

Food as medicine is a concept that is deeply embedded in Chinese culture. Often, there is a very fine line between food and medicine. Therefore, it is important that we recognize that aspect of Chinese herbs. We must balance the issues of public safety and the public's right to have access to foods that is part of their culture.

Our recommendation to the commission is that we should recognize the different roles of Chinese herbs. It is not restricted to its medical use only. Restricting access of Chinese herbs by legislation would not serve the best interest of the public.

Thank you.

THE ACUPUNCTURE CENTER

Roger Wei-Ming Tsao, Ph.D., L.Ac.
David Ka-Man Lew, L.Ac.
Board Certified in Acupuncture (NCCAOM)
Licensed in New York, New Jersey, California, and Florida

Our goal as concerned health-care professionals is protecting America's health and safety. The biggest threat to Americans involves the use of traditional, Chinese herbal medicine and acupuncture by untrained or minimally trained persons.

There are practitioners who have completed a nationally accredited program by the Accreditation Commission of Acupuncture and Oriental Medicine (ACAOM). Some are trained in conventional, western medicine, and have undergone the 2000 hour, three-year acupuncture program. Unfortunately, there are others who choose not to educate themselves. In fact, they may not be required to do so but still allowed to practice acupuncture.

In many states, medical doctors are not require to have training in order to practice acupuncture. Some states, like New York, allow doctors to practice after 300 hours of training. Others, like New Jersey, allow doctors to practice with no prior education. In fact, Hawaii is the only state that requires doctors to complete at least 1500 hours of course-work. This is like night and day between the states.

When people see the benefits of traditional, Chinese herbal medicine and acupuncture, some will practice with minimal or no training. Others will choose sufficient training in order to truly help patients and the public.

As a community concerned with health-care ethics and safety, we need to educate the public on these differences by providing information and pamphlets on current qualifications. This will protect us from fraud and misuse. In addition, those wishing to practice traditional, Chinese herbal medicine and acupuncture, should undergo complete training. America's trust in TCM practitioners can only be accomplished through a national standard of education.

210 East 68th St., 1-G, NY, NY 10021, Tel: 212-517-4040, E-mail: AcupCentre@aol.com

The following diagrams compare a standardized acupuncture program and an abbreviated program.

In the diagrams, Education 1 represents an accredited program by the Accreditation Commission of Acupuncture and Oriental Medicine (ACAOM). Education 2 represents an abbreviated 300 hours program. ACAOM is the accrediting agency that sets the standards for acupuncture education in the United States.

For Education 1, courses and total hours are from a Master's program at Pacific College of Oriental Medicine, an ACAOM accredited college. Acupuncture programs in other accredited schools follow similar course guidelines.

Diagram 2 breaks down the total classroom hours for the following five categories: Acupuncture Points, Acupuncture Theory, Clinical Acupuncture Assistantship, Clinical Acupuncture Internship, and Electives/Non-Core. For Education 1, these are the exact hours at Pacific, not including biomedical sciences.

Using percentages, the hours for Education 2 would be: 54.9 hours for Acupuncture Points, or 18.3% of 300, 86.4 hours for Acupuncture Theory, or 28.8 % of 300, 52.8 hours for Clinical Acupuncture Assistantship, 80.4 hours for Clinical Acupuncture Internship, and 25.5 hours for Electives/Non-Core.

As we see, Education 2 satisfies only 14% of the standard acupuncture education (300 hours as compared to 2142 hours).

To reiterate the importance of thorough education, a list of textbooks that are basic to acupuncture education is included. This sums up to approximately 14,000 - 15,000 pages of required acupuncture reading.

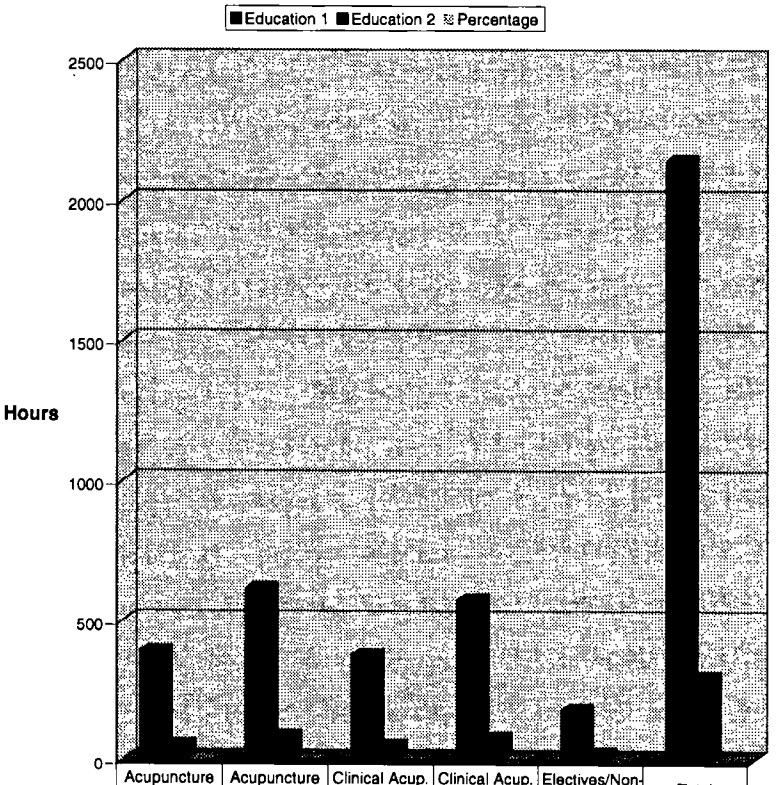
Standard Educational Requirements for Acupuncture

(Education 1 - Excluding Biomedical Sciences)

Acupuncture Points	Acupuncture Theory	Clinical Acup. Assistantship	Clinical Acup. Internship	Elective/Non-Core
Acupuncture Points 1	Oriental Medicine 1	Acupuncture Assistantship 1	Acupuncture Internship 1	Tai Ji
Acupuncture Points 2	Oriental Medicine 2	Acupuncture Assistantship 2	Acupuncture Internship 2	Qi Gong
Acupuncture Points 3	Oriental Medicine 3	Acupuncture Assistantship 3	Acupuncture Internship 3	Required Elective 1
Acupuncture Points 4	Oriental Medicine 4	Acupuncture Assistantship 4	Acupuncture Internship 4	Required Elective 2
Acupuncture Points 5	Oriental Medicine 5	Acupuncture Assistantship 5	Acupuncture Internship 5	CPR and First Aid
Tuina Hand Technique	Oriental Medicine 6	Acupuncture Assistantship 6	Acupuncture Internship 6	Practice Management
Tuina Structural	Oriental Medicine 7	Diagnostic/Evaluation 1	Acupuncture Internship 7	
Clinical Technique	Oriental Medicine 8	Diagnostic/Evaluation 2	Acupuncture Internship 8	
Needle Technique	Oriental Medicine 9	Diagnostic/Evaluation 3	Acupuncture Internship 9	
Acupuncture Technique	Oriental Medicine 10			
Auricular Acupuncture	Chinese Philo. And History			
	Counseling 1-3			
	Herbology 1			
	Oriental Diagnosis			
Hours: 392	616	378	574	182
Total Hours for Education 1				**2142**

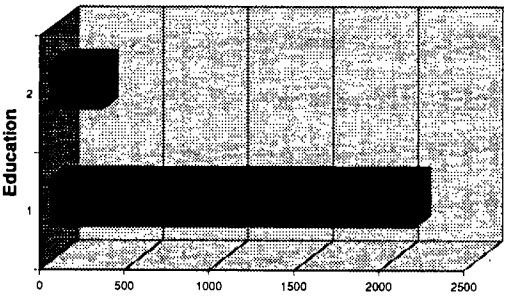
Created by: David Lew, L.Ac.

Comparison of Acupuncture Education (Excluding Biomedical Sciences)



	Acupuncture Points	Acupuncture Theory	Clinical Acup. Assistantship	Clinical Acup. Internship	Electives/Non-Core	Total
Education 1	392	616	378	574	182	2142
Education 2	54.9	86.4	52.8	80.4	25.5	300
Percentage	18.3%	28.8%	17.6%	26.8%	8.5%	100%

Comparison of Total Acupuncture Education Between 1 and 2



Education 2 Satisfies Only 14% of the Standard Acupuncture Education

	1	2
Total	2142	300

Required Textbooks Basic For Acupuncture Education

(At an ACAOM Accredited Program)

***Totals to Approximately 14,000 – 15,000 Pages of Basic Acupuncture Reading**
**** Not Including Readings For Research and Case Studies**

Acupuncture, A Comprehensive Text, O'Connor and Bensky, 741 pp.
Acupuncture Risk Management, Essential Pracitce Standards, Kailin, 336 pp.
Practical Therapeutics of Traditional Chinese Medicine, Wu, 750 pp.
Chinese Acupuncture and Moxibustion, Cheng, 544 pp.
Practical English-Chinese Library of TCM, Clinic 1, Shanghai College of TCM, 455 pp.
Fundamentals of Chinese Acupuncture, Ellis, Wiseman, Boss, 484 pp.
Handbook of Traditional Chinese Gynecology, Flaws, 243 pp.
The English-Chinese Encyclopedia of Practical TCM, Higher Education Press
Acupuncture Case Histories from China, Chen and Wang, 300 pp.
Clinical Counseling Reader, (Pacific College Bookstore)
Clean Needle Technique Manual, 4th Ed.
Clinical Technique Reader, (Pacific College Bookstore)
Foundation of Chinese Medicine, Maciocia, 498 pp.
Fundamental of Chinese Medicine, Wiseman and Ellis, 532 pp.
Introduction to Wiseman's Glossary, (Pacific College Bookstore)
Statement of Fact in Traditional Chinese Medicine, Flaws, 107 pp.
Practical Diagnosis in Traditional Chinese Medicine, Deng and Ergil
Practice of Chinese Medicine, Maciocia, 924 pp.
Tongue Diagnosis, Maciocia, 164 pp.
Pulse Diagnosis, Li Shi Zhen, 128 pp.
The Secrets of Chinese Pulsse Diagnosis, Flaws, 160 pp.
Acupuncture 1 Reader, (Pacific College Bookstore)
Navigating the Channel, Dr. Ni
Graspinng the Wind, Ellis, Wiseman, and Boss, 462 pp.
Locations of Acupoints, China Academy of TCM, 276 pp.
Chinese Bodyworks, San Chengnan, 250 pp.
Essence of Tai Chi Chuan, Lo and Inn
Sources of Chinese Tradition, Vol. 1, Debary and Bloom
Acupuncture Point Combination, Ross, 476 pp.
The Web That Has No Weaver, Kaptchuk, 402 pp.
Sticking to the Point, Vol. 2, Flaws, 276 pp.
Acumoxa Therapy, Vol. 1, Feit and Zmiewski, 195 pp.
Acupuncture: How it Works, Mann
Insights of a Senior Acupuncturists, Lee, 140 pp.
Chasing the Dragon's Tail, Manaka, 453 pp.
Japanese Acupuncture, Birch and Ida, 348 pp.
Chinese Herb Medicine: Formulas and Strategy, Bensky and Barolet, 562 pp.
Chinese Herbal Medicine: Materia Medica, Bensky and Gamble, 556 pp.
Study Guide of Chinese Herbs
Commonly Used Chinese Herbal Formulas
Acupuncture and Moxibustion, A Guide
NCCAOM – Clean Needle Technique
Medical Interview: Mastering Skills, 3rd Ed., Coulehan, 369 pp.
Clinical Assistant Reader, (Pacific College Bookstore)
Reader for Clinical Technique
The Chinese Medicted Diet, Luk
Modern Guide to Ear Acupuncture, Wexu191 pp.
Homeopathic Medicine at Home, Panos
Homeopathy Medicine of the New Man, Vithoulkas
Designing Clinical Research, Cummings, 247 pp.
Medical Board of California, Laws and Regulations Relating to the Practice of Acupuncture, Sacramento: 1991
Business Mastery
Medical Board of New York, Laws and Regulations Relating to the Practice of Acupuncture, Acupuncture Committee, Sacramento: 1991
Family Practice Review, Swanson

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Statement for White House Commission on Complementary and Alternative Medicine January 23, 2001

My name is Sheldon Lewis. As a journalist, I have covered alternative and complementary medicine for more than 20 years. As a parent, I am the father of an almost 17-year-old young man with special needs, who depending on the label of the moment—and the labeler—has been diagnosed with pervasive developmental disorder, Asperger's syndrome, Tourette's, ADHD, and many more. For 17 years, my family and I have dealt with pediatricians and medical specialists who for the most part know little about human development—by which I mean, the development of the whole person, not just his or her body. And they know even less about healing: and by that I mean, changing our relationship—as individuals, families, communities, and society—with illness and disability and health and ability.

On our own, as case managers, driven by hope and desperation, we sought help from other approaches to health and healing—including homeopathy, chiropractic, cranial sacral osteopathy, nutrition, environmental medicine, reiki, meditation, prayer, social therapy, movement therapies, and many others—most of which were helpful. Unlike most parents, my wife and I knew where to look and had personal contacts to help us.

But just as the medical model is limited, so is a scattershot approach to alternative and complementary medicine. In both cases, you are searching for a magic bullet—when none is available.

"Conditions" haven't been cured, "problems" haven't been fixed. What ultimately has been the most healing has been the journey, the conversations, the love, interactions with caring people—and building a life for our children and our family.

Children don't develop "medically," "homeopathically," or "chiropractically." They develop socially, intellectually, emotionally, and spiritually as well as physically. Unfortunately, in the current climate, physicians, educators, therapists, healers, and parents generally operate independently of one another, which results in a fragmented, antidevelopmental, non-holistic model.

One of the great triumphs for my family has been to get a school psychiatrist to talk with a neurologist who prescribes essential fatty acids as well as psychotropic medication, to get a Freudian school social worker to talk with a performatory psychotherapist. And to get everyone to talk to us, the parents, and most of all to talk—and listen—to our son. He is the one truly holistic member of our team (which includes his older brother by the way). He talks to his doctors about prayer, amino acids, and blue green algae. He teaches his therapists and friends to do deep breathing and other behavioral or mind/body techniques he calls "preventions."

We need to follow his example and create new models that include every aspect of a child's development, including the family, the school, and the community.

We need to make information, support, and care of all kinds available, accessible, and affordable to all parents, so that they can make informed choices for their child and their family.

We need to build new models so that people who raise and teach and treat and heal and help children and their families can talk to each other and listen to each other and learn from one another and work together for the collective healing and development of ourselves, our children, our health care and educational systems and the world we all live in. Thank you.

Sheldon Lewis
Co-author, with Jimmie C. Holland, MD, of *The Human Side of Cancer* (HarperCollins 2000). Co-author, with Sheila Kay Lewis of *Stress-Proofing Your Child* (Bantam 1996). Editorial Director, Inner Doorway.

FRANK LIPMAN MD

I speak to you as a practitioner with 20 years of clinical experience, most of it in Integrative Medicine. I would like to share with you what that experience has taught me and how it could be helpful to the next generation of practitioners.

I have learnt from books, workshops and master teachers, but by far, my best teachers have been my patients. From the books I learnt the science of medicine, from my patients I learnt the art of medicine. Getting to see real patients, developing interpersonal skills and seeing that every patient is unique, in how they present, how they cope with disease and how they respond to various treatments, should be a major part of any teaching program. Clinical training should be the gold standard for practitioner training.

Doing this in a multidisciplinary setting, where no discipline or system dominates, is best for patients and practitioners alike. I have gained tremendous insights and knowledge from working together with practitioners of other systems. In fact most of my finest teachers have not been medical physicians.

Finally, Integrative Medicine is more than integrating complementary therapies into our current model. To me, it is about helping my patients become more integrated. To help them become more integrated, I had to become more integrated. What has helped me do that, has been a regular consistent yoga practice. It has helped me be more present and centered, which improves my ability to listen to, to educate and to treat my patients. I feel strongly that teaching self-awareness techniques to practitioners, should be an essential part of any training program.

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To: White House Commission on Complementary and Alternative Medicine Policy
From: Yong Ming Li, MD, PhD, DCH
Re: Proposal on the regulation of medicinal herbs

Li's Proposal on Selling Toxic Herbs

It should be a mandatory requirement at a federal level that:

Any herbal stores including online retailers who sell potentially toxic herbs or herbal products should have a qualified herbalist on site to consult costumers on the toxicity, dosage, contraindications, and other available information.

Note:
1. This proposal is based on the fact that most recent reports on incidences of herbal toxicity are due to misuse, abuse and unawareness of medicinal herbs and herbal products. The proper consulting in most cases is not available to the consumers when they need it. Most incidences in fact can be avoided by simple consulting to herbalists.

2. The qualified herbalist is defined as those who have received minimal three years education in herbology, medicinal herbs, pharmacology, and herbal toxicology, and/or those who are board-certified in herbology such as NCCAOM certification in Chinese Herbology. The category of toxic herbs should be determined by an expert committee.

3. Each state may have additional requirement for the qualifications on consulting herbalists.

4. The proposer recognizes the diverse of schools of herbalists in USA; however, the minimal requirement for the qualification of consulting herbalists should focus on the safety and toxicity.

Proposed by

Yong Ming Li, MD, PhD, DCH

Bachelor in Traditional Chinese Medicine (MD, China)
Master in Physiology, Illinois State University
PhD in Molecular Immunology, University of Illinois at Urbana-Champaign
MD in USA (USLME certified)
Resident Physician in Pathology, North Shore University Hospital, NY Medical School
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The New England Journal of Medicine –
October 26, 2000 -- Vol. 343, No. 17

To the Editor:

The outbreak of Chinese-herb nephropathy in Belgium is an example of serious misuse and abuse of medicinal herbs. The toxic effects are not caused by the ingestion of herbs as they are commonly consumed but by the consumption of a toxic product for an extended period of time as a result of human error and perhaps inadequate training of the practitioners. The original formula for dietary treatment should contain fang ji (Stephania tetrandra) and huo pu (Magnolia officinalis). But the formula used for a mean period of more than 12 months by the patients with renal nephropathy contained guang fang ji (Aristolochia fangchi), as proved by chemical analysis. It is indeed the aristolochic acid in guang fang ji that had renal toxicity.

It is clear from the Chinese National Pharmacopoeia that fang ji is the root of the S. tetrandra plant, whereas guang fang ji is from a totally different plant, A. fangchi. (1) Since fang ji does not have a renal toxic component, the tragedy would never have occurred if the correct herbs had been used in the Belgian dietary clinic.

Guang fang ji and related herbs have antiarthritis and diuretic effects and are often used together with other herbs to optimize efficacy and reduce toxicity. None of these herbs have been used in traditional Chinese medicine for weight control. They have a low level of toxicity and should be used with caution; they should never be used during pregnancy. The proper dose is 3 to 9 g of the decocted herb per day, and the herbs should be used for only a short period of time. The patient's renal function should also be monitored regularly. In the Belgian cases, the physicians apparently did not follow these guidelines of traditional medicine.

Yong Ming Li, M.D., Ph.D., D.C.H.
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References

1. Chinese national pharmacopoeia: color atlas of Chinese herbs. Hong Kong, China: Wang Wen, 1991.

Intakes

An Acid Test for a Carcinogenic Supplement

Despite an FDA Recall, Consumers May Not Find It Easy to Avoid a Toxic Substance in Chinese Herbals

Tuesday, January 23, 2001; Page HE07

The U.S. Food and Drug Administration (FDA) recently asked distributors of Chinese herbal medicines to recall herbal products containing aristolochic acid, which the agency says causes kidney disease and cancer.

"Aristolochic acids are potent carcinogens" and kidney toxins, the FDA reported last year. Even a small amount, which for years may cause no apparent adverse effects, can ultimately cause serious, irreversible damage, including kidney failure. The FDA cites a Belgian case in which more than 70 people who took a months-long regimen of diet pills -- whose ingredients were later found to include aristolochic acid -- subsequently required kidney transplants or dialysis. A study published last year in the New England Journal of Medicine (NEJM) analyzed these cases of kidney damage and associated the acid with renal disease and urothelial cancer.

The FDA action may protect people from aristolochic acid in eight products recalled earlier this month by two firms -- Lotus Herbs and FineMost/QualiHerb, both based in California. But consumers who want to avoid the substance completely face at least two obstacles

First: While one might expect that a staunch FDA warning, backed by authoritative, peer-reviewed research published in NEJM, would dissuade all distributors from selling suspect products, there are still many U.S. vendors selling Ma Dou Ling, Virginia Snakeroot, Canada Snakeroot and Wild Ginger, all of which the FDA says are likely to contain aristolochic acid.

The FDA -- whose authority to regulate the marketing of dietary supplements was severely restricted by Congress in 1994 -- says companies engaged in interstate sales of herbs that contain aristolochic acid will be asked to issue a "voluntary" recall. If they refuse, the FDA can make the recall mandatory.

But many in the alternative and Asian medicine communities oppose efforts to restrict their ability to use herbal treatments. "Many of these herbs have been used for 2,000 years, or longer," says Robbee Fian, president of the American Association of Oriental Medicine, which is based in Catasauqua, Pa. "If there were going to be problems, they would have been showing up."

David Kessler, a former FDA commissioner who is now dean of Yale Medical School, finds such thinking dangerous. "I'm astonished that, in light of the evidence that's been published, anyone would ever consider taking" products that contain aristolochic acid. "I think the evidence is overwhelming," he says.

In a letter to NEJM after the study appeared, Yong Ming Li, a professor of Chinese medicine at the New York College for Wholistic Health, Education and Research in Syosset, N.Y., defended "proper" use of the herbs. Li said they they are often used together with other herbs, which reduces the toxicity of the acid. He also said they should only be used for a short period of time and never by women who are pregnant.

Second: It's nearly impossible for even a well-informed consumer to know which products contain the potentially deadly substance. The FDA says about 30 herb species are likely to contain aristolochic acid. (A list can be found on the Web as "Attachment A" at http://vm.cfsan.fda.gov/~dms/ds-bot2.html.) Another 28 species (listed in "Attachment B") do not naturally contain aristolochic acid but are considered likely to be adulterated with the substance.

Chinese herbs are usually bought through an herbal medicine practitioner, not in a retail environment with standard packaging and labels. "There's no good way, unfortunately, for a consumer to know what's safe," says Kessler.

-- Marc Borb ▮ y

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The comments from TCMA* for the New York City Town Hall Meeting held by HWCCAMP
Jan. 23, 2001

The traditional Chinese medicine including acupuncture is a portion of Complementary and Alternative Medicine and as we don't know others well so our comments are concentrated on the traditional Chinese medicine. Traditional Chinese medicine and acupuncture have certainly played an important role in health care system.

Today, more and more people prefer the natural health care. Complementary and alternative medicine is a tendency which wouldn't stop. Traditional Chinese medicine, in particular, emphasizes the physical and mental balance of the human body. The central philosophy of traditional Chinese medicine is that human beings have the ability to adjust their physical and mental balance with (or without) help from the therapies to improve their system so thus their bodies can overcome the diseases.

It is estimated that 40 states have passed an acupuncture law and about one billion visits per year are related to Chinese medicine including acupuncture, many medical doctors have incorporated acupuncture into their regular practices as well. However, the attraction of huge profit and the variety of educational backgrounds of practitioners plague traditional Chinese medicine in the United States since there is no law at present to regulate the field.

Therefore, we strongly suggest the following measures to be adopted.

1. To help people understand more about traditional Chinese medicine and acupuncture. The federal government should assist the associations with financial support in order to issue an information brochure and magazine and set up a website and hotline for the public.

2. To support the associational finance so that it could use traditional Chinese medicine for health care. The association would introduce a list of the disorders that can be treated effectively by both modern medicine and traditional Chinese medicine. In this manner people could choose the treatment to follow.

3. To support the associations financially so that they could organize and catalogue herbal medicine. The catalogue would contain the herbs functions, indications, contraindications and dosages as well as the composition of the herbs. In addition, the catalogue will be divided into two parts, one lists the herbs are appropriate for daily use as a diet complements and another for treating disorders. The catalogue should be approved by the F.D.A..

4. To pass a law permitting qualified traditional Chinese medical doctors to practice by organizing a standard examination system. Applicants must have 5 years learning in a traditional Chinese medicine school either in USA or China. The applicants that pass the examination will receive the title of traditional Chinese medicine doctor

(T.C.M.D.) and are licensed to practice . In addition, a T.C.M.D. could specialize in a certain area by taking a specific training course and meet the requirements in dermatology, gynecology etc. After the course the T.C.M.D. would be called a T.C.M.D. specialist. The examination for herbology from NCCAOM is not adequate for this qualification.

5. To make it lawful for license acupuncturist to accept payment by patients through Medicaid and Medicare so as to provide the services to a wide segment of the population.

Health care is a profession which related to lives of human and medicine is a science not magic. More evidences should be collected to prove the positive and negative comments on TCM to provide people with accurate and updated information, more strict rules and regulation should be made to control TCM education system especially the qualified teachers in the school.

TCM is originated from China and huge amount of researches is being performed now to offer the best benefit to people. It's better to cooperate with Chinese medical society particularly those work on Chinese medicine and acupuncture. The progress of traditional Chinese medicine in the United States will be dramatically enhanced if there is an active relationship can be developed between two countries.

*TCMA is an academic organization with a commitment to introduce the extraordinary benefit of TCM to the people. All members are graduates from a traditional, Chinese medicine school in China (5-6 years program) and in the United States (3 years program). TCMA publishes a journal semiannually and has her own website (USTCMA.org). In addition, a seminar is held every two months. TCMA is charting the course of the future for TCM as no other association does.
We can be contacted as follows:

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TCMA President Ding L. Peng

To: Michelle Chang, White House Commission on Complementary/Alternative Medicine
From: Joseph Loizzo, M.D., Columbia-Presbyterian Center for Meditation and Healing
Re: Policy recommendations on CAM's role in healthcare waste-reduction

From the vantage of complementary psychiatry, the single largest source of waste in American healthcare today is the neglect of complementary methods of teaching consumers and providers time-tested, evidence-based practices of self-healing and health promotion such as mindfulness-based stress-reduction (MBSR). The disease-fighting strategies and provider-driven interventions of American medicine are at best incomplete and at worst inherently wasteful, because they are reactive rather than preventive; and because they systematically ignore the single most important variable in disease-prevention and health-promotion: consumer health behavior. While mainstream medicine has made remarkable strides in its fight against the obvious killers of modern civilization—heart disease, substance abuse, mental illness and cancer—it has hardly begun to face the insidious killer behind all these masks: our own stress-driven, disease-prone habits. Fifty years of stress research have shown beyond any reasonable doubt that disease-prone habits of mind and action exert a pervasive, corrosive effect on natural systems of defense and healing, leaving us prey to diseases of all kinds. Fortunately, stress research has also brought the good news that stress-reduction methods can tame the killer within by teaching skills to unlearn disease-prone habits and build the natural self-healing competence of our body and mind. The most effective methods of stress-protection and health-promotion to emerge from the new "mind/body medicine"—such as Herbert Benson's relaxation response, Jon Kabat-Zinn's MBSR, James Gordon's mind/body skills learning and Dean Ornish's lifestyle therapy—in fact distil the time-tested self-healing traditions preserved in the Asian healthcare systems of Ayurveda, Chinese and Tibetan medicine (i.e., systems designed to heal without our high-cost, high-risk technological methods). These methods deserve to be singled out as the cutting edge of complementary and alternative medicine, both because they have been shown to be among the safest and most evidence-based of CAM practices, and also because they directly target the largest source of waste in American healthcare: the systematic neglect of the patient's responsibility and right to act in pursuit of his or her own health. Based on this analysis, my policy recommendations to the committee are simple.

- In the short run, to put teeth into the March 1999 National Institute of Health initiative to develop mind-body medical centers by advancing legislation (such as a patients' bill of rights) supporting insurance reimbursement of mind/body programs such as those mentioned above or comparable programs to teach the basic concepts and skills of self-healing.

- In the long run, to build public and professional awareness of the need to complement the reactive, provider-driven paradigm of modern medicine with the proactive, consumer-driven paradigm of self-healing preserved in Asian healthcare systems and applied in mind/body medicine, by seeing that courses in stress-protection and self-healing become required in the basic education of all health professionals.

In Support Of Federal Legislation To Protect Complementary and Alternative Physicians

By Attorney Stephen L. Lockwood
Delivered to the White House Commission
On Alternative Medicine
New York City
January 23, 2001

Federal Legislation should be enacted to protect complementary and alternative physicians from discriminatory disciplinary proceedings by state regulatory bodies whose staffs are uninformed about and therefore biased against safe and effective complementary and alternative medicine (CAM) treatment modalities which compete with current accepted methods of conventional care. The impact of current regulatory enforcement schemes deprives patients of their constitutional right to choose among various CAM treatment modalities by discouraging physicians from pursuing CAM therapies for fear of being the subject of disciplinary actions designed to revoke their licenses. Disciplinary proceedings against physicians are costly to defend. The mere threat of such disciplinary actions has a chilling effect on the use of non-conventional treatments by physicians even though many such treatments are far safer, more cost effective and more efficacious than the accepted conventional treatments. This results in higher health care costs to patients and the nation.

Several states have enacted legislation to provide some protection to physicians who use non-conventional treatments; however, these laws are neither uniform nor sufficient to protect CAM physicians from unfair disciplinary actions. New York State's Alternative Medical Practices Act (Chapter 558 of the Laws of 1994) serves as an example. Passed in 1994, the Act mandates at least two of the more than 200 members of the Board of Professional Medical Conduct be physicians who devote a significant portion of their practice to the use of non-conventional treatments yet there is no requirement mandating that such CAM members of the Board serve on the investigatory or hearing panels in disciplinary actions against CAM physicians. New York's Office of Professional Medical Conduct utilizes medical experts unfamiliar with CAM therapies to evaluate CAM physicians during its investigations. Furthermore, one never learns the identity of the person or persons whose complaints have generated the investigation and disciplinary proceedings.

New Federal Legislation could be part of a Patient's Bill Of Rights designed to protect patients' constitutional right to choose among various CAM therapies by protecting physicians using these therapies from unfair disciplinary actions. Such legislation could mandate education in CAM therapies for state regulatory bodies and that CAM physicians serve on investigatory and hearing panels which are assessing CAM physicians.

Kathleen A. Lukas
300 East 71st Street
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STATEMENT FOR WHCCAM
January 23, 2001

Good evening, I am a founding member of the New York Natural Health Coalition, a consumer group doing research and educating the public about citizen access to **all** health care practices, most especially to those which are natural, low risk, and unregulated in almost all states.

In an era when perhaps half of the citizens of our country use complementary and alternative practices for prevention and treatment, we want you to know that many of us, if not the vast majority, use the services of unregulated practitioners; that is, practitioners currently deemed illegal due to overly broad regulation of the healing arts.

While we understand that the federal government may have little to say about state laws regulating the unlicensed practices we use, from homeopathy to shiatsu, we also understand that the regulatory environment flows in both directions. We know that if it is recognized by this commission that citizen access must be broadened in a way which is reasonable, then it will be easier for our state regulators to hear us.

At present, our access to natural health care practitioners throughout the land is in great danger – and tens of thousands of citizens that use these unlicensed practitioners, often because their disciplines are the only ones having a positive affect on some illnesses, are in danger of losing the most effective and affordable health care they have found. And when we lose a practitioner, the medical doctors, hospitals, and insurers often inherit conditions for which they have no answers, and for which the cost in lives and public and private funds is inestimable.

- Respecting coordinated research and development, we ask that you understand that the practices that we use cannot be tested by the means which allopathic modalities are tested. Natural modalities require new research paradigms, and we cannot be without our health care providers while these paradigms are developed.

- With respect to reimbursement, we believe that nothing interferes with the healing relationship more than a third party payer, although they are sometimes necessary. The natural practices we choose are affordable and effective. We have used them successfully for decades, and we are not seeking the help of insurers.

- With respect to education, certification, and accountability, again the allopathic paradigm cannot be applied. Next month, you will go to Minnesota and see there a model of regulation we can all live with – one which protects the consumers' welfare and leaves citizens with their right of choice.

- With respect to dissemination of information - *support consumer access* - and reliable and useful information will materialize as our practitioners are freed to enjoy all the privileges and responsibilities of their allopathic colleagues, including the right to practice, educate, and advertise.

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[002a]

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The White House Commission on Complimentary and Alternative Medicine Policy (WHCCAMP)

6701 Rockledge Drive, Suite 1010, MS-7707
Bethesda, Maryland 20817-7707

Public Hearing, January 23, 2001

Ames Auditorium, Lighthouse International Conference Center
111 East 59th Street, New York, NY., 10022-1201

Brian J. MacNamara
(b)(6)
Holland, Pennsylvania 18966-2139

Dr. Gordon, Commission members, fellow citizens.

In 1929, an Act of Congress declared Naturopathy a distinct and separate branch of the healing art on the same basis as medicine, osteopathy and chiropractic, and was self-definitive. The authority of this Congressional Legislation, came from codified lex scripta- *The Herbalist Charter* 34 & 35 Henry VIII, c.8 (1542) as common law.

SSA and IRS recognize naturopaths as legitimate healthcare providers as federally defined in the Department of Labor's #079.101-014; continuously listed since 1939. States must yield to federal law when in conflict. Subsuming Naturopathy into medical regulation goes against congressional legislation and intent.

Citizens have the right to access the natural practices and practitioners of their choice without breaking the law.

Integrating all modalities into the current system does not serve the majority of holistic practices. Research methods for efficacy cannot be applied to natural modalities in most cases; traditional forms of regulation do not fit natural modalities, many of which reach proficiency through non-traditional methods including, practicums, apprenticeships, distant learning and study with the masters. For instance, I had the opportunity to study with world renowned Clinical Nutritionist, Dr. Bernard Jensen, DC,ND,PhD on the tenets of Replenishment Nutrition and Iridology. However, the 136 hours of coursework and certification won't appear on any curriculum transcript. Distant learning courses offered by Westbrook University, Trinity and Clayton are but a part of one's education as a nutritional or health consultant, or classical Naturopath. Many already have degrees from traditional schools or are seeking additional related coursework from traditional colleges.

I do not want health insurance reimbursement for natural practices. Our current insurance system has failed by increasing the cost of care and services and by restricting the rights of practitioners and consumers. Low-risk natural modalities should not be put into this failed system. I am happy with the practitioners and their fees as they stand now. However, virtually all clients I have seen have asked if my nutritional services were covered by insurance. I want to be within the law when I see a natural practitioner and I want them free from risk when they see me.

Naturopathic Physicians are first and foremost medical doctors and must be licensed medical doctors. They are already regulated by current means. Naturopaths are *not* medical doctors, they do not practice medicine and the nutritional supplements and herbs they use are not drugs. Therefore, the effort to subsume Naturopaths into medicine and current medical regulation should be stopped.

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002b. testimony	Brian MacNamara (partial) (1 page)	01/23/2001	b(6)

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[0026]

I am a student member of the American Naturopathic Medical Association and certified in Nutrition from the American Naturopathic Medical Certification and Accreditation Board, Inc. which is endorsed by the Federal Intermediary Council of Alternative Medicine (FICAM) registered with all government offices. ANMA's membership is made up of many medical doctors who recognize the value of classical, non- medical Naturopathy. It is through organizations such as these that standards and ethics can be established through certification.

Physicians, Naturopathic or otherwise are already MD's, and must adhere to current law and regulation. The government's acceptance of these organizations will allow consumers to obtain information about modalities and practitioners. I believe those claiming to be Naturopathic Physicians without Doctor of Medicine degrees are breaking the law.

Funding can promote research without licensure or restricting the naturopath's right to exist.
To abolish the non-medical, Naturopath, nutritional consultant or health counselor's right to exist and homogenize Naturopathy into the current medical establishment would not only be unethical, but, I believe, unconstitutional under the previous congressional references, as well as, the Ninth Amendments' protection of innumerable rights we all hold precious.

Brian J MacNamara

Brian J. MacNamara
(b)(6)
Holland, PA 18966

Coordinated Research:

a. *What can be done to expand the current research.*

Enable nutriceutical companies and professional organizations equal access to funding grants. Recognize international studies and practice of alternative therapy.

b. *What types of incentives are needed to stimulate research.*

A radical change in the current policy and attitude toward nutritional supplements and herbs by the FDA including the costly and timely process of approval. Firm U.S. Policy regarding the protection of consumers right to access nutritional supplements and herbs. In example, The United States should not participate in or ratify the CODEX Alimentarius treaty.

c. *How can we integrate CAM and conventional research.*

You cannot. Alternative therapy and Allopathic medicine are diametrically opposed. Conventional research supports the development and patent of chemical compounds and treatment involving these drugs. Alternative therapy advocates natural substances in maintaining health, which cannot be patented or synthetically re-formulated in a pharmaceutical laboratory.

Guidance for Access

a. *Do you have ready access to CAM practices and interventions.*

Yes. The CAM community provides sufficient resources to access a variety of interventions.

b. *How can access to safe CAM be improved.*

By acknowledging existing professional organizations that support current regulations for medical practitioners, as well as, the role of non-medical practitioners ie., American Naturopathic Medical Association (ANMA), American Association for Drugless Practitioners (AADP) Organizations, such as these, recognize the benefit of classical Naturopaths (ND) distinct from Naturopathic Physicians (NMD)which are already regulated and licensed as specialized medical doctors (MD).

Organizations, schools and associations who advocate pseudo-medical training should be investigated and stopped. The standard acceptance, nationwide, of the non-medical, non-licensed Naturopath (ND) and the licensed Naturopathic Physician (NMD) should be implemented and supported through public information.

c. *What types of CAM interventions should be reimbursable through Fed. Programs or health care coverage.*

None.

Training, Education, Accountability

a. *How can uniform standards of training , education, licensure and certification be applied to CAM practitioners.*

By officially recognizing the difference between Naturopathy and Naturopathic Medicine. Naturopaths are non-medical and current schools should participate in and be recognized in the establishment of a national curriculum. Naturopathic Physicians, obviously, must complete current requirements to obtain medical degrees and licenses to practice medicine before studying Naturopathy. Protocols exist regarding the examination and Board certification of Naturopaths and Naturopathic Physicians by organizations which recognize the ethical and legal differences and definitions of both.

Schools which advocate pseudo- medical training and the title of Naturopathic Physician without the proper medical degree (MD) are in violation of the law, in my opinion, and should be stopped. It must be clearly understood that medical doctors require licenses and naturopaths do not.

b. *Training and education*

Current schools, traditional or otherwise, which have a nutritional or Naturopathic curriculum should be invited to participate in the development of a national standard.

Using this standard, medical schools should review it and/or adopt it into their current curriculum, ***if they so choose*** .Medical students may then obtain reliable education in alternative interventions. In any event, medical doctors wishing to become *Naturopathic Physicians* would have access to the curriculum of the previously mentioned schools.

In my opinion, it is the medical establishment which is seeking "complementary" interventions because of its popularity with the public. Alternative practitioners' ideology is not of a medical nature, and therefore, are not concerned with the practice of medicine.

c. *What funds exist for the training of CAM practitioners?*

None that I am aware of.

d. *Are performance standards or practice guidelines needed.*

Yes, only in the sense that practitioners need to be certified in their field by an appropriate professional organization. They need to be licensed, ***if required by current laws.*** Organizations mentioned earlier maintain standards and ethics for their members. I am opposed to the trend to try and pass legislation which would subsume Naturopathy into medicine, and therefore, abolish classical Naturopaths leaving only Naturopathic *Physicians* which, of course, require licensure.

Delivery of Information

a. *CAM information accessibility.*

Official recognition of a national standard of education, certification from an appropriate professional organization and licensure, ***if required by current laws***, would qualify practitioners in the eyes of the public.

Next, practitioners need to be permitted to convey information regarding alternative interventions and modalities to the public without fear of restriction or action from the FDA.

Again, professional organizations dedicated to CAM can provide a reliable source of information to member practitioners and the public at large.

b. *As a consumer, what kinds of information about CAM practices and interventions are most important to you.*

In the event that a condition arises outside the scope of Complimentary/Alternative Medicine, I am most interested in medical doctors who are open to the goals of CAM. I believe, due to the current political atmosphere, medical doctors are generally reluctant to acknowledge any relationship to the benefits of CAM. This is noticed in all branches of medicine. I feel this is out of a need to keep CAM "at bay", rather than ignorance about modalities. For instance, I have experienced the discredit of herbal remedies from several medical doctors in spite of the *Physician's Desk Reference* publishing its second volume of *Herbal Medicines.*

c. *As a healthcare provider, what kinds of information about CAM practices and interventions are most important and needed by you.*

I am extremely concerned about the proper perimeters I am allowed to operate within concerning Nutritional Counseling. However, it is through my own political activism and business research that I have understood my scope. A publication of ***current*** laws and regulations should be issued on a federal and individual state level, rather than trying to pass new restrictive legislation.

I am also concerned with obtaining research information from "accepted" sources regarding herbal compounds and nutrients. This, of course, is required under DSHEA, 1994. Reliable information is published on this subject, but not in direct relation to CAM. I feel a government council empowered to correlate CAM related research would be beneficial to me and the public. I feel it is important to recognize foreign research, as well, even if research methods vary.

Reference:

Act of Congress 1929.

Ch. 352 p. 1326, S-3936; publication #831.
Also found as: 45 St. 1339, 2/27/29

Amendments: HR12169 of 5/5/30 and 1/28/31; House Report: #24321 of 1/30/30

Common Law: codified lex scripta- *The Herbalist Charter* 34 & 35, Henry VIII. C.8 (1542)

Federal Definition: Department of Labor # 079.101-104

Zvenia, NMD,JD, Benjamin. "Status Regarding Colloidal Ag+ +, CODEX and Practice Rights." ANMA Monitor 1.4 (1997) : 18-19

Tuesday, January 23,2001
180 Riverside Drive #10E
NY, NY 10024

To: The White House Commission on Complementary and Alternative Medicine

From: Sherri Heitner/Margalit, Patient Advocate, Breast Cancer Survivor
SHARE Representative - NYC

I am here today as a voice for women whose cancers have recurred. Today I am fifty-one years old - it is my birthday. I attribute the fact that I am alive and healed to my medical care, my family and friends support and love, and to complimentary treatments.

When I was 44 years old I was diagnosed and treated for breast cancer with a mastectomy, CAF chemotherapy, and a saline implant reconstruction. The disease was quite a shock, but after treatment I wanted to go on with my life like it was before cancer. That just did not happen. Three years later I recurred with a Local Recurrence with the same breast cancer, on the same side. At that point despite varied medical opinions, I participated in a Phase II Clinical Trial with High Dose Chemotherapy and Stem Cell Rescue at NY Presbyterian Hospital, which was promoted as a 'cure' and my best chance for 'long term disease-free survival.'

Of course now we know that Professor Bezwoda of South Africa falsified his data, but it has taken 1 1/2 years to disprove his information, and by then many hundreds, perhaps thousands more women had participated in Phase Two Clinical Trials with high dose chemotherapy/stem cell rescue. Currently, it has still not been proven that high dose chemotherapy/ stem cell transplants do increase disease-free survival. We know that HDC/SSR continues to be promulgated as a 'cure' to increasing long term disease-free survival, and offered as treatment alternatives in government sponsored clinical trials. Yet, we also know of the horrific, many times irreversible, side effects of high dose treatments, despite the fact that these drugs at those dosages are ever proven effective as treatments.

During and after each of my medical treatments I employed complimentary treatments to help sustain and heal my physical body, as well as my emotional-spiritual side. I have had a thirty year history of following a vegetarian diet, practicing yoga, employing meditation techniques, massage therapy, and herbal remedies. Yet, my background could not prepare me for dealing with such toxic substances and their side effects. My body was stripped of it's natural immunity which has literally taken years to recover, and I am still wrestling with each winter flu season. I continue to suffer peripheral neuropathy in my feet, as well as osteo arthritis in my back and knees almost three years later due to the Taxol. I have had to fight with insurance carriers to give me a minimum of PT and OT services, for fine motor and gross motor problems due to the chemotherapy treatments. The transplant oncologists knew how to administer these high dose, highly toxic treatments, but not how to reverse their traumatizing effects. Initially, I had been paralyzed from the high dose Taxol, unable to move, walk, or lift a cup without assistance. I required 24 hour care for six weeks.

I had to learn to walk again with a walker and a cane. Did being so debilitated warrant stopping the treatment? Not to the transplant doctors who wanted to give me more high doses of different chemos. I decided not to proceed with further high dose treatment. I felt that it would be ironic to die from the side effects of breast cancer treatment, than the breast cancer itself.

Since that point of transplant almost three years ago, I have lobbied for supplementary services to be provided by the hospital as After Care. These services were not and are still not in place at NY Presbyterian Hospital, where my treatment was done. Patients should not be sent home with a lack of follow-up care, especially if a large portion of their medical treatment was done on an outpatient basis.

I put together my own 'umbrella of supplemental treatments' to help sustain me, but much was out of pocket expenses, because they were not covered through insurance. If government can fund incredibly expensive chemical treatments, why should there not be supportive, supplemental services available for Patient After Care? There should be a center providing traditional Chinese medicine, acupuncture, massage, nutrition counselors, rehabilitative water exercise, counselors to deal with the post traumatic shock of treatment, homeopathy, and herbal remedies, vitamins and supplements, movement and yoga classes, as well as aromatherapy and music therapy. I propose linking research dollars for After Care treatment in these types of Clinical Trials. No IRB's should permit HDC/SSR on human participants without these supportive After Care services.

Thank you for your time listening to this proposal.

WHITE HOUSE COMMISSION
ON
COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

JANUARY 23, 2001
NEW YORK CITY

Ansel R. Marks, M.D., J.D.
Executive Secretary
New York State Board for Professional Medical Conduct

(brief outline of presentation)

1. MISSION STATEMENT of BPMC/OPMC
   -see addendum

2. BOARD - approximately 200 members (2/3 MD, 1/3 public)
   - largest of its kind in world

3. Sensitivity to issues of Complementary and Alternative Medicine
   - Public Health Law §230
     - 2 members of Board/Comp. Medicine
   - Seminar of Annual Meeting of the Board in Plenary Session

4. Origin of cases - 6690 complaints in year 2000
   - reactive not proactive
   - no hidden agenda specifically identifying physicians in a specialty of medicine

5. Investigation Strategy
   - includes over 750 experts

6. Standards of Care
   - national standards
   - negligence/Incompetence - deviation
   - divert patients from acceptable standards → patient detriment

7. Hearing - Fair Due Process
   -findings
   -appeal

BPMC/OPMC MISSION STATEMENT

The Office of Professional Medical Conduct (OPMC) is authorized pursuant to New York State Public Health Law Section 230 (PHL 230) to investigate on its own any suspected professional misconduct and to investigate each complaint alleging misconduct received regardless of the source. This same statute creates the state Board for Professional Medical Conduct (BPMC) which is authorized to conduct disciplinary proceedings and assist in other professional conduct matters by committees on professional conduct. OPMC's mission is as follows:

To protect the public from medical negligence, incompetence, illegal or unethical practices by physicians, physician assistants, and specialist assistants.

To deter the incidence of professional misconduct by physicians, physician assistants and specialist assistants.

To promote and preserve standards of medical practice which conform with applicable laws and regulations.

To respond to expressed public questions and concerns over the quality of medical care.

I am a therapist in two grant programs at a major city hospital in New York City. The hospital serves a poor black community, and I work with abused women, occasionally abused men, and their children in individual and family therapy. There are four points I would like to raise today about which I have become increasingly concerned during my work at the hospital over the last twelve years.

The first area of concern is nutrition. The hospital is a designated heart center, because this community has an extraordinarily high rate of heart disease, stroke, diabetes and other diet-related health problems. Despite this, the city hospital has given the lobby restaurant franchise to McDonald's--this, despite the fact that there is a McDonald's one block away. Every day lines form out into the lobby as staff people, patients' visitors and patients themselves buy unhealthy food. There has been, to my knowledge, no serious, community effort to organize any guidance toward healthier eating, despite the fact that there is no question their diet is killing people.

The second area of concern is that an inordinate number of black boys, ages five to fifteen, are being diagnosed with Attention Deficit Disorder or other, related disorders, and prescribed Ritalin or some other drug. I would guess that seventy-five percent of the boys in this age range whose mothers have been my clients have stated that their children were acting up in school, usually as a result of the chaos at home, and had been tested and treated for ADD. I recently spoke with a pediatrician in a white, middle class, Upper West Side private practice, who told me that his estimate of the percentage of boys he sees with ADD is about five or seven per cent. Two boys who were in danger of this diagnosis but who entered weekly individual and family therapy in our program are no longer thought to be at risk for ADD. This suggests to me that if many of the boys who are acting out at school or at home were given therapy, better attention at school, or some other kind of intervention, they could avoid the special education route which, in the inner city, is often the first step toward dropping out.

A third area of concern is the widespread use of anti-depressants and anti-anxiety drugs that I see. The women who come into our program are in crisis; they are often leaving abusive relationships or simply unable to cope with them any more. They are often depressed. However, when they are referred to Psychiatry, they are usually given anti-depressants, little or no therapy, and sent on their way, often with a referral but without follow-up outreach. Several women who came into our program after a referral from

Psychiatry were on anti-depressants but stated that they were numbed and mentally a little unclear from the drugs. It is very hard to compare cases, but if I could generalize about the women I have seen, those who arrived depressed but unmedicated made faster and better progress in therapy than those who were on anti-depressants.

The fourth problem I wanted to mention is the shortage of batterers' programs in the community and the city in general. Anger management classes, batterers' programs--which are two very different things--and other organized approaches to reducing stress, increasing insight and making behavioral changes should be part of the core of any health organization, including a hospital. It is simply neglect and denial of family violence that allows our city and our country to ignore the need for these inexpensive programs.

For all of these problems, I think that inexpensive, effective resources are available and unutilized. Stress reduction techniques, nutritional guidance, therapy and support groups can all be cheap and effective. It is also worth noting that the older generation of the black community had home remedies and different dietary habits that have been lost to the present generation, which might be recovered or built upon within the community.

WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

TESTIMONY OF DIANE C. MCENROE, ESQ.
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ON BEHALF OF THE NATIONAL NUTRITIONAL FOODS ASSOCIATION

Good evening. My name is Diane McEnroe of Sidley & Austin in New York, General Counsel for the National Nutritional Foods Association ("NNFA"). NNFA is the largest trade association in the United States for manufacturers, distributors and retailers of natural products, including health food products and dietary supplements. NNFA might be viewed as having a less-personal position than many of the people or groups who testified before you today, primarily because it is a trade association. However, many of its members share with millions of others a deeply held conviction regarding the use of complementary and alternative medicine. The retail membership also has an unusual relationship with their consumers as a result of years of face-to-face contact regarding their consumers' health and nutrition goals.

For a number of reasons, consumers are looking for alternate avenues to reduce long-term health care concerns and to decrease costs associated with conventional medicine. NNFA members have seen this and, for years, have been ardent supporters of this approach, sometimes in the face of relentless controversy. More and more consumers recognize the importance of nutrition and new methods of health promotion and disease prevention. NNFA supports this growing desire by individuals to assume more responsibility for their own healthcare.

NNFA members believe in diversity and freedom of choice in matters relating to the health of individuals. An open and competitive marketplace leads to more high-quality options for the consumer. As a national association, NNFA carefully reviews state legislation that would unnecessary limit or constrain the right of people to make health choices for themselves. NNFA would be wary of unwarranted laws that would prohibit qualified people from providing accurate, supported health information and treatments.

NNFA members believe that dietary supplements and other health food products are an integral part of complementary and alternative medicine. NNFA was a strong proponent of the Dietary Supplement Health and Education Act of 1994 ("DSHEA") and the Nutrition Labeling and Education Act of 1990 ("NLEA"), and has been working with its members to continue to educate them on the various provisions of these Acts as they evolve and mature through their respective implementing regulations.

NNFA members believe that these laws are invaluable resources in terms of educating consumers about what products can and cannot do. Manufacturers and retailers are in a position of telling their consumers what a product can do through the use of

"structure/function" claims and health claims. DSHEA's statutory "labeling exemption" also allows for the dissemination of "third party literature" to consumers in the context of a sale, which helps to foster scientific discussion about the attributes of many of these products. NNFA supports further research on these products, so that there is adequate and reliable substantiation for all statements made on product labels and in advertising.

In addition, other labeling requirements established by DSHEA and NLEA help to provide consumers with information about the content of dietary supplements and other nutritional food products. In order to ensure that products are properly formulated and labeled, NNFA has embarked upon the only industry supported program of good manufacturing practices ("GMPs"), jumping ahead of FDA, which has yet to publish its proposed GMP's. As a leader in the industry, NNFA takes very seriously its mission to ensure that safe, quality products are on the market.

The continued access to these products is dependent on DSHEA. NNFA does not want to see legislative or other challenges destroy these essential provisions of DSHEA. NNFA would seek the support of the Commission if any such challenges should come into focus. NNFA would also request continuing efforts to educate the public on complementary and alternative medicine, including the appropriate use of dietary supplements, and request further funding for research into their long term benefits and safe use.

Finally, NNFA expends enormous resources attempting to refute the unfounded position that this industry is entirely unregulated, which, given the adoption and implementation of DSHEA and NLEA, is clearly false. Any support NNFA could receive from the Commission in terms of helping correct this misconception would also be appreciated.

NNFA stands ready to help the Commission in its future endeavors to gain national recognition and understanding of complementary and alternative medicine. NNFA will also continue to lobby for additional funding for complementary and alternative medicine programs, a point that will be reemphasized by NNFA representatives in Washington when formal hearings are held on this matter.

Thank you for allowing us this time. We welcome any questions.

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Statement for White House Commission on Complementary and Alternative Medicine
January 23, 2001

I'll distinguish between conventional or scientific medicine and traditional or natural medicine, which developed before science.

I speak as a consumer who has used natural medical interventions since childhood; as a mother who has raised 2 children with the required annual medical exams and occasional x-rays, but without any conventional medical interventions; and as a traditional practitioner who works only with clients who are also using medical care. I am also founder of the Institute for the Advancement of Complementary Therapies, to raise public awareness of the value of these therapies and to make them more accessible. I have no medical credentials, but I have worked extensively in medical environments, and I have excellent working relationships with a number of physicians, many of whom I have trained in healing. I come from 3 generations of nurses. My parents used physicians but never assumed that doctor visits alone were adequate health care.

20 years ago, it was very difficult to find pediatricians who would work with me, and I was continually reminded that there would be trouble if it ever appeared that my children were not well cared for. Over the years, I developed good relationships with my often astonished pediatricians, who frequently acknowledged that we got faster results with natural techniques than they could not have gotten with conventional medicine.

I didn't find choosing natural practitioners any more difficult than choosing a good conventional doctor. What has been difficult is knowing that most services we depend on, and all of the services I provide, are actually illegal because the government does not separate natural, non-invasive health care practices—many of which are really lifestyle interventions—from the practice of scientific medicine, which clearly requires a high level of expertise.

I never needed a physician or lab test to tell me something was wrong with my health or my children's—I always knew from subtle observations. And it's not that I've been so successful with natural medicine because I have a constitution of steel, because I don't. On the contrary, I'm very sensitive, and as a single mother supporting 2 children, I'm often over-worked. My health care involves constant tweaking to bring me back to balance and very little time spent actually in balance.

Patients who are treated with natural medical techniques by conventional medical professionals, are most likely not getting the best traditional care. Conventional medicine

rests on science, is highly technical, and requires rigorous training. Natural medicine rests not only on traditional knowledge, but also on intuitive skills and wisdom. The best traditional practitioners have meditative skills that are built with years of practice. Very few people are able to take both conventional and traditional medical practice to a high level of expertise.

Please use your influence to create an environment of diversity and freedom in health care. Nowhere, not even in our chosen worship, do we enact our beliefs the way we do when choosing our health care. Patients who believe in their care-givers and their techniques have better medical outcomes. We need to be able to follow our passionate commitment. Most people who use natural therapies do so as an adjunct to conventional medicine. But there are those, like myself, who through living with traditional values and lifestyle, will avoid the need for much of the medical care that Americans use routinely and think is irreplaceable. Please remember us and include our well-being in your recommendations.

Thank you for all the good work that you are doing and for the opportunity to speak today.

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The following are responses to the specific questions I checked in my registration. Responses are in bold type.

1. Coordinated Research and Development to Increase Knowledge of Complementary and Alternative Medicine Practices and Interventions.

What can be done to expand the current research environment so that practices and interventions that lie outside conventional science are adequately and appropriately addressed?

There needs to be a vehicle through which science can recognize the limits of its usefulness, its delineation of practice. Clearly science is very useful, but many valuable aspects of life simply do not fall under scientific inquiry. Once scientists recognize the inherent limitations of scientific investigation, perhaps there can be an appreciation of what science can learn from beyond the boundaries of its paradigm. In society, in education, and in politics, we hear a lot about diversity. Science hasn't recognized the powerful way in which diversity enhances our understanding.

Science is a closed system. Natural medicine is an open system. Science may be used to prove the efficacy for specific techniques in specific situations, but it can never prove natural medicine as a whole. Scientific medicine has so much more to learn from natural medicine than a few techniques to substitute for pharmaceuticals. There is the context of holism, so vital protecting the patient. There are also issues of personal responsibility, mental hygiene, lifestyle, the empowerment of participation, what science dismisses as placebo.

That being said, valuable research into CAM can only be done by teams that include expert natural medicine practitioners. It's not enough to have someone who is technically advanced in the specific intervention being studied; that practitioner, or another, must be wise in the ways of traditional medicine. I say that with the experience of having done research.

2. Guidance for Access to, Delivery of, and Reimbursement for Complementary and Alternative Medicine Practices and Interventions.

Do you have ready access to CAM practices and interventions?

I have ready access, but most of it is illegal. The legal scope of medical practice is very broad, and only those therapists who are identified by licensing, such as acupuncture, are protected from the charge of illegal medical practice. Most of the therapies I use are not licensed, nor should they be. They are so low risk that they do not warrant licensing. But because they are so safe as to not require licensing, and because the legal definition of medical practice is so broad, they fall under the legal practice of medicine.

How can access to safe and effective CAM practices and interventions be improved?

Through disclosure of practitioner's education and experience. Why not let the consumer decide what is safe and effective? Look at all the people who are using CAM under their

own auspices already, with far fewer errors than happens when pharmaceuticals are used accurately by highly skilled physicians.

We need stronger protection for those products, such as herbs and supplements, that are under federal jurisdiction, something that guarantees that we won't lose access to these products because of a piece of legislation

What types of CAM practices and interventions should be reimbursable through federal programs or other health care coverage systems?

I am not a fan of the third party payer. For one thing, it cements the myth that our health care is outside our reach, and does not encourage patient participation in any real way. As a practitioner, I am not interested in having my services covered by insurance. Most CAM practices are very affordable when compared to medical services. Of course, there is a population for whom even very affordable is not affordable, and so it makes sense to have CAM practices available in clinics which treat people on government assistance. I have set up some programs, for example, in which people with AIDS or cancer are trained in Reiki self treatment to help them manage stress.

If insurance is going to cover services, it makes sense for it to reimburse at least practices which give people skills of self care, such as meditation, yoga, t'ai chi, Reiki, aromatherapy. If not coverage, perhaps there could be incentives for taking such training, or for active participation in on-going groups, such as meditation groups or yoga classes.

3. Training, Education, Certification, Licensure, and Accountability of Health Care Practitioners in Complementary and Alternative Medicine.

How can uniform standards of education, training, licensure and certification be applied to all CAM practitioners?

It doesn't make sense to have uniform standards for such a wide range of therapies which clearly require different levels of training and involve different levels of risk. Some practices obviously don't require monitoring—meditation, vibrational or subtle energy healing such as Reiki, aromatherapy, to name a few. Why not have full disclosure of training and experience for all practitioners—even those with medical licenses—and let the public use common sense?

It would be helpful to include some level of education regarding practitioner-client interaction for all therapies. Learning a healing technique does not necessarily make one sensitive to clients' needs, or aware of how to create a positive healing environment. These are of concern to all health care practitioners. Alternative practitioners as well as physicians have been known to exhibit a fanaticism that is not conducive to healing.

What training and education should be required of all health care providers to assure access to safe and effective CAM practices and interventions?

Patients are safer when health care providers have a deep understanding of holism, a sense of watchful waiting, and knowledge of how to recognize true emergencies. Learning respect for holistic principles in medical school would give physicians a wise perspective in which to use invasive but necessary medical procedures and protect patients immeasurably.

In addition, providers, especially those likely to be supervising treatment plans, should understand the various levels of care and participation necessary to maintain health, such as physical manipulation, nourishment, self-expression, spirituality, etc. Knowing the fundamentals of several approaches in each category is helpful. For example, physical manipulation includes everything from dance, yoga, and sports to massage and chiropractic. It's important that providers learn about self-care techniques and lifestyle interventions as well as clinical interventions.

Are performance standards or practice guidelines needed to ensure the public will have access to the full range of safe and effective CAM practices and interventions?

No, but full disclosure about a practitioner's training and experience is. Patients should be informed that a physician may have as little as 100 hours of acupuncture. Then they can decide if they feel safer there or with a non-physician who has years of training. An educated consumer is a safer consumer, and practitioners should be encouraged to inform clients of the basics tenets of their approach. But performance standards or practice guidelines written from a medical understanding will only serve to restrict the benefit of traditional medicine, because it does not fall within the scientific paradigm. Natural medicine, for example, includes healing and a change in consciousness as central to successful treatment. Conventional medicine is satisfied with cure, and often leaves the patient cured of a specific disease, but very unhealthy.

4. Delivery of Reliable and Useful Information on Complementary and Alternative Medicine to Health Care Professionals and the Public.

How can useful, reliable, and updated information about CAM practices and interventions be made more accessible? How would you like to receive such information?

It will likely take a government investment in a public awareness program. The information that is available in popular media is generally superficial. Much of it comes with meaningless advice like "Be sure to tell your doctor what you're doing." What patient will tell his doctor something that may threaten their relationship? And patients are discouraged from confiding to the doctor because even an open-minded doctor generally isn't informed. Good information that includes not simply facts but also perspective must be available through all media.

As a consumer, what kinds of information about CAM practices and interventions are most needed and important to you?

Fundamental to both consumers and providers is an understanding of holism. Otherwise we are simply substituting herbs for pharmaceuticals, which has some benefits, but which leaves out so much of value, and does not engage the consumer. Patient participation is an important part of traditional medicine, and consumers need to be educated not just about therapies they receive from providers, but also about what they can do, or easily learn to do, at home and throughout their day. Both consumers and providers need to be aware of any practices that involve real risks.

As a health care provider, what kinds of information about CAM practices and interventions are most needed and important to you? **See the above response.**

In closing, it is important to realize that CAM really involves bringing some techniques, and perhaps a little perspective, into mainstream medicine, and that effort is to be applauded. Most people will use CAM therapies in that way. But there is a larger issue at stake. Americans must be free to choose those health care approaches that reflect their deepest beliefs, even if they fall outside mainstream medicine, and our government must

protect the inviolable relationship between spirituality (not religion) and healing. People cannot deeply heal without accessing spirit. This is a basic tenet of traditional medicine from all cultures.

Let physicians control the medical environment—as long as individual patients are able to have workable concessions to their trusted approaches, such as homeopathic arnica or Reiki vibrational healing to speed healing post-op, as adjuncts to needed medical care, but allow those of us who reach beyond the parameters of conventional medicine to pursue our values legally in the private sector.

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New York State 1994 Legislative Session

S-3636 A-5411

THE Alternative Medical Practice Act

Providing complementary options to conventional care

AN ACT to amend education law in relation to the use of alternative and complementary medical therapies by licensed physicians. Would provide guidelines for the use of these therapies; would prohibit charges of professional misconduct based solely on the use of alternative or complementary medical therapies with the patient's informed consent.

The objective is to bring professional medical conduct statute in conformity with case law and allow patients to receive the treatment options that they seek from licensed physicians.

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COURTESY OF
Monica Miller and Tim Sheridan, representing the
Foundation for the Advancement of Innovative Medicine
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REPORT OF THE PHYSICIAN DISCIPLINE PROCESS EVALUATION PANEL ON NON-CONVENTIONAL MEDICINE

By Chapter 735 of the Laws of 1992, the New York State Legislature created the Physician Discipline Review Panel ("Panel") to review the structural and procedural aspects of the physician discipline process in New York State. The Panel is charged with assessing the overall goals and objectives of physician discipline, how well the goals are being met, and whether and to what degree the process serves to minimize or deter misconduct.

By Chapter 558 of the Laws of 1994, the New York Legislature expanded the scope of the Panel's charge by directing it to make recommendations to the Governor and the Legislature by June 1, 1995, concerning:

(1) The use of experts, including experts in medical specialties or experts in non-conventional medicine by the office of professional medical conduct in the investigation of complaints which involve issues of clinical practice, and

(2) the appointment of physicians, including physicians in a medical specialty and physicians practicing non-conventional medicine, to committees on professional medical conduct hearing a case in

which a physician in such specialty or a physician practicing non-conventional medicine is the respondent.

In addition, the Chapter expressly authorized physicians' use of "whatever medical care, conventional or non-conventional, which effectively treats human disease, pain, injury, deformity or physical condition." It also provided that there shall be at least two physicians appointed to the physician discipline board "who dedicate a significant portion of their practice to the use of non-conventional medical treatments that may be nominated by New York State medical associations dedicated to the advancement of such treatments." Further, the legislation provided that the investigation committee could retain experts to aid in the investigation of cases referred to the investigation committee who also might be recommended by associations "dedicated to the advancement of non-conventional medical treatments."

We understand that this legislation was generated by concern that physicians practicing non-conventional medicine were being unfairly punished for their use of their unorthodox methods of treatment. We sought to determine whether, in fact, this was true.

Non-conventional medicine is not defined in the statute. We adopt for our purposes, however, the definition used by the New

England Journal of Medicine (Eisenberg, et. al., "Unconventional Medicine in the United States", January 25, 1993 at 246-252) as "medical practices that are not in conformity with the standards of the medical community" and as "medical intervention not taught widely at U.S. medical schools or generally available at U.S. hospitals."[1]

Using these definitions, we have identified eight physicians practicing non-conventional medicine who have been disciplined since 1988. We have reviewed each of these cases and we conclude that none of the doctors was disciplined for practicing

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[1] The Office of Alternative Medicine of the National Institutes of Health classifies seven separate types of "alternative medical practices": (1) Structural and energetic therapies, including, for example, acupressure, chiropractic, massage therapy; (2) pharmacological and biological treatments including anti-oxidating agents, metabolic therapy and cell treatment; (3) bio-electro magnetic applications including use of electro-magnetic fields, electro-stimulation, artificial light treatment; (4) diet, nutrition and lifestyle changes, including macrobiotics and megavitamin treatment; (5) mind and body control, including bio-feedback, relaxation techniques and hypnotherapy; and (6) traditional and ethnomedicine, including acupuncture, homeopathic medicine, Native-American medicine and other ethnic remedies which are significantly different than prevailing western medicine; and (7) herbal therapies.

non-conventional medicine per se.[2] Rather, the physicians were disciplined for failing to adhere to universal standards of care applicable to all physicians, whatever their philosophy concerning appropriate treatment. In most of the cases, the physician failed to take adequate patient histories; failed to undertake proper diagnostic procedures; failed to properly advise patients of their condition; failed to keep adequate records of patient progress; or failed to refer patients to specialists when their condition warranted such referrals. In many of the cases, the hearing committee expressly declined to consider the appropriateness of the alternative therapy used. Thus, we do not find that physicians practicing non-conventional medicine are being unfairly treated in the physician discipline process.

Of course, the efficacy and appropriateness of a particular form of therapy cannot be ignored in any proceeding

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[2] One physician was disciplined for treating patients with nutritional therapy that the hearing committee found to be a fraud on his patients. This determination was based, in part, upon the committee's belief that there was no scientific evidence to support the therapy and that the physician failed to obtain patients' informed consent to perform experimental treatment. This determination was reversed by the Board of Regents, which found the Committee's conduct of the hearing to be flawed and its reasoning unsupported by the evidence.

Another physician was disciplined for treating patients with agents unapproved for the treatment of cancer that had been shown by scientific study to be ineffective. However, he was also disciplined for failing to refer the patients for hospital treatment and for improper record-keeping. In a subsequent disciplinary proceeding, the same physician was disciplined for persistent errors in diagnosis, record-keeping, and other practices unrelated to the form of treatment.

challenging a physician's competence. In this regard, we note that Chapter 558 allows physicians to use non-conventional medicine "which effectively treats human disease, pain, injury, deformity or physical condition." Where a physician undertakes a course of treatment which has not been shown to be at all effective for the patient's condition, such treatment could raise questions of competence and outright fraud.

We have reviewed the literature relating to non-conventional or alternative medicine, met as a group with Dr. James Gordon, Chair of the Advisory Committee for NIH's, Office of Alternative Medicine, about the myriad forms of non-conventional medicine, and have received the Position Paper of the Foundation for the Advancement of Innovative Medicine. We are aware that many of today's accepted procedures were once considered non-conventional. We recognize the desire of patients, especially those faced with conditions that conventional medicine cannot effectively treat, to try experimental therapies which have not been shown to be effective through controlled studies, and therefore are not generally accepted by the medical community.[3]

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[3] In allowing physicians to use non-conventional medical care which "effectively treats human disease, pain, injury, deformity or physical condition," the Legislature may have unduly limited patients' opportunities to try alternative therapies. As Dr. Gordon points out, "people leave conventional medicine and go looking for something else, not because they're sure the other thing is going to work, but because they want to see whether it might work." (emphasis in the original). Gordon, "Why Patients Choose Alternative Medicine." The Internist, September 1994 at 7.

In such cases, we believe it is imperative that the physician adequately disclose to the patient the experimental and untested nature of the therapy proposed and advise the patient of the availability of conventional therapies. Non-conventional treatment without such disclosure is, in our opinion, medical misconduct.

We now proceed to review the specific issues referred to us by the Legislature.

I. Use of Experts in Non-Conventional Medicine In the Investigation of Complaints.

Where appropriate, the Office of Professional Medical Conduct ("OPMC") should be free to use experts in non-conventional medicine to investigate complaints concerning physicians practicing in that field. However, OPMC should not be bound by any requirement to use such experts since the charges against such physicians may involve deviations from standard medical practice. As licensed physicians, those practicing non-conventional medicine must still adhere to accepted standards of practice, including use of appropriate diagnostic procedures, the provision of full and accurate information to the patient and the referral of the patient to appropriate specialists or other caregivers where appropriate.

II. Appointment of Physicians Practicing Non-Conventional Medicine To the Hearing Committees.

We agree with the Legislature's decision to include physicians practicing non-conventional medicine in the physician discipline process. However, we believe that legislation mandating the appointment of such physicians to every hearing committee involving the discipline of a physician practicing non-conventional medicine should be rejected for three reasons:

First, it is not necessary to have on the hearing committee an expert practicing in the same specialty or form of medicine as the respondent in order to determine whether the physician practiced universally-accepted standards of medicine. Where procedures particular to a specialty or form of non-conventional medicine are at issue, the OPMC and the respondent are free to call expert witnesses to educate the hearing committee.

Second, such a rule would embroil OPMC in unnecessary and undesirable legal challenges over the non-conventional credentials of hearing committee members.

Finally, OPMC never has been required to constitute its hearing committees to conform to the particular specialty or field

of expertise of the physician respondent. To require it to do so now would only complicate the already severe difficulties that OPMC has in constituting hearing committees and scheduling hearings. The Legislature's policy of having physicians judged by their peers has obvious advantages; but it also has the disadvantage of making it more difficult to bring hearing committees together for the many multi-day hearings that must be conducted. Requiring physicians practicing the same non-conventional medicine as the respondent to be part of the hearing committee would create an administrative nightmare.

June 1, 1995

Respectfully submitted,

PHYSICIAN DISCIPLINE
PROCESS EVALUATION PANEL

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Comments on the Report of the Physicians Discipline Process Evaluation Panel Pursuant to Chapter 558, Laws of 1994

dated June 1, 1995, released June 21, 1995

On behalf of the Foundation for the Advancement of Innovative Medicine

We are surprised by the departure of this report from the mandates of §4 of C.558, L.1994, which was a specific request for a report limited to two issues defined as 1) using similarly practicing experts in investigations of misconduct and, 2) using similarly practicing physicians in hearings on misconduct.

Two immediate concerns arise from our review of this document:

- The report is dominated by a misplaced, and yet cursory, investigation of the claim that non-conventional physicians have been treated unfairly in the past. In addition to stepping well beyond the bounds of the panel's charge, this preoccupation has given rise to erroneous conclusions in regard to the issues that were mandated by the statute.
- The report indulges in a quasi-judicial opinion which is wholly inappropriate within the parameters set forth for this panel by §4 of C.558, L1994 and §6 of C.735, L1992[1] viz., opining that the use of non-conventional treatment without adherence to a criteria beyond the requirements of law (the panel's prescribed disclosure), constitutes misconduct.

In explaining further the particulars of our first concern, it should be noted that the review of misconduct cases involving non-conventional practitioners cases appears to have been very brief. No information is given regarding the breadth and depth of the review, and whether hearing transcripts were read in full. This point is crucial because of C.558, L1994. Before, it was common for the hearing committees to decline to give time to considering the appropriateness of the non-conventional treatment because the assumption was that by being non-conventional, the treatment, and all that led to it, was inappropriate. The change of law in 1994 eliminated that assumption and the exclusion of evidence and expert testimony[2] that resulted from it. The relevance of non-conventional cases prior to the change of law in 1994 to the mission charged to this panel is directly impacted by that change, which can only be evaluated by reviewing the full transcripts of the hearings and re-assessing the evidence based a upon the new standard of inclusion. There is no indication in this report that such a reassessment took place. Instead, given the brevity of the presentation, it appears that the review of those cases included only hearing committee or administrative review reports both of which, of course, include only that which substantiates their findings.

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[1] §6 of C.735, L.1992 originally constituted this panel to assess the goals, objectives, and performance of the physician discipline process and whether its outcomes are in the public interest.

[2] It is this point, the exclusion of evidence, which led to the Regent's last reversal, to which a footnote in the report did allude, but did not explain, and which the report ignored in determining there had been no unfairness.

The report's first conclusion, that there should be no requirement for the use of experts from the field of non-conventional medicine to investigate complaints against non-conventional physicians, fails to consider that the deviations from standard medical practice may be medically appropriate to the non-conventional treatment and the patients using it, and hence, that an expert practicing similarly must be a part of any investigation where such clinical decision making is at issue. The discussion here also fails to even mention the merits of such linkage where quality of conventional care is at issue.

The report has three reasons for then concluding that there is no need to mandate a non-conventional physician for hearing committees judging non-conventional physicians:

First, that any physician can determine misconduct against "universally accepted standards," and that panelists may be educated to more specific concerns by expert witnesses. The reliance on expert witnesses to educate the panel would be appropriate were the case heard by a jury panel of lay persons, or an administrative law judge alone. But the system in New York is review by peers for the purpose of a having access to certain knowledge and experience in the assessment of proper medical conduct. Case law has settled that the expected level of assessment is accomplished by physicians possessing the "requisite knowledge and expertise," Enu v. Sobol 171 A.D.2d 378.

Second, that such a rule would "embroil" OPMC in litigation challenging the credentials of panelists. Perhaps — but, we can imagine wording for such a rule that would give format for that challenge within the procedure and preempt costly judicial review.

Their *third* reason is two-fold. Appropriate peer-review is simply unnecessary because it has never been required before, and that there is already enough difficulty in constituting panels for review without adding further requirements. Citing the difficulty in constituting panels of working professionals may be a fair assessment of current operating conditions. But, to give this situation greater weight than the advantages afforded by appropriate peer-review — which the report does recognize as the legislature's policy — without the analysis which the legislature requested of the panel, is prejudicial.

In conclusion, we can only attribute the wayward execution of this report to the desire of the panel to meet some purpose other than that which was placed before them by the legislature. This report avoids the real analysis and discussion of the pros and cons of specialty or modality specific peer-review which was called for by the legislature. This has the effect of diminishing the overall value of peer review, and it falls short of the effort anticipated by the statute.

Sincerely,

Monica Miller
June 26, 1995

Kerry Marsh, Esq.
Marsh and Associates, P.C.

NEW YORK STATE

LAWS OF 1994 CHAPTER 558

Senate bill 3636-c/ Assembly bill 5411-c
Amendments to law are underlined

Section 1. Subdivision 4 of Section 6527 of article 131 (The Practice of Medicine) of Title Eight (The Professions) of the education law is amended to read as follows:

4. This article [Article 131.] shall not be construed to affect or prevent the following:

a. The furnishing of medical assistance in an emergency.

b. The practice of the religious tenants of any church.

c. A physician from refusing to perform an act constituting the practice of medicine to which he or she is conscientiously opposed by reason of religious training or belief.

d. The organization of a medical corporation under article forty-four of the public health law or the organization of a professional service corporation under article fifteen of the business corporation law.

e. The physician's use of whatever medical care, conventional or non-conventional, which effectively treats human disease, pain, injury, deformity, or physical condition.

Section 2. Subdivision 1 of section 230 (Professional Medical Conduct) of the public health law as amended by chapter 606 of the laws of 1991, is amended to read as follows:

1. A state board for professional medical conduct is hereby created in the department in matters of professional misconduct as defined in sections sixty five thirty and sixty five thirty one of the education law. Its physician members shall be appointed by the commissioner at least eighty five percent of whom shall be from among nominations submitted by the medical society of the state of New York, the New York state osteopathic society, the New York academy of medicine, county medical societies recognized by the council of medical specialty societies, and the hospital association of New York state. Its lay members shall be appointed by the commissioner with the approval of the governor. The Board of Regents may also appoint twenty percent of the members of the board. Not less than eighty five percent of the physician members appointed by the Board of Regents shall be from among nominations submitted by the medical society of the state of New York, the New York state osteopathic society, the New York academy of medicine, county medical societies recognized by the council of medical specialty societies, and the hospital association of New York state. Any failure to meet the percentage thresholds stated in this subdivision shall not be grounds for invalidating any action by or on authority of the board for professional medical conduct or a committee or a member thereof. The board for

professional medical conduct shall consist of not fewer that eighteen physicians licensed in the state for at least five years, two of whom shall be doctors of osteopathy, not fewer than 2 of whom shall be physicians who dedicate a significant portion of their practice to the use of non-conventional medical treatments who may be nominated by New York state medical associations dedicated to the advancement of such medical treatments, and not fewer than seven lay members. An executive secretary shall be appointed by the chairperson and shall be a licensed physician. Such executive secretary shall not be a member of the board, shall hold office at the pleasure of, and shall have powers and duties assigned and the annual salary fixed by, the chairperson. The chairperson shall also assign such secretaries or other persons to the board as necessary.

Section 3. Paragraph (a) of subdivision 10 of section 230 of the public health law as amended by chapter 606 of the laws of 1991, is amended to read as follows:

(a) Investigation. (i) The board for professional medical conduct, by the director of the office of professional medical conduct, may investigate on its own any suspected professional misconduct, and shall investigate each complaint received regardless of the source.

(ii) If the investigation of cases referred to an investigation committee involves issues of clinical practice, medical experts shall be consulted. Experts may be made available by the state medical society of the state of New York, county medical societies and specialty societies, and by New York state medical associations dedicated to the advancement of non-conventional medical treatments..

Any information obtained by medical experts in consultations, including the names of licensees or patients, shall be confidential and shall not be disclosed except as otherwise authorized or required by law.

Section 4. Amends chapter 735 of the laws of 1992 to read as follows:

The panel shall also report to the governor and the legislature by June 1, 1995 concerning (i) the use of experts, including experts in medical specialties or experts in non-conventional medicine by the office of professional medical conduct in the investigation of complaints which involve issues of clinical practice and, (ii) the appointment of physicians, including physicians in a medical specialty and physicians practicing non-conventional medicine, to committees on professional medical conduct hearing a case in which a physician in such specialty or a physicians practicing non-conventional medicine is the respondent.

NEW YORK
STATE
SENATE
ANY, NEW YORK 12247

JOSEPH R. HOLLAND
SENATOR, 38TH DISTRICT
CHAIRMAN
SOCIAL SERVICES COMMITTEE

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5578

July 20, 1994

Elizabeth D. Moore
Counsel to the Governor
Executive Chamber
State Capital
Albany, NY 12224

RE: Legislative Sponsor's Memorandum in Support of S. 3636C

Dear Ms. Moore:

It is my understanding that the above referenced legislation has passed both houses of the Legislature and will shortly come before the Governor for Executive action. I would like to lend the following comments in support of the legislation.

The bill is a result of negotiations with the State Department of Health, the State Office of Professional Medical Conduct and the Higher Education Committees of the New York Senate and Assembly.

This legislation recognizes the role of licensed physicians in the practice of legitimate non-conventional medical treatments. It does so by stating in Article 131 of the Education Law, which deals with the practice of medicine, that nothing in that section of law shall be construed to affect or prevent a licensed physician from using medical care conventional or non-conventional which EFFECTIVELY treats human disease, pain, injury, deformity or physical condition.

The first part of the bill does nothing more than specifically acknowledge non conventional medicine in Education Law as to what they already should be able to do.

The language for the new paragraph in subdivision 4 of section 6527 is actually a restatement or affirmation of the language in section 6521 which defines the practice of medicine in New York State as treating for any human disease, pain, injury, deformity or physical condition.

Just last year the New England Journal of Medicine (the accepted journal of standard, conventional doctors) admitted that 1 in 3 Americans have used alternative or non-prevailing medical therapies, with visits to alternative practitioners exceeding those to primary care physicians in 1991. If we prevent or discourage physicians from non conventional treatments, it is clear that the estimated 6 million New Yorkers who seek these treatments will be undeserved and we will force them to resort to unlicensed providers rather than our highly trained and skilled doctors.

Case law already overwhelmingly extends the rights of patients to make non conforming medical decisions and extends that right to enable licensed physicians to assist in those decisions. [Schloendorff v. New York Hospital, 211 NY 125 (NY's highest court) and Atkins v. Chassin NYS 2nd (1993)]. The Federal government has recognized non conventional medical practice and in fact Senator Harkin sponsored and implemented a $12 million study allocated to the National Institute of Health (NIH). Columbia University Medical College and Albert Einstein Medical College both have existing Departments of Alternative Medicine. Albany Medical College now offers classes in alternative medicine pursuant to requests by the medical students.

The next specific act of this legislation amends section 230 (1) of the Public Health Law to provide that at least 2 of the licensed physicians who serve on the existing State Board for Professional Medical Conduct shall be physicians who devote a significant portion of their practice to the use of non conventional treatments. Licensed physicians who are investigated

and charged with professional misconduct pursuant to Public Health Law must undergo a peer review process to determine the validity of the charges and what, if any, penalty should be imposed. The peer review hearing committee consists of 3 people from the membership of the State Board for Professional Medical Conduct. The process is supposed to ensure that a doctor charged with misconduct receives fair consideration by those best qualified to judge his practice and treatments. Since there are currently no non conventional doctors who are members of the Board, no legitimate peer review currently exists. Therefore, this bill would add 2 peers to the Board.

The Assembly sponsor and I agreed to 2 members since it was suggested as a fair representation by the Counsel for the NYS Department of Health. Actually, by my calculations since there are 230 members currently on the Board (18 is the statutory minimum) and there are approximately 71,000 doctors in NY, then a weighted representation would be that each Board member should represent 323 doctors. Since about 1,000 of those 71,000 doctors currently provide non conventional therapies, there should be 3 members on the Board.

Again, this section simply addresses that the potential for abuse exists in a peer review system that does not have any peers. According to the community of non conventional doctors they are judged prejudicially by conventional doctors who discount their treatments and often impose upon them penalties more severe than those assessed against conventional doctors found guilty of equivalent charges. This bill does not provide representation to one type of specialist. Alternative Medicine is not a specialty but rather treatments that differ from the prevailing. In fact, there are various specialties of Alternative Medicine but this bill does not address those specialties just as existing law regarding the Board does not address conventional specialties.

The bill also allows the investigation committee to consult experts that can be made available from non conventional medical associations.

The last subject that the bill deals with is simply a directive to a current study panel to study issues of non conventional and specialty physicians as related to the Office of Professional Medical Conduct (OPMC).

Accordingly, this legislation is designed to safeguard patient's rights and guarantee legitimate due process for non-conventional physicians by removing institutional disincentives to the use of sound non-conventional physicians on the board for professional medical conduct, a degree of equity will be restored to the process. No rights or privileges would be granted to non-conventional physicians through this legislation that are not also granted or do not already exist for conventional medical doctors. Most importantly, quality of care will be enhanced through the constructive participation of non-conventional physicians in the disciplinary process. Providing for nominations and other contributions from organization of New York physicians supporting these therapies will encourage the development of responsible community standards. Ultimately, by protecting the rights of non-conventional physicians throughout the misconduct process, this legislation secures the rights and freedom of patients to choose their medical treatments.

Thank you for your time and consideration.

Sincerely,

JOSEPH R. HOLLAND
State Senator

JRH: sbk

White House Commission on Complementary and Alternative Medicine Policy
January 23, 2001

Good morning Commissioners;

My name is David Molony. I am an Oriental Medicine professional and the Executive Director of the American Association of Oriental Medicine.

As health care providers, we appreciate your efforts to gather information about traditional and modern methods of health care diagnosis and intervention. We have been surprised at how many have come forth to comment before your commission, and we look forward to receiving the compilation of your efforts so we can better work with our patients as they wander the maze of "alternative" therapies.

We believe that quality standards of care are best developed and assured through high standards of education and examination. Our goal is to develop the professional doctorate degree as the standard for the practice of Oriental Medicine in the United States, as it is also being developed in the European Union, and as it has been found to be best practiced in the Asian countries from which it originates. Of course, in any field of medicine, there is room for many levels of health care providers, from vocational to professional, and many niches to be filled by these varying levels of education, even within Oriental Medicine.

While standards vary from state to state, we have come a long way since 1973, when no licensing existed for our profession. Today, we are licensed in most states.

One of our nationally accredited exams is in Chinese Herbal Medicine. Recently, there has been some misleading reports in the press about the dangers of certain Chinese herbs, and we expect another of the same this week. The FDA has forced the recall and destruction of products for which there have been no reports of illness or injury.

Nearly ten years ago, a number a kidney failures were reported in Belgium after patients took a cocktail of drugs and herbs prescribed for weight loss, including the Fen-Phen drug combination. Who prescribed them? Licensed medical doctors with little or no herbal training who used their reading skills to create cocktails much like a bartender would. They knew little or nothing about Chinese herbal medicine, proven by the fact that those herbs are never used in that form, for that reason, or for that length of time, so that any toxic results could not have been predicted. Not only that, but they were also the incorrect herbs because of misidentification, which once again goes along with a poor education. Two more similar cases appeared in Great Britain in 1998, once again resulting from failure to seek the advice of a qualified Chinese herbal practitioner who might have noticed that the herbs being taken had been misidentified, misused, and/or combined inappropriately with conventional medications.

How can such illnesses and injuries be minimized? Simply by adopting the educational and examination standards that are already in place for Chinese Herbal Medicine in the United States and China. It's an easy and effective choice. While FDA-approved drugs prescribed by medical doctors kill hundreds of thousands of people in this country, Chinese herbal medicine, in the hands of qualified practitioners, is not only effective, it is relatively benign. In the hands of untrained individuals, however, we can make no guarantees.

Please feel free to contact us with any questions on this and any other subject relative to Oriental Medicine.

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003. testimony	Tsao-Lin Moy (partial) (5 pages)	01/23/2001	b(6)

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Testimony to: The White House Commission on Complementary and Alternative Medicine Policy. January 23, 2000 – Commission Meeting on Training, Education, Certification, Licensure, and Accountability of Health Care Practitioners in Complementary and Alternative Medicine; Topic: Standards of education, training, licensure and certification in the field of Acupuncture and Oriental Medicine.

Good Afternoon Members of the Commission, thank you for your attention today. My name is Tsao-Lin E. Moy, I am a second year student at Tri-State College of Acupuncture, working towards a Master's Degree in Acupuncture and Oriental Medicine. I am also in the two year accredited Chinese Herb program. (this is a 450 hour program which prepares me to sit for the NCCAOM national exam in Chinese herbology and receive diplomat status)

I am a Licensed Massage Therapist since 1998 with a practice in NY and I assist in teaching at the Swedish Institute for Massage Therapy. In addition I have a BS in Int'l Trade and Marketing.

I will be offering the Commission testimony and insight on the standards of education in an accredited Acupuncture and Oriental Medicine program; the rigor of the program, the didactic hours, the hands on skills and supervision, observation/clinic hours, electives, human service skills and independent study.

I am passionate and committed to my education and training. What has been most challenging for me as of student of Acupuncture and Oriental Medicine is learning to open my mind, to put aside my cultural biases and develop creative and abstract thinking.

An accredited Acupuncture and Oriental Medicine program is 3-4 years; approximately 2,200 hours of study and training. More than 50% of those hours is devoted to hands on skills and supervision, observation and clinical experience. The remaining hours are for lectures, electives and independent studies.

[003]

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The commitment to study, the hours of hands on skills, and clinical training provide an educational foundation for the theories of Acupuncture and Oriental Medicine.

I have outlined a description of coursework and hours.

First Year- 850 hours
170 hours of lecture:
Chinese philosophy provides the philosophical basis of Acupuncture and Oriental Medicine; The 5 diagnostic filters (Yin Yang, Qi/Blood/Fluids, Zang Fu, Five Elements and Meridian). Describing and distinguishing which filters a practitioner uses for arriving at an acupuncture diagnosis.

The fourteen major pathways of acupuncture energetics; including internal pathways, acupuncture points (locations and energetic functions), symptomatology and indications. The secondary vessels (tendino-muscular, divergent, luo) and the 8 Extraordinary Vessels.

Treatment planning and basic techniques and strategies; The Four Examinations, Nine Steps of Treatment Planning and Eight Principle Evaluations; pulse, tongue and Hara confirmation.

250 hours - Skills review and hands on contact: 80 hours includes palpation of meridians, point location, hara evaluation, tongue and pulse; in small supervised groups we practice basic techniques of needling, moxibustion; gua sha, cupping, auriculo-therapy and clean needle technique.
50 hours of body work training. A minimum of 20 hours of written independent patient documentation/project. 100 hours of direct patient interaction experience.

60 hours- Observation/Grand rounds, Clinical Hours: As part of our clinical experience we observe and learn from senior acupuncture practitioners treating actual patients.

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At Tri-state we are exposed to a unique synthesis of various traditions of acupuncture such as: Japanese, TCM, Meridian, Vietnamese, Korean and French. These practitioners include: Dr. Mark Seem, Kiiko Matsumoto, Arya Nielsen, David Legge and Dr. Richard Tan.

These practitioners are long time leaders in the field of Acupuncture in the U.S. and have all published texts that help set the standard of education for the future Acupuncture and Oriental Medicine provider in the US.
The students in the Chinese Herb program are taught by Andrew Gamble, translator and editor of the Materia Medica Chinese Herbal Medicine.

70 hours – Human Service Skills:
Addressing communication and evaluation skills, client – centered training, patient / practitioner and professional training for clinical encounters.

90 hours – Independent Study Project:
Monthly workbooks, personal journals, and writing and research assignments.
170 hours – Anatomy & Physiology, Pathophysiology
40 hours – Electives

Second Year – 635 hours:
170 hours lecture:
We learn in depth the fundamentals of Chinese physiology and how that physiology may be used to trace the etiology of a disharmony. A much deeper understanding of the philosophical basis of Acupuncture and Oriental Medicine is applied to recognize signs and symptoms, and learn appropriate treatment strategies in each individual case rather than just memorizing a set of points for a text book pattern.

100 hours - Skills review and hands on contact:
In small supervised groups we learn and practice needling protocols through the meridian/zang fu, 5 elements and TCM diagnostic filters.

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135 hours- Observation/Grand rounds, Clinical Hours: Clinical Observations and Grand rounds become core to our learning experience. Following and documenting the treatment strategies and protocols used by senior acupuncture practitioners, gives us further understanding and insight into clinical application of Acupuncture and Oriental Medicine.
70 hours – Human Service Skills
90 hours – Independent Study Project
40 hours – Electives
30 hours – Pathophysiology

Third Year – 720 hours
In the third year, the training, knowledge and experience in Acupuncture and Oriental Medicine comes to fruition. Students take the NCCA exams.
Influenced by various traditions in acupuncture, students are encouraged to develop their own style. A deeper understanding and clinical knowledge is applied in clinical rotations. Students plan treatment strategies and treat patients in Clinic under the supervision of senior acupuncture practitioners. Having access to senior practitioners for advice in clinic is an invaluable clinical experience.

120 hours Lecture
55 hours Field Seminars
100 hours Skills Review
85 hours Grand rounds/ Clincal hours
250 hours Clinical Practicum
90 hours Independent Study Project
20 hours Supervision.

The Tri-State Acupuncture and Oriental Medicine program is representative of the standard of education in an accredited program and the minimum requirement to practice as a competent provider of Acupuncture and Oriental Medicine.

[003]

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Recommendations to the Commission:

1. I recommend that the Commission look to the existing creditialing bodies for guidance, and support the standards of education in Acupuncture and Oriental Medicine that have been established by the NCCAOM, ACCAOM and the State Education Dept of NY.

2. I recommend that the Commission not support abbreviated training programs, that these greatly diminish existing standards of competency and training; and ultimately diminish the quality of care available to the general public.

Thank you for your time today, I am available for follow up and assisting the Commission with further inquiry and documentation.

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Testimony to the White House Commission on Complementary and Alternative Medicine Policy

January 23, 2001

Ridgely Ochs
Health and medical reporter
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Good evening, ladies and gentlemen. My name is Ridgely Ochs and I am a health and medical writer for Newsday, a 600,000 circulation daily that covers Long Island and Queens. Thank you for giving me the opportunity to address you today. This is an issue of genuine importance to consumers and one that frankly deeply frustrates me as a journalist.

Almost two years ago now, my editors and I decided that I should do a project on alternative medicine. I was excited at the prospect. Every day then--as now--I received letters, call or emails from companies touting some wonder "all natural" cure for everything from impotence to flabby thighs to cancer. I received calls from advocates who felt that their treatment was either being ignored or maligned by mainstream medicine and deserved to be publicized And I also received a fair number of queries from people curious--like me--about whether any or which of this stuff worked.

At a deeper, cultural level, I, like many others, also sensed that the alternative medicine movement represented a profound frustration with mainstream medicine where the focus is all too often on the illness, not on the patient. What a great story, and also what a great opportunity for the paper to help the consumer figure out how best to help him or herself. Based on the evidence, I was going to tell people what works, what doesn't and how to tell the difference.

Or so I thought. When I finished the project, I was downright depressed.

Newsday had been ambitious. We worked with Hofstra University in 1999 to conduct a random digit dialing poll of 1,056 Long Islanders and 600 Queens residents patterned on the Harvard poll conducted by Dr. David Eisenberg in 1990 and again in 1997. We asked them in-depth questions about whether they used any of 16 alternative therapies, how often they used them and why. We asked them how much they paid for them and whether they were covered by health insurance.

What we found was that about 58 percent of Long Islanders and 50 percent of Queens residents had used one form of alternative medicine in the previous year and one third had used two or more. We found that usage cut across gender, age, class, racial and ethnic lines: no one group was more or less likely to use an alternative therapy. Most reported that they were using the therapies to keep themselves healthy and most were fairly new to alternative medicine. Two-thirds of herb users--the most popular alternative medicine, used by about one-third of respondents--had been using them 5 years or less. It was clearly a popular and growing phenomenon, not a marginal movement of a fringy few.

The most disturbing finding was that although 59 percent said they considered doctors to be the most reliable source of health information, less than half of those surveyed said their doctors knew they were using the treatments. Only 17 percent said they began using the treatment on advice of their doctor. About 3 in 10 of herb users said they didn't know whether the herbs caused any interactions with other herbs or drugs.

This was particularly alarming because we were getting reports from local doctors that more and more patients were showing up for surgery with erratic blood pressure or bleeding problems that they suspected could be caused by supplements. Other doctors I interviewed told stories of patients, who, when asked, would show up at the office armed with shopping bags full of expensive and exotic supplements. I interviewed a man from Queens who suffered a subarachnoid brain hemorrhage. There was no sign of an anuerysm, the usual cause of such an event, and the doctor said he initially wondered if the man had ingested rat poison. It wasn't rat poison.

It was two aspirins a day, several garlic preparations, 240 milligrams of ginkgo biloba and 3 teaspoons of omega oils--all of which can thin the blood. In addition, he was taking niacin, coenzyme Q10, high doses of vitamin C and E, a vitamin B complex, chromium, potassium, magnesium, bilberry, cranberry juice, grape seed extract and lecithin. He hadn't told his doctor about any of these supplements and his doctor hadn't asked.

Why hadn't his doctor asked? Probably because he didn't know much about these preparations and perhaps had a strong bias against their use.

And this gets into probably the most frustrating aspect of covering alternative medicine. Generally in covering a mainstream drug, device or procedure there are studies one can read and experts one can interview. There may be considerable controversy about the safety and efficacy of the drug or device but there is at least the assumption that there is some sort of objective, scientific truth out there somewhere, or soon to be revealed in a study under way.

Not so with alternative medicine. I soon learned that there were precious few studies and precious few experts whom I could trust.

I probably don't need to tell this commission that what is and isn't allowed under the DSHEA amendment in terms of structure and function claims is downright confusing to the average consumer. Look at a bottle of echinacea capsules and it says "helps maintain immune function." What does "helps maintain immune function" mean? Food helps to maintain immune function. This is essentially a meaningless phrase, and since the companies don't have to base their claim on scientific studies, doubly so. And as you well

know, there's little financial incentive for herb or supplement companies to do the studies.

And some companies, particularly those that operate on the internet , simply flout the law. I did a story on colloidal silver, sold on the internet and in some heath food stores to cure everything from acne to AIDS, although the FDA has concluded "it is not generally recognized as safe and effective.''

Indeed. In some cases it can lead to argyria, an incurable condition in which the skin turns permanently gray. I interviewed a former Long Island woman who has spent the last 40 years the color of a gray filing cabinet because her doctor believed it would help her sinus condition. Nevertheless, you can still go in the internet and find sites that tout its use.* The sites are also full of scientific-sounding testimonials that do not stand up to close scrutiny but can certainly can be misleading to consumers.

Getting solid information on more "mainstream" supplements can be equally frustrating. Because herbs were the most popular alternative medicine used and the ones that had the most obvious potential for causing physiological impact, we decided to look at the scientific evidence on five of the top-selling herbs, ginseng, saw palmetto, echinacea, ginkgo biloba and St. John's wort.

I consider myself a fairly good ferreter of information--that is, after all the job of the journalist But it often took me weeks to find studies. The National Library of Medicine's PubMed, which certainly is a primary source of studies on mainstream therapies, remains a poor source of information on alternative medicine. Information on the website of The National Center for Complementary and Alternative Medicine, while comprehensive as far as it goes, is quite limited: there are essentially three fact sheets available.

When I did find studies, I found that most up to now have been small, not always well designed and for the most part can't be called definitive or "proof' that the herb works. Most were done in Asia or Europe, primarily Germany, and until recently have not even been available in English--meaning that most U.S. doctors --forget the consumer--would not have been familiar with them. Many I looked at included handfuls of participants, were short-term--lasting weeks--were not always double blind or looked at end points or diagnoses that included terms not used in this country. For instance, many of the studies examining ginkgo biloba looked at its effectiveness in treating "cerebral insufficiency,'' a term most U.S. doctors are not familiar with

In some cases there were dosage and purity questions. What was the active ingredient? Was the right ingredient being tested? For instance, three types of echinacea are used medicinally. In addition, different parts of the plant are used. Different studies have looked at different combinations of preparations and different doses. Which is correct?

Or the studies looked at the herb in ways it's not usually used. Many of the studies conducted in Asia I saw on ginseng, for instance, have looked at its use in athletes or healthy young volunteers. But generally it is used as a tonic in older people or in people lacking vigor. So how applicable are these studies? Not very, I suspect.

The bottom line, I found after months of research and thousands of words, was in most cases as clear as mud. Were these herbs safe? Most were probably, although some like St. John's wort should probably be treated more like a drug. Were they effective? Some were, maybe. Should people take them? I couldn't really say.

As for the experts, I realized soon that the world of alternative medicine generally divided into two camps, the practitioners and mainstream doctors and scientists: The true believers and practitioners often choose to remain outside of mainstream medicine and often care little for scientific study or objective analysis. In many cases, I believe they are motivated by a genuine desire to help their patients; in some cases, I suspect they are simply ripping off the consumer. But since much of alternative medicine remains unregulated, there was and is no easy way for me as reporter to help the consumer figure who is who.

Many mainstream doctors--who normally would be a source of information for me--remain ignorant or strongly biased against alternative medicine, precisely because it has not been studied in a rigorous way. Those doctors or researchers who try to act as a bridge to both worlds often do so at their own peril. I covered the rise and fall the alternative and complementary center at the State University of New York at Stony Brook. The debate over the role of the center and its director deeply divided the faculty at the university, attracted national attention and mirrored what one source termed the "religious war" going on in this country between the believers in mainstream medicine and the believers in alternative approaches. Finally, the university let the director go and closed the center. Many Long Islanders were deeply disappointed; they were looking for a source in the community they could trust. As in many wars, the ultimate victim was the innocent bystander.

Which brings me again to the ultimate problem: Where does one go for reliable information? No where really. While I have found a handful of researchers and doctors I

trust to help me through the thicket of hype and hysteria, there are very few sources out there who don't have a financial or political agenda and not enough real studies to offset those agendas. The public needs help.

Thank you for your attention.

*A random and not comprehensive search for websites touting the curative qualities of colloidal silver for everything from sinus problems to Lyme Disease to AIDS include: www.wishgranted.com; www.ctaz.com/~mystical/silver/; www.colloidal-silver.com

I first realized many years ago that I wanted to be a dancer. I went to college and studied with the best professors and instructors that money can buy. But ultimately, it was my uniqueness and skills that would land me job opportunities. It was what I could do that made my services sought after, most prominently, in teaching. No one ever asked to see my license to dance or to teach dance for that matter. It was understood. So, I've lead the life most Americans dream of: absolute freedom of choice and persuit of happiness in my work-until now.

Learning reflexology seemed a very natural extension of my dance career. I am already in teh business of adjusting bodies, strengthening muscles and postures through movement. I offer sound advice based on my experience inthe trade. When I was informed that I would have to go to massage therapy school and obtain a massage therapists license to do reflexology (this in addition to the years of study alreday in teh field). I was angered at first, then confused. Reflexology is not the same as massage therapy. That's when I found out about all the other healing modalities that must lie in wait to be discovered because licensing is not available in their field.

Natural healingpracticioners need not fear being accused of practicing medicine without a license. They do not claim to be medical doctors. We practicioners must be able to practice our art. We are a vital part of society. In some societies, we existed before western medicine ever set a penicillen coated, pharmeceutically driven foot on it. They have their place in the world but so do we. Must we be judged by their standards solely?

My solution to this situation is simple. Let the practicioners govern themselves. Allow them to provide full disclosure of their pertinent information to their clients/consumers. Perhaps their trainuning was in an institute of higher learning or through time honored traditions past from generation to generation. Let the professional affiliations and referrals lend credibility, where they exist. Does it really make sense for me to get a cosmetology license to be able to perform reflexology? I guess it would if I also wanted to paint toenails.

Ultimately, a consumer will persue what brings them happiness and a sense of well-being, it just makes things a whole lot easier when it can be done legally.

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To the Members of the Commission: **January 23, 2001**

My name is C. C. Pai. I am a co-founder of AcuMD.com, a content-based website that aims to deliver comprehensive and comprehensible data and information on Chinese Medicine to medical professionals and the general public.

We have experienced a number of difficulties in developing the first-class content for our site:

1. Data that meet scientific standards are very limited.
2. Most lab and clinical data are from China and Taiwan and are in Chinese.
3. Few websites and databases provide comprehensive and comprehensible information for consumption by the general public.
4. Translation from Chinese into comprehensible English is challenging.
5. There are no clear rules, regulations, and guidelines about what can be published on the Web.
6. Funding of such a project is difficult.

Chinese medicine has remedied billions of people for more than four thousands years. More and more scientific studies have confirmed that Chinese acupuncture and herbs can be highly beneficial for patients with various medical ailments and diseases. Credible information should be delivered to the general public as soon as possible so that people understand Chinese medicine and can make sound decisions as to whether to pursue such alternative treatments.

To help overcome difficulties in compiling such information, we recommend the following:

1. Encouragement of investment and funding to develop websites with credible information.
2. Establishment of guidelines as soon as possible concerning presentation of lab and clinical data in the Internet.
3. Aggressive funding of scientific testing for Chinese medicine in order to collect reliable clinical data, with special attention to clinical data generated from China and Taiwan.

Thank you very much for your attention.

Chao-Chyan (C.C.) Pai, Co-Founder
AcuMD.Com
26 Deerfield Road
Brookfield, CT. 06804
(203) 775-1681(Phone)
(203) 775-2110(Fax)
E-mail: Laobai@aol.com

- Members of the Committee, Ladies and Gentlemen of the audience good afternoon. My name is Janice Pingel and I live in Scarsdale, New York.

- I have had two bona fide cures with the help of Accupuncture, of that I am certain. - In 1990, after eight years of excruciating lower back pain, which no medical doctor could help me with, I turned to Alternative medicine which was Accupuncture. I turned to it, but with no expectations of success. Six sessions later I left that office, pain free. I have never had another seizure; that was eleven years ago.

- In 1996 I suddenly developed severe leg pains. This time I went directly to Accupuncture treatment to my present doctor, Doreen Chen. After eight treatments and the consumption of Chinese Herbal tea, I left her office healed with no further problems.

- Now to my present situation:
In 1997 I was diagnosed with, incurable neuro-endrocrine cancer of the lung with metastises to the liver. I began very aggressive Oncology treatment with Dr. Sara Sadaw and at the same time returned to Dr. Chen for bi-monthly needle treatment to support my immune system. At that point my oncologist would allow no consumption of herbal tea from Dr. Chen. A small remission occured and I was out of treatment for six months. I continued with Dr. Chen and was now able to drink her tea. That was sometime in 1998.

- In October 1999 I returned to Dr. Sadaw for weekly treatments of Taxol, which continues to this day. At the same time a new tea, Cordyseps-Militaris was released in China for treatment of lung, liver and kidney cancer. This time I prevailed upon Dr. Sadaw to allow it to be part of my

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treatment. She was very openminded to this request and agreed.

- CT scans are given every three months. In September of 2000 my scan showed all leisons in the lung are gone and Cancer growths, which had covered the liver were decreasing.

- Both Dr. Sadaw [who has written testimony on my case to my insurance Company] and Dr. Chen believe as I do that the Combination of allopathic and homeopathic medicines are having a Curative effect on my kind of Cancer at this present time. My January 10th CT scan also showed very positive results in tumor stabilization.
- Thank you very much for allowing me to share my story.

Mrs. L. W. Pingel
(b)(6)
Scarsdale, NY 10583-2724

(b)(6)

The White House Commission on Complementary and Alternative Medicine Policy
Town Hall Meeting – Tuesday, January 23, 2001, New York, NY
Presentation by William Prensky

Commissioners of the White House Commission on Complementary and Alternative Medicine Policy, staff to the Commission, fellow panelists and presenters, and friends –

It is an honor to have been invited to address you today concerning the issues of integration in education for Acupuncture and Oriental Medicine and the barriers to integration in both education and in the practice of my profession. My name is William Prensky, and I am Director of the Graduate Program in Acupuncture and Oriental Medicine at Mercy College, in Dobbs Ferry, NY, and Chief of the Division of Acupuncture at Sound Shore Medical Center in New Rochelle, NY.

Mercy College is the first regionally accredited, Comprehensive Graduate Institution to introduce and integrate the study of Acupuncture and Oriental Medicine into the normative curriculum in professional Health Sciences. In 1996 Mercy College merged the study of Acupuncture and Oriental Medicine into a community of students and faculty working in all aspects of health care in a full array of graduate program in Allied Health, while maintaining the specific flavor and separateness of this field of study.

In a unique collaboration, Mercy College has joined with Sound Shore Medical Center of Westchester, an accredited teaching hospital with five accredited residency programs and three post-graduate specialty fellowships, to introduce the education and clinical training of Licensed Acupuncturists into the hospital inpatient setting. In addition, we have created at Sound Shore Medical Center the first fully implemented Division of Acupuncture staffed and led by Licensed Independent Providers of Acupuncture and Oriental Medicine which functions to bring Acupuncture services to all patients within the hospital.

As you are undoubtedly aware, the barriers to the integration of these practices, which have demonstrated a clear value to contemporary health care, remain in place long after the evidence of their value has been presented. Many things contribute to the reluctance of the system to accept new modalities and systems of thought, and chief among these barriers are inequities and insufficiencies in the education of professionals in all branches of medicine and health care.

We are faced with a number of questions, which surround the question of integration. Key among these are:

- What is the role that Acupuncture and Oriental Medicine can play in contemporary health care?

- What is the role for Acupuncture and Oriental Medicine in hospital based practice?

- What is the most cost effective way in which to deliver this medicine to patients?
- What is the most cost effective way in which to train and educate the professionals in AOM?
- What education is needed for contemporary medical students and physicians to allow them to integrate the knowledge about the availability of AOM for their patients?
- To what extent should AOM be considered a part of medicine?
- To what extent are AOM practitioners physician extenders?
- How do we prepare teachers for this medicine, and who teaches it in both AOM schools and in medical schools?
- From where will we get the future educators and researchers in this field?
- How can this practice be made more available to those patients for whom it is most beneficial?

We can address some of these questions by presenting you with a picture of what we have been doing and what we have learned over the past five years as we have integrated acupuncture and oriental medicine into hospital-based practice. It is important to note that until now acupuncture and oriental medicine, as practiced both by its own independent licensed providers and as practiced by physicians with no standardized training in the field, has been largely isolated from the mainstream of health care delivery. This isolation has resulted from a number of things, chief among which are failures of reimbursement schemes and resistance to integration by hospitals and clinics.

This isolation has been exacerbated by the isolation of AOM education. Taught until now only in stand-alone, small schools built upon the technical training model, there has been no strong academic infrastructure support, and, therefore, no buy-in by academic medicine or by academic allied health care.

But AOM offers us a unique opportunity to revisit both the nature of allied health care education and the relationship of allied health care to medicine, both in practice and in academics. Let me explain.

All students in the Mercy College graduate AOM program earn a masters degree in acupuncture and oriental medicine. To earn that degree these students must engage in two educational activities that are unique to the program.

1. They must engage in 5 semesters of in-hospital, inpatient training, during which time they rotate with a variety of medical teams in the hospital.
2. They must complete a formal research thesis, which generally consists of designing and implementing a clinical trial in the integration of AOM into contemporary therapeutics.

Indeed, four of the theses recently completed have pilot data so compelling that they are being used as the foundation for NIH research grant applications.

Why is this important? Because there must be two new intentions fulfilled by education in this field.

1. Evidence for the inclusion of acupuncture and oriental medicine must be a priority for our educational system.
2. Training for hospital based practice must be seen as a necessary step in developing pathways towards employment that will bring this medicine to the place where sickest patients are – that is, hospitals.

To accomplish this we are in the process of expanding our program and developing a new offering, the first post-graduate clinical and research specialty residency program for acupuncture and oriental medicine. Beginning in 2000, Mercy College funded 3 full-time post-graduate Teaching Fellows in AOM, who are engaged in developing with us an academic and clinical program which will prepare them to develop Acupuncture Services in hospitals around the country and to serve as the Chiefs of those services.

Our message, then, is clear. AOM must develop, and we are developing, the academic and clinical educational structures, knowledge, training and research to provide the information needed to integrate this practice into contemporary health care. This must, by its nature, be done not by marginally trained professionals in other fields, but by dedicated professionals in this field who wish to move the bar on academics to the highest level. The development of a true Ph.D. in the field of AOM is the necessary next step.

Given these goals, what policy changes need to be made to help implement them?

1. There must be enhanced federal support for AOM education at the highest academic levels. Certainly these supports must include participation in the Federal Stafford Loan Forgiveness Program, as well as enhanced outright grants for study for those groups under-represented in the field.
2. Federal funding support for hospital based residencies in AOM for AOM professionals needs to be developed.
3. We need increased federal support for AOM research, aimed at both providing evidence for the value of integration and, at the same time, for developing innovative means of asking questions. This support must be aimed at developing research competency within the field itself. And this research support needs to open funding availability to unconventional approaches to

research, exploring methodology which is not only linked to Randomized Clinical Trials based upon pharmacologic research but also is rooted in inquiry into the cultural context of medicine and the questions which pertain to each paradigm.

4. Training grants as well as research grants are needed, to develop the fundamentals of basic allied health education in this field and the nature of advanced academic research and education for the field.
5. The educational infrastructure of AOM has to be clearly identified and supported as separate from other disciplines, both in medicine and allied health. Respect for AOM as its own discipline and its own scholarly pursuit must be placed against the interest of medicine and other health sciences in the components of this discipline.
6. Federal policy which opens Medicare and Medicaid reimbursement for AOM is crucial if hospital based patient service is desirable, which it is.

Over the past five years our students have been a part of the hospital life at Sound Shore Medical Center, and the medical students and residents and house staff of Sound Shore Medical Center have rotated through the Acupuncture Center. As the two groups of dedicated students and providers have interacted, a number of lessons have been learned.

1. AOM students and faculty and medical students, faculty and residents can all learn to work together to enhance patient comfort. As the AOM Service has become a part of the tapestry and backdrop of normal everyday hospital life, patients and staff have come to expect it. Indeed, one of the most telling moments for us in these five years was the instance when a gerontologist was speaking with a patient in long-term rehabilitation and commented: "What more can we do for you – you have the anesthesiologist, the physical therapist and the acupuncturist who have all been seeing you every day. We are doing everything that we can." At that moment we knew that we had integrated and had become a part of the daily life of the unit.
2. The ways in which AOM can assist patients and hospital staff to attain better results are numerous – pilot projects we have conducted include the use of acupuncture in helping patients tolerate hemodialysis, in controlling peri-operative pain, in reducing dependence upon inhaled medications for acute and chronic respiratory disease, and in controlling intractable pain in terminally ill patients.
3. AOM students have not contributed significantly to our knowledge about the efficacy of integrated AOM because we have isolated them until now in separate schools and away from hospital based research. When they are integrated they contribute significantly.
4. The greatest barrier to integration is lack of understanding of the complexity of AOM and the nature of training in the field. As the medical and other staff at Sound Shore Medical Center came to understand the complex nature of the three-year, 141 credit program in which the Mercy College students were

enrolled at the masters level, they came to respect and rely upon the AOM faculty and students for daily service.

Let me leave you with one thought.

The future is not some place we are going to, but one we are creating.

The paths to it are not found, but made, and the activity of making them changes both maker and destination.

By creating a system which is built upon mutual respect we have arrived at an integration of service which has excited everyone in both institutions and involved educators and clinicians at every level in developing new integrative models. With your help we can develop models which can be applied for patient benefit throughout the country.

Thank you.

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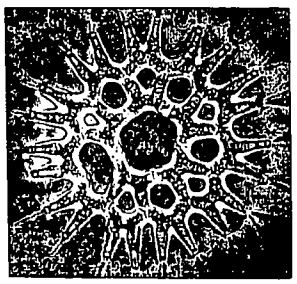

White House Commission on Complementary & Alternative Medicine
Tuesday, January 23, 2001
By Camilla Rees

Panel theme: *"Maximizing the Economic Impact of Assimilation of CAM Modalities Through Enhancing Market Forces, Creating Efficiencies through Individual Empowerment, and Waste Reduction by Targeting Root Causes of Illness"*

Good morning. Thank you for this opportunity.

My name is Camilla Rees. I speak to you today from the perspective of a patient who has had chronic health problems for 5 years

I was very surprised by what I learned being a patient in our health care system—especially the crushing realization that the insurance premiums I had paid bought me—and millions of others with chronic illness—little value. Most of what was helpful I paid out of pocket and would fall into the category of CAM.

I suspect most individuals, including policymakers—unless they have had close personal or family experience with serious or chronic illness—do not realize there are deeply rooted, misguided orientations in the health care system today that fuel costs, and that contribute to poor outcomes that further fuel costs.

I will focus today on 5 issues I found to contribute to inefficiency and waste. My overriding policy recommendation to you is to see these qualitative issues become quantified. **I firmly believe the dialogue with policy makers needs to focus on the economic ramifications of the *quality of care* today--the root of the problem—and to associate CAM with the solution.**

If these economic ramifications were communicated to the corporate market, they too would act quickly to support CAM, providing important horsepower.

For background, in my own case, it took 3 years of endless doctors appointments and lost productivity before I arrived at root causes of autoimmune conditions, which I was told were unknown, but which turned out to be environmental.

The 5 issues are:

1) Doctors seem to have very little **education** about how to support health, and focus narrowly on drug solutions. *Patients need information on how the human being works—not medical consensus on how to live our lives—but on what supports life, across all dimensions, and why.*

2) The health care system is not oriented to looking for **root causes** of serious illness, including environmental causes that are very significant. *We need to have courage to work at the root level, and to conduct research into programs and methodologies that address root issues. It is only when we look at root issues that we can find solutions.*

3) There exists a **slow "serial" approach** to treatment based on a single practitioner's limited knowledge, instead of on a much broader body of knowledge that exists. *We need to lay out information as broadly as possible for each condition, covering multiple perspectives—and acknowledge that patients' wisdom and intuition are then crucial aspects of choosing the right solution. We need acknowledgment of the value of multiple perspectives, and investment in information infrastructure.*

4) Physicians who practice outside of the orthodox norms are marginalized, if not investigated, resulting in a **fear-based culture**, patient hesitation and confusion, delay in getting care and often unnecessary duplication of medical support. *We need to stop private medical and dental associations from essentially using the power of the state, through licensing boards, to enforce narrow medical protocols—stifling competition in the name of fighting fraud. We need to support CAM practitioners—at a minimum through equal representation on licensing boards.*

And finally,

5) The health care system is **not oriented to results**—there is no "health" goal in health care, and no accountability.

We talk about inflation in the health care sector, but no one is counting the dollars spent by people who never get helped in the allopathic model, and whose situations escalate, resulting in more intensive usage. No one is counting the people with chronic illness who go from doctor to doctor but never get well, because there is no model for supporting health.

We need independent leadership in this sector—to honestly highlight the structural flaws in the system, shine a light on their sources, understand their economic implications, and create vision for what the health care system could become.

Thank You.

Camilla Rees is a strategic business consultant in private practice in New York. She is also an executive coach, and counsels business people on taking a multi-faceted approach to supporting health and performance. She was formerly in investment banking, and during the health care reform debates in 1994 co-produced a white paper entitled "The Economic Impact of Health Care Reform" (with co-panelist Grace Marie Arnett) on behalf of Montgomery Securities. Camilla combines 15 years of business experience in investment banking, venture capital, marketing communications and corporate identity with 5 years as an active student of health optimization, wisdom traditions and technologies fostering integrated wellness.

Good morning. My name is Sharon Reilly and I am from Windsor, CT. I am here as a mother and consumer of direct-entry midwifery services as well as the president of Friends of Midwives in Connecticut (FOM/CT).

My husband and I have 2 daughters. While we considered having a homebirth with our first, it was difficult to obtain information about this option and I was unable to locate a midwife.

During my first birth – a breech born in the hospital – I was not permitted to drink water during labor despite tremendous thirst, I was strapped to a continuous electronic fetal monitor, attached to an IV stand, my labor was artificially induced with Pitocin, an episiotomy was cut without my permission, the placenta was pulled out of me almost immediately following the birth, my baby was whisked away from me for testing minutes after her birth, and what little sleep I got was regularly interrupted for blood pressure checks. Even though this was considered to be an exceptionally "good birth," it was, without a doubt, a medical birth. I wondered what non-medical birth was like.

For the next pregnancy, I paid out-of-pocket for the services of a Certified Professional Midwife (CPM). My prenatal visits generally lasted 1-2 hours with no wait. The routine was that when I arrived, I checked my own urine, weighed myself, and reported my findings to the midwife. Much of the remaining time was spent talking about nutrition and all the things I could do to maintain a healthy pregnancy and prevent complications. My midwife provided me with copious information, counseling and support – tools that enabled me to take personal responsibility for my health and that of my baby.

On the day of our second daughter's birth, the midwives arrived and checked heart tones and blood pressure intermittently. I gave birth with the assistance of two relaxed, experienced midwives without ever having a single internal exam. With gentle massage, our newborn started breathing without crying. Then she nursed within minutes after being born. An hour after her birth, she was lovingly handed over to her father while the midwives helped me into my own shower. Then they organized our house again, brought us a home-cooked meal and some juice, and left us alone. The midwives stayed for four hours, occasionally checking in to make sure we were thriving. Follow-up home visits were scheduled for the next day, four days post-partum, two weeks post-partum, and six weeks post-partum.

The Midwifery Model of Care is completely different from the Obstetrical Model of Care. Midwives use natural means of preventing and resolving complications that, under obstetrical care, would normally be treated with medicines or a host of other unnecessary, expensive technological and surgical interventions. Direct-entry midwives frequently refer women to alternative health care practitioners for complimentary therapies, and many are dually trained in midwifery and another healing modality. The benefits of midwifery care are many, including substantially lower costs, larger, healthier babies, higher rates of breastfeeding, and greater satisfaction with the birth experience. Barriers of access include the lack of state licensure of direct-entry midwives, lack of insurance reimbursement, and an absence of easily obtainable, objective information for consumers.

Over the past 2 years, the number of telephone inquiries our organization receives has grown. After its founding in 1994, FOM/CT received roughly 1-2 phone calls per month from women seeking information and referrals to midwives. Last fall, around the time of our childbirth conference, we received 2-3 calls per day. Since then, the number of calls has remained steady at 1-2 calls per week. Many women do not even realize that it is legal to have a homebirth in Connecticut, but that is changing with our efforts to educate. FOM/CT would like to see our state license CPMs using the NARM's certification process as the licensing mechanism. CPMs are currently licensed in 18 states using this approach, while neighboring Massachusetts has introduced a bill this session to do so.

CAM practitioners should welcome direct-entry midwives under its umbrella of health care professionals. It is time for us to follow the leads of other Western industrialized nations in the area of evidence-based maternity care, including the full integration of direct-entry midwifery as a safe and healthy option for families.

Thank you.

Sharon Reilly/43 Remington RD/Windsor, CT 06095/860-688-4703

To: White House Commission on Complementary and Alternative Medicine Policy

From: Caroline V. Rider
consumer

Date: Tuesday, January 23, 2001

First, thank you for all the time, effort, thought, and concern you are giving to this project. It is very important for America.

Second, the MOST important thing I have to say is: Please do what you can to help us as consumers get, if we are in a state where we don't have it, or retain, if we are in a state where we do have it, the FREEDOM to purchase the complementary and alternative health care services from the providers WE choose, trained the way WE want them to be trained. Please DON'T advocate the spread of the traditional regulatory model for these services.

Please DON'T try to apply uniform standards of education, training, or licensure to all CAM practitioners. Let CAM practitioners disclose their qualifications to me as a consumer, and LET ME CHOOSE. Our present regulatory tools are clumsy, expensive, and not tremendously effective. Moreover, they take away the consumer's right to make a choice, informed or uninformed, as the consumer chooses. Although I can sort of see the logic, in theory, of having some specialist who is going to cut me open with a knife and do fancy things to my insides be qualified and overseen by other, similar specialists who work for the state and have the power to license and de-license; in practice, that power operates more to limit the supply of practitioners and increase their cost than it does to uphold the quality of the work done....and it certainly does not prevent iatrogenic illness and death.

How much LESS sense, then, does it make to apply that clumsy, expensive approach to those complementary and alternative health care services which have low risks of direct harm and/or side effects? PLEASE.....let my CAM practitioners be LEGAL, let them DISCLOSE their qualifications to me when I go to see them in their office, and then GET OUT OF THE WAY and let me choose for myself.

In the same vein, then, please DON'T have government-required education and/or training for each modality. Let the practitioners themselves figure out what they should do, let their professional associations debate these questions, and let the public vote with their feet. There is a very low risk of harm, so Big Brother is not needed.....and the complementary and alternative health care field will develop, evolve, and blossom into ever more effective ways of helping people heal and be well, much faster and less expensively, if the government does nothing more than make them legal, and mandate disclosure.

Performance standards and practice guidelines set and supervised by regulatory authorities are NOT needed for the complementary and alternative health care community. As in many other fields, practitioners in their professional societies will develop peer certifications, and will publicize them, and over time, the public will choose some certifications as being more valuable than others. The government should let this process take care of itself.

From my point of view as a consumer, insurance reimbursement is not that important. I paid about $480, over the course of a year, to a homeopath to get major, permanent relief from pet allergies. That is a small fraction of what it would have cost to get less permanent relief from a board-certified MD allergist in the same geographic area. It doesn't bother me that my insurance company didn't pay for it. I would rather have the care I want from the person I want, delivered without any HASSLE from the insurance company, than have some portion of it paid for by them. But if some of it were reimbursed, that would be fine, too, as long as it didn't begin to warp the nature or extent of the care because the insurance company wants to tell my homeopath how to practice.

I do NOT have the ready, unfettered access to complementary health care services that I would like to have. Because of the threatening regulatory climate, there are too few practitioners in the Hudson River Valley where I live. If it were clear that these low-risk practices are legally open to practice by anyone, without licensure or registration, but with the obligation to disclose whatever qualifications the person did have, then schools would spring up, there would be more practitioners, and I would have a greater range of choice. There would be more publicity about these practices from professional societies, schools, and practitioners, and I would have a much better range of reasonably priced services to choose from.

Let me emphasize that I am not some "irrational wildwoman" or some "knee-jerk, anti-science kook".....indeed, my undergraduate degree was in biochemistry, with honors. I did my own research on the ATPase activity of dystrophic muscle in the mouse. Though I am now a practicing attorney and a tenured professor of management, I still subscribe to and read Science News. I think that western methods of scientific research are very useful for solving certain types of problems. I think that they are of extremely limited usefulness in discovering and understanding the nature of the body-mind interaction, and I think that the body-mind interaction is absolutely central to healing many types of illness.

Like almost all users of complementary and alternative health care services, I also purchase the services of allopaths. I have a very fine OB-GYN, an excellent internist, and an extremely competent and kind surgeon who did one hernia in 2000 and will be doing another in 2001. I am grateful for their care, and I wouldn't do without them for the things that they are good at. Parenthetically, they are such conscientious, caring people that they would be JUST as good as they now are even if there were no licensure for MDs in the State of New York. I found them by following chains of personal testimonials from their patients and colleagues.

But I know, even if they don't, what their limitations are, and what OTHER kinds of health care providers I need, for certain types of health problems. I have been very successful finding cures using alternative health care modalities for problems that my children had that could not be cured by allopathy alone. I would be furious if the licensed health care community decided to take it upon themselves to try to impose the licensure/scope of practice/standards of practice model upon the CAM community. In my view, that model serves the pecuniary interests of the licensed practitioner far more than it serves either the safety or the prospect of healing of the consumer.

For analysis of the structure of the traditional system of health care regulation, and the weaknesses of that system, I commend to your attention the work of Michael Cohen, most particularly his book Complementary and Alternative Medicine.

In closing, let me reiterate: complementary and alternative health care practitioners need to be sure that they are legal, even though they are unlicensed, and they need to be left alone. If they do harm somehow, we already have a very well developed tort law system, advertised regularly and, may I say, unattractively, on TV every day, that can take care of the accountability and compensation problems. But most of them are low-risk modalities and will generate very few problems. We JUST DON'T NEED the form of consumer protection that licensure and state-mandated scope and standard of practice regulations are at least MEANT to confer.

What we NEED is freedom to choose the practices we want to use, and the practitioners we want to have. If I think that the best thing for me would be a reiki practitioner who is also a homeopath, then I want to be able to choose that. If we have the traditional regulatory system for complementary and alternative health care practitioners, my access to such people will be limited or nil, because very few people will be able to AFFORD the formal schooling, examinations, fees, and so on, which will be required. Given the low risk of me harming myself using complementary and/or alternative health care practices -- not NO risk, but LOW risk -- it seems to me that it would be good for me and good for society if you could help me make my practitioners legal, and then LEAVE US ALONE!

Thank you.

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