*White House Commission on Complementary and Alternative Medicine Policy*

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# White House Commission on<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" /> Complementary and Alternative Medicine Policy

**January 23, 2001**
**New York, New York**

## Opening Remarks

**GROFT:** Good morning everyone. If you could please take your seats we'll get started on this unbelievable agenda and list of speakers that I think will keep us busy. We're hoping to get out of here around 9:00 tonight, but we're not sure. So with respect to the people that are coming at the tale end of the day, we'll get started real briefly.

I'm Steve Groft and I'm the Executive Director of the White House Commission, and it's hard for me to welcome you, but thank you for coming out because without you we wouldn't be here. And the overwhelming response I think has led us into a number of situations that will be a little bit different. First we felt we could give everyone about five minutes of presentation time, but we're going to have to reduce it to three, as you've been informed. But we do look forward to your expanded comments, if you could either give them to us today or send them in to the office after today's meeting. So we would appreciate them. And any other supporting information or any other information you'd like the commission to look at, at that point please enclose that as well, because that does become part of our record that we will review as we prepare the report.

The report is going to come in two phases. The first one will be an interim report in July, that we hope about mid-July we'll have an interim report; primarily the recommendations. So we'll just have you take a look and follow out Web site. I think we've got information on the Web site within the background information. Please look at it. We'll have the highlights of the meetings and the agenda for all the meetings, so please just keep up with it. And if you have any questions, there's a section there, if you could send us a message. But after the interim report we are looking for comments from you, the public, about the recommendations, so please let us know what you think.

We are required to be out of business by March 7, 2002, so that will mean in all likelihood we should have the report done in early January of that year. So there will be a lot of creative writing between this time and that time next year. But all of a sudden we started last June and the seven months that have transpired since that time have just flown by. So I know how busy it's going to be the rest of the way. And with a series of meetings to come in Washington, we do have a bit of a revised schedule of meetings. On February 22 and 23 will be the next full meeting of the commission. And then there will be a meeting on March 26 and 27, tentative, but it's looking like they are the dates. Then May 14 through the 16th. So just keep tabs on the Web site.

Today, since we do have so many speakers, we're going to break you into panels, and you all received the agendas. And we do have a panel coordinator from the staff. They're floating around, so if after the meeting at any time you would like to speak with anybody, use the panel coordinator as your point of contact to get into the office. I think we'd like to establish that relationship, so please check in with them. And if you need to speak with me or Michelle Chang, the executive secretary, who just disappeared, we'll be happy to help you however we can. So please think about that.

We've reserved seats here in the front of the auditorium for the speakers. And there's going to be a lot of motion as the day goes on. And these seats are reserved for you as speakers for just the session until we break. After that, if you're going to stay, we just ask you to move to the back of the room and make room for the next group of 50 or 60 speakers. So it's going to be really, really hectic. And we do

have the timer here. We're going to flash to you, and Michelle and I have a one minute warning that we'll put up. So we'll ask you just to respect the time. And as your presentation goes on, please focus on the recommendations. We'd love to hear more about you and your institution or organization, but we really need to hear about the recommendations. The time, three minutes goes by awfully fast, but if you use it wisely you can get everything in that you have to. So we ask that.

There will be a ten minute follow-up session of questions that, oh, five minutes. They're compressing me. So we'll be speaking quickly and we ask the commission members to make a very very brief questions to you and then for your response to be very brief as well. And then you can expand on that after the meeting as well. So it will take an awful lot of cooperation if we're to hear from everyone. It's going to be a very busy day. I think there's a lot of enthusiasm, even though the audience isn't large right now, I think the sum of the entire day you're going to find that there are a lot of people who will be coming through the door as we go on here. And so we ask you to bear with us and we're looking for a cooperative spirit here today, I think that will carry us through.

And I would just like to introduce Dr. Jim Gordon who is the chair of the commission. He'll take care of the rest of the introductions and get us started. Thank you very much for coming out and supporting our activity. We really do want to hear from you, and we need to hear from you. Thank you.

**GORDON:** Thank you very much, Steve. One of the things that we do at the beginning of the commission meetings is we take a moment just to sit quietly in silence and center ourselves. So if we can all begin that way, just sitting together in this space together and breathing together. Thank you very much.

I'm going to introduce my fellow commissioners and speak for a few moments, but first I would like to introduce Dr. Gilberto Cardona, who is the Acting Regional Director of the Department of Health and Human Services here in Region II. Dr. Cardona.

**CARDONA:** Thank you. I needed that. I'm sorry I came late. It took me over three hours to travel 20 miles from northern New Jersey, the George Washington bridge was impossible today.

**GORDON:** Deep breathing is essential.

**CARDONA:** Thank you. I'm going to be brief because I'm late and because there is important business to be transacted. So on behalf of the Region II of the regional office number II New York, the Department of Health and Human Services, please receive our welcome and greetings. Our special thanks to the commission for meeting in our jurisdiction and to all the participants in the hearing.

The charge given to the commission is one of great importance, given the proliferation of complementary and alternative remedies in the market today. It is an industry with very little regulation and open to . . . claims that are of doubtful validity. On the other hand, we need to be open to legitimate alternative approaches to patient treatments. Certainly I look forward for an exchange of information that will help us have a better understanding of the benefits and the risk of these interventions.

As a pediatrician I have been witness to a number of occasions in which these remedies have done more harm than good. A case in point, some medications coming through Texas that have high contents of lead, after the use, lead intoxication in a number of children, one of which had to be treated quite aggressively. So, but on the other hand, there are potential beneficial uses, so I do not want to prejudge the outcome of this meeting. But I welcome everybody to our region. We comprise the states of New York, New Jersey, Puerto Rico, and the Virgin Islands. And being a native born in Puerto Rico, I'm used to complementary medicine and alternative medicine, because that's part of our culture.

So greetings, again, to all of you, and I look forward for a very productive day.

**GORDON:** Thank you very much Dr. Cardona. And we are very interested in public health concerns

about complementary and alternative medicine, as well as the effectiveness of the therapies, so we'll be in touch and we look forward . . .

**CARDONA:** I'm going to sit with . . .

**GORDON:** Wonderful. Thank you very much.

Let me begin by introducing the other commissioners. The total number of commissioners is 20, and at first we thought we were just going to have a few at the New York meeting, but everyone wanted to come. And so the people here are all extremely eager to be here and to listen to everyone. And they knew ahead of time it was going to be a long day, as well. And they're a distinguished group, and you can, Steve, they have access to the bios of the commissioners.

**GROFT:** Yes.

**GORDON:** So you can look at the bios. We don't have time to introduce everybody in depth, so I just want to make sure you know who they are. And you can check the bios out. And in addition to having the opportunity to speak today and to listen today, you can also, if you want, get in touch with the commissioners through the office, through the White House Commission Web site. To my extreme right, and that has nothing to do with political orientation, Dr. Effie Chow. And next to her, Dr. David Bresler. And next to him, Charlotte Herr, Linnea Larson. And you've met Dr. Steve Groft and Michelle Chang. And Dr. Conchita Pasz, Dr. Joe Fins, Dr. Ming Tian, George DeVries, and Dr. Veronica Gutierrez, at the extreme left.

And the way we're going to be working today is we're going to have each group of six or so will come up. Each person, as Steve said, will have three minutes. And then we'll have five minutes to ask questions. And we're going to choose only two commissioners probably will have a chance to a question of each panel. And if there, as Steve said, if there are other information you would like us to have beyond what we've said, please make sure you submit it to us in writing and be in touch with us. And again, the way to be in touch with us is through, and I'll be mentioning this throughout the day, so you'll forgive me if there's repetition, but as new people come in, there will be a commission staff member. And the staff are really the heart of the commission. They're the ones who make it possible for all of you to come. They, and for this meeting in particular, Michelle Chang, arrange people for the panels, and contact you all, and they will be your conduits to the commission. And so each of you will have an opportunity to meet with staff. For those of you who are not speaking, you can get in touch with us directly through the White House Commission office.

I just want to say a couple of words about us being here in New York. This is the one, two, three, the third of our town hall meetings. And we have two kinds of meetings. We have meetings of the full commission in Washington, D.C., where to a significant degree, to a major degree we set the agenda. For example, our next meeting is on professional education, licensure and credentialing on February 22 and 23 in Washington, D.C. So we decide pretty much who is going to come in. We ask people for written testimony, as well as to come and appear publicly. We have a particular focus on that topic. We also, incidentally, do have time for public comment on any aspect of the commission's work at all of our meetings.

The town halls are somewhat different. In the town halls, you all set the agenda. We have some thoughts, we have ideas, we know people in the community, we invite those we know. And we thought we would invite the people whom we had in mind to come, and we would have plenty of time left for the occasional person who might also want to talk. So we invited about 60 people, I believe, and there are about 70 or 75 more who have said, we want to talk, which is wonderful. This is exactly the process that we want. We want to hear from you, whether you're a practitioner or somebody who is coming for health care or an interested citizen or an advocate, whether you think that these therapies and these

approaches have something wonderful to offer or whether you're extremely critical of them. We want to hear all the voices.

And the recommendations that we make, Steve spoke about our interim report. The interim report is going to be focused on a relatively small number of recommendations to the President and to Congress about legislation. And we want your input on those issues. But it's not only that we want your input, we want to remind you that legislation doesn't happen unless you want it to happen. That the reason there is an office, and now a national Center for Complementary and Alternative Medicine, the reason there is funding at the federal level, there reason there is a White House Commission is because people want it to happen. Because so many Americans are using these therapies, practicing these approaches, because people want a more effective, a more inclusive, and a more humane approach to health care. And if the recommendations that we make are going to go anywhere, it means that you all have to be our, not only activists on behalf of us, but activists on behalf of yourselves. You're the ones who have made it possible for there to be a commission, to be a national center, and you're the ones who are going to make it possible for the kinds of recommendations that we make based on what you tell us to become law. So this is a completely collaborative piece of work that we're all doing together.

And we look forward to continuing the collaboration. We hope that when we issue the final report, which Steve said will appear in March, that that will be a kind of synthesis of everything that we've heard, and we hope a blueprint for widespread change. So we look forward very much to this day. And as Steve said, again, we want especially, we want to hear your recommendations. That's what we're looking for. We want to hear a little bit about the situation that you're in. About where your knowledge and where your wisdom comes from, the experience that's brought it out, and especially we want you to tell us what you would hope that we would urge Congress and the White House to enact and why you would hope that we do that. So without further adieu, let's dig in with the first panel. Thank you very much.

**Panel 1**

**Panel Coordinator, Dr. Joseph Kaczmarczyk**

**CHANG:** Thank you. Would the following panelists please come up to the stage. And note also that Dr. Joseph Kaczmarczyk is the panel coordinator for this panel. So if you have any questions or comments, panelists, you need to see him afterwards. Dr. Ansel Marks, Margaret Buhrmaster, Caroline Rider, Stephen Lockwood, Simone Charlop, and Martin Rossman. Thank you.

**GORDON:** And when I call the panelists, I'm just going to go down the list as it is in the agenda. So we'll begin with Dr. Ansel Marks please.

**MARKS:** Dr. Gordon, distinguished commissioners, speakers, and guests, thank you for inviting me today to speak about the work of the Board and Office of Professional Medical Conduct. I do not speak for Commissioner Novello, however I can tell you that the commission has given us strong support in the work we have done.

The mission of the Board and Office is enumerated, and I've provided you with copies. But in part, the mission includes the following verbiage: to protect the public from medical negligence, incompetence, illegal, or unethical practices of physicians, physicians' assistants, and specialists' assistants. To deter the incidence of professional misconduct by physicians, to promote and preserve standards of medical practice which conform with applicable laws and regulations, and to respond to express public questions and concerns over the quality of medical care, which is a good segue into what we're doing here today.

The Public Health Law Section 230 provides for a board for professional medical conduct. The board consists now of 186 members. It is the largest board in the world of its kind. And the reason for its size is in part the law itself, which provides for extensive due process rights of physicians who are alleged to have committed acts of misconduct. The board is very diverse. It includes approximately two-thirds physicians and one-third public members. It's ethnically diverse. It is geographically diverse. It's diverse as to physician's specialty. As a matter of fact, this underscores the fact that the whole process includes the entire medical and lay communities in its work. This board and the law is sensitive to complementary and alternative medicine. As a matter of fact, the law provides that at least two members of our board be physicians who provide complementary and alternative medical care. And actually there are more than two, and we are currently soliciting additional qualified candidates to serve on the board.

At a recent annual meeting, an entire seminar was given to alternative medicine with distinguished members of the alternative medical community making presentations to our board, which meets in plenary session, at that time annually, now bi-annually.

This Board and Office is a reactive board. We have no agenda where we go after certain types of misconduct, other than for major fraud cases. So since we are reactive, in the year 2000 we received approximately 7,000 complaints.

My time's up?

**MAN:** Yeah.

**MARKS:** I will leave it with the thought that this Board and Office is very responsive to the agenda today. We're here to listen and learn and also to answer any questions.

**GORDON:** Thank you Dr. Marks. Three minutes is indeed very brief for everybody. And we're really sorry about that. And we welcome, as I said before, we welcome any of your thoughts. And as you look, as you, Dr. Marks in particular, and as others look at what appears on our Web site, we welcome your comments and your thoughts. So I think particularly in this area of licensing, of credentialing and disciplinary actions, we're going to be having a whole meeting on the 22nd and 23rd, so anything else you'd like to call, or if you'd like to call me personally I'd very happy to talk with you.

**MARKS:** Thank you doctor.

**GORDON:** Thank you. Next is Margaret Buhrmaster.

**BUHRMASTER:** Good morning, and welcome to New York State. As the old saying goes, I'm from the state and I'm here to help you. And I mean that.

I'm Margaret Buhrmaster. I'm Director of the Office of Regulatory Reform, New York State Department of Health. The Office of Regulatory Reform was created four years ago in an effort to mediate and facilitate the processing of health regulations and make them more user friendly, more outcome based and to try and develop sensible, rational regulations without overregulating people in the health care industry.

A year ago our office agenda was expanded to take a look at complementary and alternative medicine. And we expect over the upcoming years to be the facilitator and researcher in this process in New York State. We've received a number of inquiries in our office over the last year with very serious interest in this subject. And they've been received from all sectors of the health care industry, CAM providers, traditional medical doctors, facilities, educators, and, of course, consumers. And what we have learned is this is an area of health care with a great deal of conflicting information and the subject elicits a great deal of emotion, as we all know.

Today I'm not prepared to discuss specific recommendations, but I did want to say that we're looking at this from the perspective from what the state's role, the state government role should be in regulating or, as the case may be, not regulating CAM techniques or anything in the complementary area.

There are several areas that we're giving very definite attention to. One is CAM education curriculum. We've been working with some of the medical schools and realize that there is a genuine interest in providing adequate CAM education for new doctors, and also a continuing education for doctors. One of the big problems is finding the proper or appropriate education. And that's the credibility of the information that is being passed on. And I think that's discussed by people who have varying opinions on the subject. That how do you get credible information.

We found that probably the area with the broadest interest of concern is the issue of safety and education information on herbs and nutrients. And we really feel that that should be handled at the federal issue, but we're trying to become informed on it. We hope that we'll be able to dialog back and forth with you and collaborate on this process.

**GORDON:** That will be wonderful. Thank you very much. Caroline Rider.

**RIDER:** Thank you very much. Thank you for all the time, effort, thought, and concern you're 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 complementary and alternative health care services through providers that we choose, trained the way we want them to be trained. Please, 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 the 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, in my experience that power operates more to limit the supply of practitioners and increase their costs than it does to uphold the quality of the work done, albeit the regulation is done with the best of intentions. And it certainly does not prevent the actrogenic(?) illness or 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. Let the public vote with their feet. There's 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 CAM community. As in many other fields, practitioners and their professional societies will develop peer certification, will publicize them. Over time the public will choose some certifications as being more valuable than others. The government should let this process take care of itself.

I do not have the ready unfettered access to complementary health care services that I would like to have. Because of a threatening regulatory climate there are too few practitioners in the Hudson River

Valley where I live. Let me emphasize that I'm not some irrational wild woman or some knee jerk anti-science gook. Indeed, my undergraduate degree was in biochemistry with honors. I did my own research on the ATP . . . activity of dystrophic muscle in the mouse. Though I am now a practicing attorney and a ten year professor of management, I still subscribe to and read *Science News*. I think that western methods of scientific research are very useful for some problems and not for others.

**GORDON:** Stephen Lee Lockwood.

**LOCKWOOD:** Thank you Dr. Gordon and distinguished commissioners. I'm here to speak in support of federal legislation to protect CAM, or complementary and alternative physicians. I'm an upstate New York health care attorney, and I've represented several CAM physicians. The problem is that the state schemes that are set up to regulate physicians have a discriminatory impact upon CAM physicians, mainly because the regulatory staffs are uninformed and uneducated on complementary and alternative treatment modalities. And so they view CAM therapies as being different from conventional therapies and then prosecute the CAM physicians.

The effect of these disciplinary proceedings has a chilling effect on the patient's right to access CAM therapies. And I think what this legislation would really promote is the people's and the patient's constitutional right to choose what kind of treatment modalities they want. Now we all know here that there's two different paradigms, the conventional and the alternative paradigm. The one doesn't accept the other, certainly conventional doesn't accept often the alternative paradigm.

I'd like to give the New York State as an example. In 1994 New York State passed the Alternative Medical Practices Act which was widely hoped by many of us to settle out the situation. But it really hasn't. Although the Act mandates, and as Mr. Marks said, that at least two complementary and alternative physicians be on the Board of Professional Medical Conduct, it does not mandate that any CAM physicians serve on either the investigatory panels or in the hearing panels that assess the disciplinary proceedings of CAM physician. So it's just flawed because you're not being evaluated by anybody that knows anything about your therapy. And it's tremendously costly to defend, and it just raises havoc with a physician's life, his family and his patients. And in these types of proceedings too, and this not only affects CAM physicians, but no one ever knows who raised the complaint, who your accuser is. If you're charged with a crime you get to face your accuser. Not so in these disciplinary proceedings. I'm encouraged to see that the state is aware that it needs to educate itself as to CAM therapies, but I think federal legislation is necessary because only a few states have enacted laws to protect complementary physicians, and they're really not sufficient, as New York's is a good example. If you pass federal legislation it could be part of a patient's bill of rights. It could design to protect CAM physicians from discriminatory disciplinary actions, it could mandate education in CAM therapies for regulatory bodies and physicians. And it could require that CAM physicians serve on the investigatory panels and on the hearing panels that assess.

**GORDON:** Thank you very much. Simone Charlop.

**CHARLOP:** Good morning . . . I am Simone Charlop. I have been a recipient of alternative health modality for many years.

**PEOPLE:** We can't hear.

**CHARLOP:** How about now? I have a recipient of alternative health modalities for many years. I have seen remarkable results, both personally and with other people who avail themselves to these procedures. Some of the results were practically instantaneous, and some times it took a few weeks, and sometimes there were no observable benefits. But the same can be said of allopathic medicine. But the

alternatives to which I refer achieve their results without harm and without leaving chemical residues in the body or using invasive techniques. I believe that methods which facilitate the flow of block energy or offer harmless supplements to enhance wellness are the methods I want for my body and for my family. As to a definition of harmless, the easiest way to determine what is acceptable to your body is muscle testing, a procedure developed by a chiropractor many years ago. And for those of you not familiar with this technique, I would suggest that you avail yourself of learning that.

And I know I am capable of deciding which practitioner is best for whatever the particular problem may be. I want to continue making these decisions for myself without any interference from anyone. That is the real issue. I decide. It is not of interest to me if the person I choose to see is licensed or registered or sanctioned in some way. In fact, I have no idea how you could possibly develop any standards or definitions that would cover people who do this work. Many combine many different modalities and then add their own particular tweaks and embellishments. That is what is so exciting about the field. Everything is individualized since every person brings his or her own history.

I, of course, do research before I see a practitioner. I learned about his or her training and years in practice. I speak to other clients and have a consultation with the practitioner. Then if the person seems right for me we work together. One of the questions people ask me is, do I see a regular doctor? The answer is yes. When I broke my leg it was set by an orthopedist.

But the important point is that I made the choice about that care. I would like to acknowledge and praise the focus of this hearing. The new recognition of alternative practices and complementary medicine is a step forward. It should be encouraged, but it should not be an excuse for the development and promulgation of new regulations which limit or deny access to methods used with success for hundreds of years and for stifling creative healing. Thank you and blessing.

**GORDON:** Thank you. Martin Rossman.

**ROSSMAN:** Dr. Gordon and distinguished commissioners, thank you for doing your work and for allowing me to speak to you. I'm speaking today on behalf of the Academy for Guided Imagery, a post-graduate training organization co-founded and directed by Commissioner David Bresler and myself. We've been doing research over the last couple of years on mind/body/spirit interactions in medicine, which has come under the CAM rubric, although we feel that it belongs in a much wider arena.

And our research indicates that there's a pressing need to provide education about mind/body/spirit effects at all levels of the American health care system. We believe that mind/body/spirit effects differ in important ways from other modalities currently considered in the CAM arena. First, because it's not a modality. It's really the context in which all other therapeutic interactions must work. It's inherent and immediates all therapeutic interactions. Secondly, there's already a significant body of published peer reviewed research that clearly demonstrates that mental, emotional, and spiritual factors significantly affect a person's health and well-being. The resistance to disease, the progression of their illnesses, the amount of suffering that they experience in the outcome of medical interventions.

Over the past two years we've been reviewing and assessing this literature and feel that literature already exists to support the following statements:

1. That the accuracy and completeness of information a patient is given and how they interpret it significantly affect their medical outcomes;
2. The way a health care professional communicates and interacts with patients can have significant affects on their medical outcome;
3. That a person's attitude that believes expectations and hopes about illness and healing materially affect their medical outcomes;
4. A sense of connection with people, nature, and something larger than themselves has

significant effect on health outcomes; and

5. The skills of relaxation, imagery, stress management, meditation, assertiveness, and the ability to manage emotions can directly influence all of the above and it can be easily and inexpensively taught.

Because this literature is so strong yet unknown to most medical doctors, and even other CAM practitioners, we'd like to submit the following policy recommendation to the commission. That:

a. This literature be collated and reviewed by an independent panel and if it's agreed that these statements have already been proven, that an emphasis be placed on educating health care professionals and the public about what is already known in this field if choices have to be made about spending resources on education or research.

In the past 12 years the Academy has developed effective educational and evaluation methods in this field to teach both professionals and the public to work with consciousness in a way that honors both what is already known, and the underlying mystery of mind/body/spirit interactions. We would like the commission to know that we stand ready to assist the educational effort we recommend in whatever way we can.

**GORDON:** Thank you very much. I have a specific request, Marty. Please, feel free to applaud. I have a specific request. Is if you've put together that information, if you could submit that to us.

**ROSSMAN:** We will submit it. It's a bibliography of 193 selected articles that are appended to each statement, and we'll submit it to you.

**GORDON:** Wonderful. That would be very helpful.

**ROSSMAN:** Thank you very much.

**GORDON:** We have time for questions. So who would like to ask any of the panelists a question, real quickly? Anyone? A question. Yes, Effie.

**CHOW:** The gist of this panel, thank you very much for the enlightening delivery, seems to recommend independency, the general gist. And so do you see education, if you see legislation and regulation as not necessary, what about education of people who will know how to choose then, if you think that is, make comment about that?

**RIDER:** Yes. Actually, the one, if I could append one comment, I appreciate it and I applaud and I support the comments that have been made on this panel about a light hand on regulation of interventions that have been time tested and that are generally safe. And also I do think that good education and some form of evaluation and training is also necessary, because even these techniques, in unskilled hands or incompetent hands or unethical hands can be harmful.

**CHARLOP:** I would say that that's certainly true. On the other hand, education doesn't necessarily have to mean government required education, government specified education. I think if you take the situation of acupuncturists before they were generally licensed, it would take a bold person to assert that they were neither trained nor educated and that they were not evaluating themselves and each other. I think that they were doing that, and that was part of why they have been early recognized. So I think that education is, of course, necessary, but I think that all responsible professionals do that, will do that. And if it's clearly legal, they will also reach out to educate the public.

**RIDER:** I think also that there are many people who know about many methods and this information keeps spreading. And as practitioners become comfortable, if the imprimatur of being, practicing

medicine is removed, then more and more information is going to get out there and is going to circulate. And I'm not sure that it needs anything formal. I think people are very smart and there are articles that are in mainstream publications now. There will be more and more of those, and people will learn.

**GORDON:** Other questions from other commissioners?

**LOCKWOOD:** May I respond to that real quickly?

**GORDON:** Sure, please.

**LOCKWOOD:** Thank you, Dr. Gordon. I think we should recognize that the relationship between the patient and their physician, or their healer, it doesn't have to be a physician, is really sacred. And that they should be allowed together to determine what the evaluation and treatment modalities are, and we really ought to keep government out of this, for the most part, except to promote a patient's right to choose and promote these therapies. These physicians, CAM physicians, are very brilliant people. And they've developed these techniques. They know. So the patients can learn from their physicians, and vice versa.

**GORDON:** I have a question, Dr. Marks. What's the major concern that you have about CAM therapies and CAM practitioners, sort of part one. And the other is, what about the concern that was expressed by one of the other panelists about not having these CAM practitioners on the disciplinary boards?

**MARKS:** Let me answer the second question first, and I address this to Mr. Lockwood's comments. We make every every effort to have on investigative groupings alternative medical physicians. We have a cadre of over 750 experts, physicians, in the state of New York, including many credentialed and qualified alternative practitioners. We call upon them to review cases with us. Additionally, we make every effort, when there's a judicatory panel, a hearing panel, although the law doesn't require it, to include as one of the two physician members on a three person panel, to include an alternative medical practitioner, if possible. So we do address those concerns.

Regarding the issues of concern that our office has concerning alternative medicine, I would say that we hold all physicians in the state of New York to national standards of appropriate practice. These standards are promulgated by experts in the field. We rely very heavily on these external experts to establish the appropriate guidelines to practice. One of the underlying themes that we do worry about is when an alternative medical practitioner diverts a patient from traditional medicine, instead of complementing traditional medicine, diverts them from traditional medicine with adverse results. That concerns us deeply. When an alternative practitioner complements traditional medicine, certainly we're highly supportive of that action.

**GORDON:** Let me as you a follow-up question. There are certain areas, for example, many different kinds of chronic illness, where conventional medicine may have some benefit, but you may come to the end of the benefits, or there may be areas where there is real disagreement as this whole new field emerges of complementary or alternative treatments. And so there may be people who elect, given the choice between the treatment that doesn't seem to have too much effectiveness or hasn't proved to effective that's conventional and that's regarded as standard of care, and another treatment offered by a physician that may not be standard of care, but is a nontoxic treatment that may be helpful. Does the board try to accommodate, to make that kind of choice more possible for consumers?

**MARKS:** Yes. We are sensitive to the issue that you raised. We recognize that patients have rights,

inherent rights that transcend other statutory mandates, if you will, even transcend that. So we have to deal with this conundrum, and there are countervailing forces that are operative. And we have to take both the patient's right to select the kind of therapy they want from the practitioner they want, and our requirement under the law, under the police powers of the Constitution of these United States, to make sure that patients get appropriate medical care as measured by national standards. So we have those countervailing forces that impact on us. And it is a conundrum that we have to deal with, and we deal with every day, and we try to deal with it fairly.

**GORDON:** I think it would be very useful for us if you could give us some, I don't mean here, because it's too long, give us some examples of these conundra. And if you have any thoughts about what kind of suggestions we might make, not only to you but to other, what kind of guidance would be helpful to you, and perhaps to other boards as well.

**MARKS:** I certainly will do that, doctor.

**GORDON:** Great. Thank you very much. Thank you all very much, and we look forward to hearing from you again.

**CHANG:** Would the panelists who are leaving, make sure you touch base with Phil Kaczmarczyk if you have any further comments, and the same with our commissioners. If there are questions for this outgoing panel, to see Dr. Joe.

**Panel 2**

**Panel Coordinator, Dr. Joseph Kaczmarczyk**

**CHANG:** The second panel, would you please come up now. Grace Marie Arnett, Camilla Rees, Joseph Loizzo, Kevin Chen, and Leo Galland. Again, this panel being coordinated by Dr. Joe.

**GORDON:** We'll begin. Grace Marie Arnett.

**ARNETT:** Thank you Dr. Chairman, members of the commission and the excellent staff that you all have. My name is Grace Marie Arnett and I'm President of The Galen Institute, a public policy research organization based in Alexandria, Virginia, that's devoted to ideas that advance a more vibrant consumer-driven health sector. Many Americans are increasingly frustrated with the U.S. health care system because they face barriers to care. Access to care . . .

**GORDON:** I think you ought to come a little closer to the mike, they may be having a little trouble.

**ARNETT:** Is this a little better?

**GORDON:** Yes.

**ARNETT:** Thank you very much. Many Americans are increasingly frustrated with the U.S. health care system because they face barriers to care. Access to the care consumers want, sometimes complementary and alternative health treatments, is often blocked by either financial obstacles or by a lack of information about the full range of treatments available. Americans are frustrated with a system that puts someone else, either private or public sector bureaucracies, in charge of deciding what health

they will or will not receive.

In addition to oppressive regulation and licensure requirements, one core problem is the way we subsidize health care in this country. Because of the way subsidies are structured, we literally give control over life and death decisions to bureaucrats and politicians who have never met us and who care more about a balance sheet than about our health and well-being. Until we get financial power back into the hands of the American people, these frustrations will continue to grow.

Let me explain about what I mean about subsidizing care. People who are either poor or old or young are very likely to qualify for one of several government programs, Medicare, Medicaid, or the State Children's Health Insurance Program. In these programs government officials make up lists of what treatments those who qualify are entitled to receive. Those who have health coverage through the workplace are eligible for the health plan, or if they are lucky, the health plans their employer selects for them and the benefits that those plans provide. It's virtually impossible for even the smallest plan to provide coverage that suits a particular need of each employee. We are at a critical point when real policy changes are possible that will begin to put power and control back into the hands of individual consumers. President Bush is proposing a tax credit worth nearly $2,000 to families to purchase their own health plans. This is the first time that individuals, rather than bureaucracies, will have a chance to decide the shape of their health coverage. It would dramatically increase opportunities for patients to have access to CAM treatments and to seek out information about them.

My primary recommendation would be that the commission investigate changes in tax policy that would lead to greater access to CAM in a new world, instead of having bureaucracies decide what treatments are and are not covered, people would be able to choose for themselves.

**GORDON:** Thank you very much. Camilla Rees.

**REES:** Good morning, and thank you very much for this opportunity. My name is Camilla Rees. I speak to you today from the perspective of a patient who has had chronic illness for over five years. I was very surprised when I learned being a patient in our health care system, especially the crushing realization that the insurance premiums I'd paid bought me and millions of others with chronic illness little value. Most of what was helpful would fall into the category of CAM. I suspect most individuals, including policy-makers, unless they have had experience with serious or chronic illness, do not realize there are deep 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 five issues I found to contribute to inefficiency and waste. My overriding policy recommendation to you is to see that these qualitative issues become quantified. I firmly believe the dialog 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. The five issues are:

1. Doctors seem to have very little education about to support health and focus narrowly on drug solutions. Patients need information about 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.

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 the patient's wisdom and intuition are then crucial aspects of choosing the right solution. We need acknowledgement of the value of multiple perspectives and then investment in information infrastructure.

4. Physicians who practice outside orthodox norms are marginalized, if not investigated, resulting in a fear base culture, patient hesitation and confusion, 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.

5. The health care system is not . . . to results. There is no health goal in health care and no accountability. 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. Again, I firmly believe the dialog of policy-makers needs to focus on the economic ramifications of the quality of care today, the root of the problem, and associate CAM with a solution.

Thank you very much.

**GORDON:** Thank you. Joseph Loizzo.

**LOIZZO:** Thank you, Dr. Gordon and distinguished commissioners, for coming up and for inviting all of us to speak with you. I speak with you as a complementary psychiatrist and founder of the Center for Meditation and Healing and Health Educational Center at the Columbia Presbyterian Department of Psychiatry.

And I'm just going to read a brief canned statement which I think is, for some of you, will be preaching to the converted. I think you already heard most of it, but. From the vantage of complementary psychiatry, the single largest source of waste in American health care today has been neglect of complementary methods of teaching consumers and providers time-tested, evidence-based practices of self-healing and health promotion, such as stress reduction and meditative practices.

The disease fighting strategies and provider driven interventions of American medicine are 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, diseased-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 mind and body by destroying natural systems of health and healing, of defensive healing, and leaving us prey to diseases of all kinds. Fortunately, stress research has also shown that stress reduction methods contain the healer, the killer within, and teach methods to unlearn disease-prone habits and build the natural stress, the natural self-healing competence of our body and mind.

The most effective methods of stress protection to help promotion to emerge from the new mind/body medicine, such as Dr. Gordon's own memo, "Body Skills . . ." Herb Benson's "Relaxation Response," John Cabisens(?) MBSR(?) and so on. Distill time-tested traditions preserved in Asian health care systems, such as Arivada(?), Chinese and Tibetan medicine, that were developed in societies without high cost, high technological medicine. These deserve to be singled out as the cutting edge of complementary and alternative methods because they've 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 health care, the systematic neglect of the patient's responsibility and right to act in pursuit of his or her own health care.

And my recommendations are briefly that in the short run that insurance reimbursement for mind/body programs that teach self-healing methods be pursued. And in the long run, that public and professional awareness at all levels be pursued by building in stress reduction and self-healing education into all professional health education.

**GORDON:** Thank you very much. I want to make sure, is the level of sound okay for everybody? A

little louder? Okay. Great. Kevin Chen.

**CHEN:** Thank you, Dr. Gordon and commissioners. I'm a research scientist who is interested in CAM research and also especially Chi-gong(?). In the past few years I have witnessed many miracles among Chi-gong practitioners, such as disappearance of breast tumor in minutes, an incurable leukemia completely cancer free in two months. And chronic arthritis pain disappear in one treatment. I was really feel challenged by those miracles. However, when I start theories in these . . . phenomenons in terms of research I found myself in a very disadvantaged situation.

Because there are huge obstacles there for us to conduct research in CAM. That including first: fear of losing credibility among peer and . . . agency. Scientists, that other people tend to believe only what they consider reasonable and acceptable, and have a lot of prejudice and discrimination against the nonconventional medicine.

Second, lack of minimum funding to conduct . . . research. If you are serious about effectiveness of CAM, you may have to use your own time and the money to do research. Because . . . lack of minimum funds to do your research. And even though we have $90 million of budget for in CAM this year, but that is only one half of one percent of $20 billion NIH budget.

Third, lack of physical training and the knowledge of CAM among scientists. Most of scientists don't know what they're looking for in CAM research.

Fourth, it is very risky for original medical scientists to make a career transition from conventional scientific research to CAM research. You may lose opportunity to publish, lose opportunity to get a grant, and to getting promotion. You might even lose your job if you . . . in this area.

And please allow me just to remind you of a fact. If one-third of the university budget comes from the pharmaceutical company, just who will not risk lose those funds by supporting research that might conflict with those pharmaceutical industry.

So in short, it is still very risk for scientists to get involved in CAM research. So my recommendation will be dramatically increase the budget of funding the CAM research. Both consumer and scientists need it. The second, to avoid the influence of the various interests group . . . CAM into a different research institute, or add a special office for each institute to support CAM research.

Third, establishing more centers for the study of CAM funded . . . so they can play actively in both education and research. And decide what to do research independently.

Fourth, establish some special mechanism to founding an NIH to encourage more scientists to make a career transition to become a specialist in CAM research.

The last, pay more attention to education and training, and educate the current and the future scientists and the medical practitioner about various CAM therapies. The CAM therapies really work as other . . . medicine and medical education. Thank you.

**GORDON:** Thank you. Thank you for making so many succinct recommendations. We appreciate it. Leo Galland.

**GALLAND:** I'd like to thank the commission for giving me this opportunity to speak. Unfortunately I didn't receive the E-mail requesting me to bring copies of my presentation. I'll be happy to send those afterwards, and I'll speak just directly without notes, which is the way I prefer to do it anyway.

Briefly, there are two kinds of points that I'd like to make. First I would like to support what I think is going to be the general tenor of the commission's recommendations, which is the recognition that what we're really talking about here is holism in health care in the real sense of the word, rather than the integration of techniques that are considered exotic into conventional medicine. The aspect of conventional medicine, which I think is responsible for everyone being in this room is a particular perspective, which is the source of what alarms most of us about conventional medicine. I'm a

practitioner and a teacher, an M.D. Which is the perspective that equates illness with disease. It makes the disease the focus of intervention and is inherently depersonalizing. And out of this perspective comes not only the depersonalization and the lack of respect for privacy, but the tendency for conventional medicine to be overly invasive. And there's just a whole range of effects, including the lack of respect for the process of dying that come out of this disease oriented focus.

All alternative healing systems, whether they're ancient or modern, no matter how much they differ among themselves, share one perspective, which is the view that illness is the result of imbalance or disharmony. And that's a perspective that is consistent with science and really needs to be incorporated into the approach that's taken.

Two concrete recommendations. Number one, with regard to medical education, students need to learn about CAM modalities from the perspective of this alternative; that is, these are about restoring harmony and balance, they're not about treating disease. When it comes to research, we can't allow CAM research to follow the rules that have been established to support the disease centered model. Now with conventional clinical trials there are many patients that are excluded because of comorbidities. After all, you can't have somebody with too many different diseases, it muddies the water. Those are the patients that should be specifically selected for CAM research. Those people have a lot of comorbidities.

Thank you very much for your attention.

**GORDON:** Thank you. I said it to Dr. Chen, but I want to say to the whole of you that we really appreciate your concision and the recommendations. One of the things that I'm experiencing listening here this morning is the reinforcement and the elaboration of many themes that we've been hearing over the last seven or eight months. And I think that it's, some people have said, well, three minutes isn't very much time to talk. But I think for those of us who've been hearing so many people over this period of time, it's helping us immeasurably to get clearer about what the fundamental kinds of recommendations. As we hear them again and again, worded slightly differently, with slightly different perspectives and slightly different information and glimpses of very power experience, I think it's shaping all of our perspectives and will be very important to us.

We have some questions from the commissioners.

**BRESLER:** For Dr. Galland. When you say doing comorbidity research, do you have concerns that if we're using multiple modalities, multiple orientations and so forth, what kind of conclusions we can draw based on that?

**GALLAND:** I think the conclusions, the end points should be global indices of health and quality of life, rather than surrogate end points that are narrowly defined, which is what tends to happen in conventional medical research. And if you use those there may be issues about how do you compare one group with another, how do you control it. I think those need to be dealt with, but I think it's possible to do it.

In rheumatoid arthritis research, 90 percent of patients with rheumatoid arthritis are excluded from conventional research because of their comorbidities, and it doesn't make any sense that you then draw conclusions about the best treatment for the disease from the ten percent of patients who are permitted into the study and then try to apply that to the 90 percent who are excluded.

**GORDON:** Do you have any statistics on the, have you taken, I know it's a general impression, but I'm wondering if you pulled together any data on those exclusion criteria that you could?

**GALLAND:** I can get those.

**GORDON:** I think that would be very helpful for us. Other questions. Just raise your hands if you have a question. Anyone? We have time.

Okay, I do have a question for all of you. You talked a little bit about, different people have talked about research, and you've talked about funding. Is it your sense that there are certain approaches for which reimbursement, and Dr. Loizzo mentioned already mind/body approaches, are there other approaches that you feel there's sufficient evidence that they should be reimbursed now? And I mention this, and we have several months before we have our panel on reimbursement, but this is clearly a crucial issue. And I'm wondering if any of you has any thoughts about that.

**ARNETT:** Mr. Chairman, I would really strongly recommend that the commission not get so specific in its recommendations for coverage, because I think really what you want is a system in which people have the greatest flexibility to make their own choices. And I assure you, when politicians begin to get involved, even though how well meaning they may be, it will become highly regulatory, very constrained, and once something is in place in a regulatory system it's very hard to get rid of it. And for knowledge to evolve through the system. So one of the reasons I'm making the recommendations about looking at how do you get money and control to the consumers, whoever controls the money controls the choices. If they're in charge I think they will then begin to dictate the shape of the health plans that consumers are purchasing, so it's dictated by the market rather than by bureaucracies.

**REES:** One thought that I had was it took me three years before I figured out that the root of my autoimmune problems was environmental. And I would recommend that removal of mercury amalgams be reimbursed.

**GORDON:** One of the things that I would like, and this is I suppose it's a sort of Socratic trick, if you will, is that when, if you have or if you can suggest to us someone who could give us the scientific justification for the recommendations that you're making, just as Dr. Marty Rossman sort of turned it back to him and said, okay, let's see this evidence for mind/body approaches, we'd really appreciate that. And if it's not you, if there is someone who would submit that to us, that would be very helpful.

**LOIZZO:** I do agree that working into, in fact, our center doesn't accept insurance reimbursement. We're not, and as a clinician I don't. And I think that that's part of the way that these therapies are going to fry. As a psychiatrist, I also have kind of generations of understanding about the way psychotherapy has been treated by insurance companies, and I can just say that there's a lot of similarity between psychotherapy and complementary medicine because people value the relationship as a context, as a healing context, and the educational process. And there's a way in which having that be a real consumer driven contract between two people who are not bound by some big institution is really freeing to that process. And so I don't think insurance reimbursement is the way to go in general. But I do think maybe picking up a few areas.

**LARSON:** If insurance reimbursement isn't the direction, then how do the people who have the least options for receiving these services, such as the poor or the medically underserved, get treatment?

**LOIZZO:** Yeah, no, I think that that's the reason why . . . as a least common denominator, I think that that's a way to go. And then pick the one or two handful of things that are the most waste reducing, then I would say self-healing, giving people the message that what they think, feel, and do is important. It's something that would help reverse the disease-based allopathic bias that doctor active or doctor driven bias of western medicine and help complement it most effectively. So that's why I recommend.

**GORDON:** Effie, do you have a question?

**CHEN:** Yeah. You may not be able to answer this right now, but the funding and the research is so important. We believe in testing. And you brought about that perhaps there are creative ways or recommendations for research. And we'd love to get some written input on that. Whether it's accepted protocol or recommended protocols to help with CAM research. Because it is different. And then the funding aspect too. We'd like to have more written detail about what your recommendations are. Really appreciate it. Thank you.

**GALLAND:** I just wanted to respond to the insurance reimbursement. I like the concept of most waste reducing. And I would say that nutritional counseling is the other area that can really have a major impact.

**GORDON:** Thank you very much. We appreciate your coming here and being with us today.

**Panel 3**

**Panel Coordinator, Corinne Axelrod**

**CHANG:** Would the panel three now come up. This panel coordinator is Corinne Axelrod from our staff. Fredi Kronenberg, Elaine Stern, Kerri Ann Gruninger, Frank Lipman, Faye Shenkman, and Carole Margalit.

**GORDON:** We'll begin with Fredi Kronenberg.

**KRONENBERG:** Thank you, Dr. Gordon and commissioners, for providing this opportunity. I'm the director of a complementary medicine center at Columbia and one of the NIH-funded specialty centers in CAM research in aging and women's health. Women have long been the primary users of alternative medicine, and now take the lead in the use of CAM in this country, as well as others around the world, as using home remedies and using self-care measures for their families. It is important that we look at women and minorities and how they use CAM and what they're using.

Increasingly, women seek alternatives to common surgical procedures, such as hysterectomy and cesarean sections. They seek alternatives during many of the natural hormonal related life phases, during menstrual cycle, pregnancy, and child birth, natural hormone changes as they age, and during illnesses, such as breast cancer. And in many cases they seek therapies that have fewer side effects than pharmaceuticals, or seek to avoid drugs entirely during pregnancy.

A number of years ago we conducted a survey through a popular magazine and got 15,000 responses from people around the country. A third of these women were using, this was for women over 40, were using hormone therapies. And what was interesting was that 72 percent of those were also using some other complementary methods. And while women are not going to wait for scientific data, they're very good at coping with uncertainty and decision making in daily life, they do want to have information that remedies are safe and effective, and that their doctors are knowledgeable and able to either refer to CAM practitioners or have a dialog with the practitioners that's effective for them.

Now in minority groups in this country who come to this country bring medicines from their own cultures and traditional medical systems. And I think that women and minorities, it's different groups, obtain CAM goods and services in different ways. In fact, there seems to be a two-tiered system here, in ways of obtaining these remedies. Many women, particularly in recent years, buy products sold commercially at increasingly high costs. Various ethnic groups, on the contrary, seek CAM therapies in their own neighborhoods from their own traditional healers and local shops, from local practitioners, and

often at low costs. Yet hereto there's not adequate research so that the conventional practitioners appreciate when these remedies are appropriate, sometimes better than western medicines, and then however when western medicine may be the best choice.

The research that needs to be done, however, is not just randomized control trials, but studying systems of medicine, otherwise we'll never be able to test every remedy for every condition. How do you study a system, like Chinese medicine, and know that it works and therefore can trust that and not have to look at every detail? The research that's done really must remain true to the tradition being tested and not only by sort of the gold standard of randomized control trials.

The danger that we have is in overregulating and overmedicalizing. Overmedicalizing life and normal life processes and that one of the recommendations in terms of funding is that government agencies be able to cofund multi-disciplinary efforts. This is not possible right now, and it's very difficult to get some of these kinds of work funding. I think that the challenge is to make CAM accessible and not detract from what makes it successful and appealing, and that is often the ability to obtain these things outside of medical facilities.

**GORDON:** Thank you very much. Elaine Stern.

**STERN:** I am an acupuncturist and a Chinese herbal medicine practitioner. I've been in practice for 17 years. And so I've been through the beginning of Chinese in New York State I think. And I have printed in my statement some of the things that I treat and some of the conditions that I get good results with, but I think I'd like to kind of push ahead to the main recommendations and the main issues.

As a practitioner I run into a few problems. The first one is I'm increasingly treating more and more serious illnesses. I treat many many women with a very broad variety of problems, and as I go along, I need the help of my western counterparts. And this is a very difficult thing to obtain. I need to see blood tests. Sometimes I'm concerned that my patient isn't getting what they need from the western practitioner or there's a big division between the treatment they're getting from their standard western practitioner and the Chinese medical practitioner. And I think this puts a lot of stress on the patient. And it certainly makes it very difficult to have good integrated practice. I think this is partly due to some attitude issues, and also because people are very busy, and because there is a lack of education on both sides. I think many standard biomedical practitioners don't know anything about what I do, don't have any idea of what I can or can't do, whether it's safe. So when the patients say, I'm going to see an herbalist, I'm going to see an acupuncturist, they don't know what to make of that. It's very rare that doctors are open for me to call them and discuss the case, partly they're busy, but partly I think they just don't know what to make of what I do. So that's one issue.

I think another issue is that within my own field of, I specialize in Chinese medicine, but, of course people are interested in nutrition, and I had to educate myself about many other aspects of alternative medicine. It's not easy to get information. There's a lot of research being done. There's a lot of exciting research out there. Patients come to me with questions. They read this in the paper. There's not a, within CAM I think we need a more, some tool to create information resources.

And the third issue has to do with research. I was involved somewhat with Fredi with the research project she did at Columbia and is doing, and I think that one of the big problems is that the people who are skilled in research are not the people who are doing alternative medicine. And we need some kind of organization, perhaps a board, perhaps a group of people who, someone from the biomedical side who is skilled in research can come over to this board, get the information that they need and work together.

**GORDON:** Thank you very much. Kerri Ann Gruninger.

**GRUNINGER:** I'm present to testify as a patient that has used traditional and complementary

medicine. Over the past 15 years I've been diagnosed with numerous medical problems. I would first try the routine route for the treatment of cancer and chronic pain and find that complementary treatments were also very beneficial in treating my health problems. The practices of meditation, hypnosis, imagery, and yoga have become a part of my daily routine for over 15 years. I was first diagnosed with Hodgkin's disease and chose traditional chemotherapy and radiation. But I decided I needed to do something else to reach remission. Through a close friend I learned meditation and self-hypnosis, which soon became a part of my morning ritual. The psychotherapists back then worked with me on imagery and soon Pac Man was eating the bad guys that invaded by body. Yoga at that point was a final part of my equation, creating a center and balance for both mind and body.

In 1993 I was involved in an automobile accident. Once again I chose the traditional realm of surgery, medicine, physical therapy, and array of tests and procedures. Unfortunately, chronic pain soon became a part of my life. To make story go on, less than six months after back surgery I was diagnosed with stage 2 breast cancer. I was only 31 years of age. My family has a history of breast and ovarian cancer, but I held the distinction of being the youngest. My body had not yet fully recovered from surgery and hospitalization, that I had a new challenge in front of me.

After the initial diagnosis of breast cancer, I chose to have surgery, followed by eight months of chemotherapy. But I wanted other options for pain control and also to enhance my immune system. I spoke to my oncologist who openly said to me he did not know much about vitamins and herbs, but was willing to learn. I spoke to my orthopedist, who suggested narcotics, because that was his way of thinking. I asked about acupuncture. Unfortunately, during chemo my counts were too low to try acupuncture, so physical therapy, yoga, massage, and imagery were my choices.

Of great importance during my treatment was group therapy with other young women. Sharing laughter and hugs are great medicine. During my course of chemotherapy I experienced chemical menopause, hot flashes I thought were for women in their 50s, herbal remedies were the only help.

After finishing chemotherapy, my menstrual cycle returned and brought with it migraines, another new experience for which I utilized complementary medicine in the form of English fever, peppermint, and acupuncture. Acupuncture has become a very important part of my treatment. Through acupuncture my back pain is controlled, migraines are more manageable, my immune system functions at a higher level, and most importantly I feel better. My current and previous acupuncturists are licensed M.D.s. I tend to seek out an M.D. who practices complementary medicine. My supplements, both vitamins and herbs, are also prescribed by an M.D. But if I were ever to be admitted as an inpatient to the hospital again, my choice of complementary M.D. would not be allowed to treat me with acupuncture herbs as an inpatient. However, I could continue my morning ritual. Most importantly, if we are going to work together to find and create the best care for the patient, the hospital must allow the practice of nontraditional therapies.

More research and funding is needed to find complementary therapies that are safe, but the patients should have the right to receive treatment that has been proved successful for their condition. I am blessed by the fact that my physicians listen and take the time to do the research and work as a team that communicates and educates one another.

**GORDON:** Thank you.

**LIPMAN:** Thank you, Dr. Gordon and panel and applaud you for what you're doing. I'm a private practitioner here in New York and I speak to you as a practitioner with 20 years of clinical experience, most of it in integrative medicine. I'd like to share with you what that experience has taught me and how it could be helpful to the next generation of practitioners.

I've learned from books, workshops, and master teachers. But by far my best teachers have been my patients. From the books I learned the science of medicine. From my patients I learned the art of doctoring. 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 multi-disciplinary setting where no discipline or system dominates is best for patients and practitioners alike. I've gained tremendous insights and knowledge from working together with practitioners of other systems. And in fact, most of my finest teachers have been nonmedical practitioners or nonphysicians actually, sorry.

Finally, integrative medicine is more than integrating complementary therapies into a 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. If we as practitioners are to become educators and teachers of prevention and self-care, which is what this new model espouses, then we need to embody those teachings ourselves.

Thank you.

**GORDON:** Thank you. Faye Shenkman.

**SHENKMAN:** Good morning. My name is Faye Shenkman. I'm the Director of the Wholistic Health Center at the New York College for Wholistic Health Education and Research. I'm a practitioner of amitherapeutic(?) massage, a diplomat and Oriental herbalism and body work and have personally been involved in the field of complementary and alternative medicine since 1976.

I'm here today to speak very briefly on the need to incorporate holistic modalities, such as massage, acupuncture, and herbalism, into the fight against breast cancer. The public is distressed by increased cancer incidents and the absence of real treatment gains to the major cancers despite decades and billions of dollars spent since the initiation of the war on cancer. Breast cancer has reached epidemic proportions. It is the leading cause of cancer death in women throughout the industrialized world and in many developing countries. There is a great deal of fear and no clear understanding of why the incidents of breast cancer has increased so substantially.

Many women who have cancer are exploring alternative treatment, especially if their recommended treatment is very difficult to endure or doesn't produce its desired effects. Most oncologists are not familiar with alternative and complementary therapies used by many of their patients. Chemotherapies side effects have become increasingly difficult for women to tolerate, as we all desire more gentle, as well as effective, treatments. The FDA is seen as ignoring research on natural herbal products that have been standard treatment in Europe, for example, in favor of expensive technology and expensive drugs. Many women feel helpless and frightened. They do not understand why othologic medicine does not incorporate nontoxic herbal remedies, nutrition, and energy-based modalities that are standard in other nations that help to alleviate stress and diminish symptoms.

The United States is behind many European countries in integrating complementary modalities to enhance conventional othologic care. We are also behind in the concept of preventative medicine. The content to prevention of breast cancer in the United States is limited to early detection. In other words, regular mammograms. From a holistic standpoint, a great deal can be done to educate women and the public at large in ways to take responsibility for their health. Oriental medical modalities, such as amimassage(?), acupuncture, and herbalism offer treatments designed to enhance the body's ability to defend itself against disease and alleviate stress, in addition to improving the quality of life and helping those who are sick to manage their symptoms and the effects of their treatments.

It is imperative that oncologists offer their patients a supportive environment in which patients can feel free to discuss what complementary therapies they are using, and it is even more imperative that

physicians are educated in these therapies so that they can understand how these modalities can enhance their own treatments.

And I'd like to offer the following recommendations. Medical schools should be required to teach courses in Oriental medicine, not simply introductory courses, but in-depth instruction in the fundamental principles of Oriental medicine so that they can understand the viewpoint and how diagnosis and treatment is made, not necessarily so they can practice it themselves, but so that they can make appropriate referrals, collaborate, and integrate their treatments with the CAM treatments their patients are already having. Without an understanding of the concept of the energy system it is impossible for Oriental modalities, such as acupuncture, body work, herbalism to have any meaning to the western trained physician.

And I'd also just like to add that I feel that the government should promote insurance reimbursement for CAM therapies so that many patients can afford to have these therapies. Currently they cannot afford these therapies, such as elders, and have a lot of difficulty. If Medicare would pay for massage therapy, for example, that would be very helpful. Thank you.

**GORDON:** Thank you. Carole Margalit.
**MARGALIT:** Good morning. It's Sherri Margalit. I am here today.

**GORDON:** Oh, it's Sherri. Okay.

**MARGALIT:** I am here today as a voice for women whose cancers have recurred. Today I am 51 years old. It is my birthday. I attribute the fact that I am alive and healed to my medical care.

**GORDON:** Could you speak a little more closely to the mike.

**MARGALIT:** I attribute the fact that I am alive and healed to my medical care, my family and friends' support and love, and to complementary treatments. When I was 44 years old I was diagnosed and treated for breast cancer, with a mastectomy, CAF chemotherapy and 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 occurrence with the same breast cancer on the same side. At that point, despite varied medical opinions I participated in a phase 2 clinical trial with high dose chemotherapies and stem sell rescue at New York 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 Biswoda(?) of South Africa falsified his data. But it has taken one and a half years to disprove his information, and by then many hundreds, perhaps thousands more women had participated in phase 2 clinical trials with high dose chemotherapy stem cell rescue. Currently it has still not been proven that high dose chemo does increase disease-free survival. We know that high dose chemo 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 the horrific, many times irreversible side effects of high dose treatments, despite the fact that these drugs at these dosages are ever proven effective as treatments. During and after each of my medical treatments I employed complementary treatments to help sustain and heal my physical body, as well as my emotional, spiritual side. I have had a 30 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 its 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 osteoarthritis in my back and knees, almost three years later, due to the Taxol(?). I've had a fight with insurance carriers to give me a minimum of OT and PT services for fine motor and gross motor problems due to the chemotherapy treatments. The

transplant oncologists.

**GORDON:** Did you want to conclude with a sentence or something?

**MARGALIT:** Yes. Basically I want to say that I put together my own umbrella of supplemental treatments which helped sustain me, but they were out of pocket, and because they were not covered by insurance and that the main thrust is that no IRBs should permit high dose chemotherapy on human participants without the supporting after-care services.
**GORDON:** I want to thank you very much. This is the first time we've heard this absolutely sensible proposal. And it seems to me it's the kind.

**MARGALIT:** It's so logical.

**GORDON:** I'm just speaking and responding, it's exactly the kind of recommendation that this panel, and I appreciate personally and that I know we all appreciate, because it's so useful, so obvious and it seems so much a part of our medical responsibility to provide these kinds of services, so I really want to thank you.

**FINS:** Dr. Kronenberg, can I ask you a question? Thanks for coming. Earlier we heard that consumers should have choice, and there are good choices and there are bad choices, and there are forced choices, and there are free and voluntary choices. In the minority communities that you serve, how much of the choice for CAM therapy is promulgated by lack of access to conventional health insurance and it seems a low cost alternative?

**KRONENBERG:** I think that you have several issues. One is not a lack of access but, which includes lack of communication, fear of the system, etc. So that does exist. However, I think in an environment that would be best the western practitioners would be aware of when the traditional approaches are valuable and perhaps just as good as western medicine, and have that trust developed so that when western medicine perhaps is a best choice, then there will be a trust that that is something that can be used and that there will be a relationship there that makes that possible. So I think there's several different issues going on, and access is one, but it's not the only one, because if there were access, it still might not be the choice for some people for whom this is what they know. So it's complex and not one way or the other.

**TIAN:** My question is for Dr. Kronenberg. And I think you brought a very important issue first of all, like osteoporosis. I think is very important, a big issue in women's health. My question is, do you have any data to show CAM therapies, including Chinese medicine or other CAM therapies to not only should treat symptoms for osteoporosis patients, and also could show some outcome, like a bone density increase?

**KRONENBERG:** I don't have those, those data, in terms of western herbs, for example, studies are going on right now, and there will be data coming out. We've tried to collect some data from, there's a world literature that we don't have access to here, in other countries that are available through databases in other countries. And some of those studies may not be what we consider to be the best quality research, but certainly by looking at what exists around the world, we can put together information on things that look to be reasonably effective and then conduct additional studies. So I think that if you're saying, are there studies by standards of western medicine, there are few and far between. Are there studies that exist there in the world where there are data that are worth looking at and provide guidance, yes there are. And they need to be translated, made accessible to people so people can see that there is

work that has gone on.

**GORDON:** Thank you. Other questions, we're wonderfully running ahead of time, so if there are other questions, we do have some time. Joe, do you have another question?

**FINS:** Ms. Margalit, if I could just follow up on your recommendation for the IRB. Would that be something that would be tied to government funding, federal regulation? How do you envision that playing out?

**MARGALIT:** It's my idea that along with the application for the proposal for certain trials, whether they be phase 1, phase 2, phase 3 trials, the people who are enrolled in those trials could have a whole array of services offered to them. And it should be part of the package that is submitted to the institutional review board and as well to the government agency, whether it's NIH, NCI(?), whoever is funding those trials. It should be that patients participate in the trial, have side effects of varied types, and then because most of the trials are conducted as outpatient basis, they're left out in the cold. And those transplant oncologists say goodbye. So we're left to deal with a lot of these problems on our own, or with our personal internists or providers through our own insurance carriers. And they do not cover the enormous amount of services that are required once you've had such tremendous shock to your system. We're not only talking about traditional Chinese medicine and acupuncture and lyme therapy, we need basic water aerobics, we need nutritional, we need counseling. This was like a post-traumatic shock syndrome to many of these women who go these trials. It's an incredible experience.

**FINS:** If you could just supply to the commission maybe the top three or four things you think must be covered because we can't, there are priorities we have to set, that would be most helpful for us as we deliberate further. Thank you.

**GORDON:** A couple of brief questions. Ms. Gruninger, you said that you wanted to find M.D.s who used these therapies. Tell us your thoughts about why you look to M.D.s who use CAM therapies. Why you didn't immediately look to CAM practitioners or just what your thinking was behind making the choices.

**GRUNINGER:** Originally, my original reason was because I went to my internist and discussed acupuncture with him, as well as my orthopedist and my oncologist. When I finished chemo, everyone was backing it, but nobody had a name. And I was still on quite a few medications. My back pain increased due to chemotherapy and my immune system depleted. I have bowel and bladder problems from my car accident. And the name that was given to me was a physician, a licensed physiatrist who was not only an acupuncturist, but a chiropractor. And that's who I felt most comfortable with, I guess at the time. He actually did send me to an Oriental medical doctor who, when we sat down to talk and discuss all my problems and discuss the traditional medications I was taking, he had no clue as to what neurogenic bladder was or what, at the time I think I was on Levda(?) and he didn't know what it was, and he scared me. It was like I had been to hell and back and this Oriental medical doctor, who I was referred to by a physician, didn't understand all of my conditions, and that was my reasoning. I did the same with herbal medicine. I saw someone in New York City that is fairly well known for treating pre- post- during, whatever cancer patients, with herbs and supplements. And he is very well versed. And the first thing he tells you when you walk in his door is you need to become educated. You need to do your own research. And I think that's so important.

**GORDON:** I want to ask a follow-up question briefly of any of you. One of the issues that's coming up in your response is what level of education about CAM therapies, let's take it the other way. What level

should CAM practitioners, level of education about conventional medicine should CAM practitioners have. Because you're raising that issue with regard to one of the therapies.

**GRUNINGER:** I think it's kind of hard. I think as a patient with multiple levels of problems, I don't come to you to say to me, make feel better, I'm tired. I come with multiple levels of problems. And I think it's important that the practitioner that I go to understands those problems. I have used massage therapy and reflexology and other things and have had no problem with it. I do seek out other acupuncturists when I need just a balancing treatment or something. I think it's important to do the CME courses that Fredi's center does back and offer to educate doctors about it. I've been lucky that my doctors have wanted the education. They've all been wide open to it. My biggest thing is that who's going to let them in the hospital to treat you. It doesn't matter. My physician had credentials to treat at Presbyterian and he can't treat acupuncture. My new acupuncturist is the head of Ruskin's Institute, he can't treat you with acupuncture in the hospital. So I don't know what level you need to continue the care and make the patient feel good about their treatment and the choices.

**GORDON:** I wonder if any of the others of you have a response.

**SHENKMAN:** I'd like to address that if I may. In New York State it's become a, for example, massage therapists, you have to be licensed, you have to be licensed to become an acupuncturist. The curriculums in the schools and colleges in the state, about 20 to 25 percent of the curriculum are in western science modalities. I think that the burden here really has to be on the western trained physician, if 20 percent of their curriculum was in CAM modalities, then I think we would see a true integration.

**GORDON:** Thank you. Anyone else?

**STERN:** Yes. I'd like to address this as someone actually involved in this whole situation. I think that the schools do provide an increasing amount of western scientific and medical education. I do think that could be a little better. I think it could be a little more targeted towards actual clinical situations. I don't think that the schools are really quite to the point, I teach it, I've taught, and can teach, that the students graduating, they don't really, we don't have in place a curriculum helping practitioners to integrate with western medicine. So that a practitioner who wants to do this really has to self-educate. And this is very difficult if you're busy. So I do think the education could be improved, and I'm involved in that to some extent. But I also think that from the western side it's not possible for someone to do everything. It's not possible for a really good oncologist or really good western trained physician to be also totally educated in Chinese medicine or alternative medicine. So that I think we need some place, and this was my recommendation, some board, someplace where we are working out how to educate CAM practitioners in what they need to know and to educate the western or the biomedical practitioners and what they need to know to communicate.

This is a model in China. If I can have just one more minute. In China that everyone is trained a little bit in each other's medicine before they specialize.

**GORDON:** Thank you very much all of you. We're going to take a 15 minute break. It's now 17 of. We'll start promptly at 2 minutes of 11.

**Panel 4**

**Panel Coordinator, Corinne Axelrod**

**CHANG:** And if the following people can come up to the panel. Starting panel number four. The panel coordinator is again Corinne Axelrod from our staff. And we have Ann Fonfa, Cecile Schey, Johanna Antar, David Molony, David Yens, and Prabhat Pokhrel. Please.

**GORDON:** We'll begin with those who are here. Ann Fonfa.

**FONFA:** I'm the founder of The Annie Appleseed Project. It was formed to help educate, inform, and advocate for cancer patients and concerned others. Our specialty focus is complementary alternative natural therapies. Studies are showing that up to 87 percent of cancer patients are interested in this and that they rarely discuss the issues with their health care providers. So the project is working to bridge that information gap, in one part by providing a Web site with lots of down loadable information, including relevant studies in patient perspectives.

I'd like to talk about the need for a new research direction, often called the paradigm shift. I would urge this panel to use its power to help create this shift. I sometimes refer to it as the patient track. Presenters at the last three conferences of the American Association for Cancer Researchers proudly offered very positive studies of green tea. Yet no cancer patient that I know would take green tea alone. We all combine elements and the study of natural, nontoxic combinations is part of the patient track. Looking at what we do now would yield useful information of the highest quality. Studies done on the patient track could look at combinations of therapies, such as antioxidants in chemotherapy or radiation. It could examine the use of herbs in combination with dietary supplements. Many of us juice daily and do detoxification routines, as well as mind/body medicine. Patients' real life regimen should be studied under conditions approximating their use in our real world.

A study of patient use of coqueten/coQ10(?), along with anthrocyclene-based(?) chemotherapy regimens might be included for possible reduction of cardio toxicity, or the use of taxientonaphopoic(?) acid for possible prevention of neuropathy. Pharmaceutical companies might have much to gain from such studies. If it could be shown that the use of dietary supplements enhance conventional therapy this could benefit many of the stakeholders.

As a cancer patient myself, I know the frustrations of having to make treatment decisions with little or no evidence of efficacy. Yet in the nine years since I've been using natural therapies I've successfully achieved tumor reduction with three different regimens. And if I can do it, so can other needy patients.

I consider myself a highly educated patient, having attended a hundred conferences, meetings, events, journals, newsletters, books, and articles. I've helped practitioners, many are open to new ideas. Some say they oppose alternative medicine, a statement that clearly indicates ideology and not science. At the same time patients are asking questions of their providers, and it's important to get answers. And still nine years later I have to make decisions by my gut. I ask questions at every meeting I attend on the various natural regimens. The response is always, we have no studies on that, or that hasn't been studied yet. And if I've been waiting for the studies it's nine years later and there are no answers. Patients can't afford to wait. We need the answers now so we don't have to waste our money and our precious time on the wrong things. There are many possibilities, and obviously, as for my personal experience, many of them do work.

I've heard it said in clinical trials, there are no unexpected effects. Just because they were expected doesn't excuse the highly toxic and painful effects of conventional cytotoxic drugs. Because we call them side effects doesn't reduce their damage, often permanent. Great marketing idea to call them side effects, but they're not side effects of anything, they're there. Often larger number of patients experience those effects.

**GORDON:** Thank you very much. Is it Johanna Frances Antar? Yes, please.

**ANTAR:** Thank you. Thank you for allowing me to come here and speak to you today. The nondegreed mere mortal that I am. The best way that I can express my opinion on the situation of complementary and alternative medicine in this country is to tell you a story.

I have a very dear friend that has been diagnosed with liver cancer. One of those really fast growing kinds. The doctors gave her three months to live. That was over two years ago. My friend decided to use alternative therapies to handle the growth of her tumor. It obviously has worked because she is not only still standing, but she's feisty as hell. That is the good part of the story.

Here's the not-so-good part of the story. To receive her alternative therapies she had to go to a facility in Mexico. Her church helped by raising some money to send her there, since her family is of limited means. The types of alternative therapies that she needs to keep her tumor in check are either unattainable or not approved of in this country. The practitioners to help her maintain these therapies are not approved of in this country. All expenses for these therapies are out of pocket for them.

Last week I was speaking to her husband, and I was telling him about another alternative therapy that they might want to look into, and he looked me straight in the eye and said, we can't. We have no more money.

What is wrong with this picture? Here we have a family. A good family who has made an obviously good choice for her health care. It has worked and continues to work for her. They are not the new age fringe types you might consider or think about when you think about alternative medicine. He's a cop. She's a housewife. They have three kids. Two of them are adopted HIV babies. They go to church on Sunday. We're talking a family that any community would gladly have. So why do they have to fly to another country to exercise their freedom of choice in health care, and why must they totally deplete the family's financial resources to exercise their freedom of choice in health care.

This is America. Some of us still believe in the words of the Declaration of Independence, that we are endowed by our Creator with certain inalienable rights. That among these are life, liberty, and the pursuit of happiness. To many many people being able to openly and easily pursue alternative medicines and therapies is our way exercising our inalienable rights of life, liberty, and the pursuit of happiness. And for my friend it is now her only way of protecting her life, liberty, and happiness. Alternative medicine must be made attainable and legal, and yet at the same time its basic nature and integrity must be protected. Alternative medicine cannot be clumped within the traditional western medicine framework because that framework will put a choke hold on how alternative medicine operates. It's time to start thinking outside the box in terms of integrating alternative medicines into our health care system so people may exercise their rights of life, liberty, and their pursuit of happiness their way. Thank you.

**GORDON:** Thank you. David Molony.

**MOLONY:** Good morning commissioners. My name is David Molony. I'm an Oriental medicine professional and 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've been surprised at how many have come forth to comment before your commission, and I look forward to receiving a 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 doctor degree as a standard of practice of Oriental medicine in the United States, as it is also being dealt in the European Union and as it has been found to be the best practice in Asian countries from which it originated.

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 varying levels of education, even within Oriental medicine.

While standards vary from state to state. We've come a long way since 1973 when no licensing existed for our profession. Today we're licensed in most states. One of our nationally credited exams is Chinese herbal medicine. Recently there's been some misleading reports in the press about the dangers of certain Chinese herbs and we expect another the same this week. The FDA has forced a recall and destruction of products for which there has been no reports of illness or injury.

Nearly ten years ago a number of kidney failures were reported in Belgium after patients took a cocktail of drugs and herbs prescribed for weight loss, including the Fen-fen(?) drug combination. Who prescribed them? Licensed medical doctors . . . 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 . . . because of misidentification, which once again goes along with 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 and misused, and/or combined inappropriately with conventional medications.

How can such illnesses 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. Its an easy and effective choice. While the FDA-approved drugs prescribed by medical doctors kill hundreds of thousands of people in this country, Chinese herbal medicine, in the hand of qualified practitioners, is not only effective, it's relatively benign. In the hands of untrained individuals, however, we can make no guarantees.

Please feel free to contact us if you have any questions. Thank you.

**GORDON:** Thank you. David Yens.

**YENS:** Thank you, Dr. Gordon and panel. I seem to be somewhat different from the other people that I've seen up here. And we're planning to address the questions of research. How can it be done in a complementary and alternative setting. And some things that we've been doing in the osteopathic profession to try to address this.

As you probably know, members of the osteopathic medical profession are designated as physicians and surgeons, D.O. Osteopathic medicine is a complete system of medical care with a philosophy that combines the needs of the patient, what the current practices of medicine, surgery, and obstetrics. And I might mention a number of our people also practice complementary and alternative, acupuncture and a number of other things.

The osteopathic philosophy emphasizes the interrelationship of structured function, as well as the body's ability to heal itself. They focus special attention on the musculoskeletal system which reflects and influences the condition of the other body systems. They use their eyes and hands to identify structural problems and to support the body's natural tendency towards health and self-healing.

So what makes it complementary or alternative? The Natural Center for Complementary and Alternative Medicine considers the manipulation component to be alternative. So we seem to have a foot in both camps. Probably a nice place to be, although maybe not. D.O.s are widely recognized for the incorporation of manipulative medicine into the spectrum of care, but it's this manipulation component that's very hard to study, as a number of the other things that we've talked about here. And I'd like to take this opportunity to thank Dr. Galen who kind of introduced, to some extent, the approach that we want to be talking about.

While manipulative medicine is commonly associated with physical ailments, such as low back pain, this treatment modality can be used to relieve a number of other problems and musculoskeletal aptomalities(?) associated with disorder, such as asthma, sinus, carpal tunnel syndrome, migraines,

menstrual pain. A number of these issues are very complex because we have a number of different modalities that are used, depending on what the physician sees and their training and the type of procedure they use for treating it. It's kind of a multi-method multi-treat type of analysis.

So what we're proposing is the development of a national database system that would permit physicians utilizing an electronic version of something that we've called an osteopathic soap note that has been developed and is being utilized in paper version. The electronic version wold permit physicians to collect their data, input it into this soap note that would be designed to capture the nuances of the problems and the treatments. And what's needed is support for developing a national database of this type that might not just be utilized for osteopathic but also for other types of medicines. We have started. The difficulty, of course, is the support for this type of database. Thank you.

**GORDON:** Thank you very much. Questions from commissioners? Yes, Effie.

**CHEN:** Thank you very much. I would like to specifically ask, you mentioned about there's research data. Can that data be accessible to us? And the other main question is, there's a belief system that if you take complementary medicine and supplements and build your body and you're being treated with chemotherapy radiation, that it would void out the effect of radiation and chemotherapy, and that in essence you're feeding the cancer cells and there's. Can you make comment on that?

**FONFA:** In the last five years there have been 20,000 studies on nutrition and dietary supplements. The majority of them don't make it into the newspapers and they don't make it into the *Journal of Clinical Oncology*, or to some degree they do get into JNCI. I believe, and as you know, no 100 percent agreement of anything in science and in medicine, the bulk of the studies indicate that it would be okay and enhance the normal cells of the body while not protecting cancer cells. It's why I'm calling for a large scale, multi-center, randomized double masked clinical trial, so that we would know in a way that FDA and all else could accept. But until that point, as a cancer patient, I believe that the evidence indicates that it is appropriate to take supplements during, before, during, after, very much so after therapy. And my Web site shows about 40 or 50 of these relevant studies. I'd be happy to provide the references for you.

**CHEN:** Thank you. We'd like some documentation.

**GORDON:** I have a question that relates to that for both of, certainly for both of you. Which is, what success have you had? What have you done, I know, Ann, that you're very active in organizing, what success have you had in organizing and trying to get this obviously sensible study done? How have you gone about it and what are the obstacles in terms of moving the agenda ahead?

**FONFA:** One of the primary obstacles is the way that FDA conducts studies. They don't like combinations of things, even though in conventional therapy we combine chemotherapies now, called polychemotherapy. And that to some degree is researched. In everything else they seem to reject it. So it would be very difficult to find. I've been asking for these studies, and I think they could be done in two ways. A way to indicate where we are with this is to say at the end of every study, okay, patients, we know you did stuff. Who did what? Let's hear it. And that would give us an idea of is that subset of patients, are they doing better, are they doing worse? And develop studies from that. There is a lot of objection right now to doing this combination study where an arm would be people who are doing chemotherapy with vitamins. And I've always wanted to do an arm for people without chemotherapy, just vitamins. And of course that's been difficult.

However, there's a groundswell toward doing this. And eventually I do think it will happen. I've spoken to the people in the various oncology study groups, the eastern group, the Chicago group. There's some interest in it. Even the NSABP has expressed an interest. Nobody stepped up. Most of

the time when I speak to physicians, it's in the hallways. They're not comfortable talking about these issues in the mainstream of their conferences and meetings. But it's changing. I have a lot of hope. But I've been living with cancer for nine years, and I don't know how much longer any of us will be able to discuss these issues. And I regret every moment that cancer patients are lost. Fifteen hundred a day die while we don't study things that might be helpful to them.

**GORDON:** Thank you. Do you have a comment, Johanna? No. Other questions. George.

**DE VRIES III:** Mr. Molony. One of the charges of the commission relates to licensure, making a recommendation of licensure among acupuncture. Certain ways we look across the country and in some states acupuncturists are fully licensed, in other states they're not at all licensed. In some states it seems as if they're certified, potentially access to the acupuncturist is limited or they're underutilized through that certification. Would your association support this commission making a recommendation related to minimum licensure statutes to support the licensing process across the country for acupuncture?

**MOLONY:** Absolutely. We have boilerplate bills available. We have a number of bills in different states that are not only promoting licensure in the states where there is no licensure, but also expanding on what's presently there to encompass more of what people actually do in their practice.

**GORDON:** I wonder if the licensure for practicing Chinese herbal medicine, have you talked with western herbalists as well and begun to think together about what requirements for licensure should be?

**MOLONY:** We haven't really talked with them. I'm a member of the American Herbalist Guild as well, because I was a western herbalist before I was a Chinese herbalist. And we're real interested in working with them. At the same time, they're working on developing their educational criteria, and they're about . . . 10 or 15 years ago. Although they're rapidly advancing, they have a lot of work to do. I look forward to working with them.

**GORDON:** I'd very much like to see information about the licensing exam for Chinese herbalism, and also any generalizations that you can make. Because I think this is really an important area for us because this is the oldest of professions, perhaps, or one of the oldest, but also very new to this country. And so the more we can learn from your experience the better, in terms of how to, are there ways that we can facilitate appropriate licensure of people practicing a variety of different herbal therapies, and perhaps other therapies as well.

**MOLONY:** One of the problems that was talked about earlier with polypharmacy or combining things. In Chinese herbal medicine, the focus is on combining herbal medicines. And so if the FDA asked us to run tests on each single herb and each single formula, I think we'd run out of money pretty quickly. I think that we have to rely more on historical data and experience of qualified practitioners in order to advance herbal medicine in this country.

**GORDON:** Charlotte, yes, we have time for one last question.

**KERR:** I first wanted to say, Johanna, what a good friend you are. If you're looking for new friends I'd like to be one. And I would like to ask you, we often think in terms of complementary medicine what are we doing to add on? Acupuncture, biofeedback. You've talked about detoxification and I understand many therapies do do that. But I wanted to ask you, I don't hear much about detoxification, frankly. And I would like you to comment on that. Also, any input on chelation and any specific recommendations in that area.

**FONFA:** When I . . . detoxification, the primary system I'm discussing is coffee enema, although not totally. And the reason that I am very interested in this, it was devised by Matt Scerson(?), and I think his cancer program in general is the most researched of anything we have, except for traditional medicine systems. And I therefore think it's very believable, and I personally adopted it six years ago. In addition, most of the alternative practitioners who practice combination regimens usually suggest it as one of the things. It also involves detoxification is also hot baths working with certain bath salts, working with brushing the skin, working with the lymph system and stuff like that.

In terms of chelation, the only thing that I personally know about chelation is the very first conference on alternative and complementary therapy held by Marion Leib(?) Publishers in 1994, discussed chelation. And I heard some very convincing stories about its use. Most cancer patients don't do it. We do, we might do things like protocolsuncorella(?) for blood detoxification or simpler kinds of things. And I know there is some research being done with capsules of something that's a chelating agent, and I don't know personally, I don't know enough about it really to speak on chelation. I'm interested in it though.

**GORDON:** Thank you very much. Thank you all four. While the other panel is coming up, we're going to keep going on a continuing basis. And at intervals several of the commissioners will break for lunch. So if they leave, it's not out of lack of interest. It's out of excessive hunger. And so there'll always be a majority of us sitting up here throughout the panel. And we encourage you, of course, to take a lunch break when it suits you, and rejoin us.

**Panel 5**

**Panel Coordinator, Geraldine Pollen**

**CHANG:** Would the following people come up for their panel 5, which is going to be coordinated by Geraldine Pollen from our staff. Jennifer Daniels, Charles Gant, Serafina Corsello, Arnold Gore, Edna Fishman, and Helen Choat.

**GORDON:** I'm going to excuse myself for about five minutes, not for lunch though, I don't eat that fast. But we're going to begin the panel now. Linnea, would you, or David, would you take over then? So we'll begin the panel and I'll be back in five minutes, with Jennifer Daniels please.

**DANIELS:** Thank you for inviting me to speak today. You have here a handout in front of you. I'd like to share with you some suggestions for policy changes that if made would make it possible for me to do my work of helping people get well through complementary and alternative medicine. Yes, I do use detoxification.

I am presently undergoing investigation in New York by the Department of Professional Medical Conduct for getting a patient better. I advised a . . . diet and exercise for a diabetic. His blood sugar fell from 465 to 138. He became noncompliant, his blood sugar became high, he sought care in an emergency room. My office is presently closed, as of October 14, as my defense requires too much of my time and it is too big a financial liability to expose myself to additional or future investigations, since insurance only covers the first $25,000 of legal fees. Presently I have spent $35,000 over a 20 month period. And I still do not know what OPMC feels I did wrong.

I have, however, learned that OPMC is simply above the law. There exist no mechanism to determine if OPMC is following the law or to enforce the law. They are exempt from rules of evidence, and deliberations are held in secret. So the first suggestion is OPMC should be bound by the rules of

evidence. This would make hearsay inadmissible and relevant facts admissible. Second, deliberation should not be held in secret. A shroud of secrecy merely permits the guilty to be exonerated and the innocent to be convicted. It does not ensure the safety of the public, quite the opposite.

Third suggestion is that a physician under investigation by OPMC should be able to request a review by three member committee whenever it is felt that OPMC is violating the law. This committee should be composed of a lay person, an attorney with extensive malpractice experience, and an elected official. It should not be under the control of the Health Department. PL230 is written on paper and believed to control the OPMC. After 20 months of litigation I found this whole body of law is disregarded, and OPMC acts as it wishes. A few attorneys have enough experience with OPMC to know how they customarily proceed in certain situations. But OPMC can and does change its patterns from time to time. PL230 you can just hold a match to it. It's not even considered.

The fourth suggestion is, the purpose of OPMC is to protect the public health by disciplining doctors, dangerous doctors. OPMC's jurisdiction should be limited to cases of irreparable patient harm. This provides an objective standard of when a matter is the jurisdiction of OPMC. There are 13,000 iatrogenic deaths a year in New York State, should keep them plenty busy. It is inappropriate for OPMC to uphold the standard of care. This is a job with specialty societies who issue board certification based on examinations.

Since 75 percent of iatrogenic deaths are caused by doctors who adhere to the standard of care, physicians and patients need the flexibility to deviate from the standard of care when such deviation does no harm. You also see attached my resume and the last two pages research documentation. Thank you.

**GORDON:** Thank you very much. I want to say that we very much appreciate physicians who are going through difficult times with disciplinary practices, coming here and speaking with us today. So thank you. Charles Gant next.

**GANT:** I've been licensed to practice medicine in New York and practice orthomolecular medicine and CAM for 20 years. Over three years ago my drug free successful treatments of ADHD were widely publicized. New York State Office of Professional Medical Conduct subsequently launched an investigation of my practice. Since then I've endured two interrogations, an office raid, charges of negligence, incompetence, and fraud, and eight months of hearings. My family and I have suffered enormous economic emotional stress, were it not for the prayers and support I have received, the gratifying effects of orthomolecular treatments in healing my grateful patients, good lawyers and expert witnesses who have generously allowed me to defer my economic debt, and a spiritual basis for my life, I could not have survived this hell.

During the office raid the OPMC seized nine charts for which charges were drawn up. Six of those nine patients eventually followed through with my CAM orthomolecular care and had good outcomes. A patient's prostate cancer was reversed and arrested. A patient with disabling severe fibromyalgia is relatively pain free and has the energy to work again. A vegetative severely autistic child has been educationally mainstreamed. A child with juvenile rheumatoid arthritis is medication free and mostly asymptomatic. A teenager with chronic sinusitis and migraines on nine medications is off medication and has fewer headaches. Another teenager with chronic severe gastritis and colitis is well. These were the worst charts the OPMC could find in my office.

The OPMC has broken New York State law in many areas. Education law, section 6527 subsection 48 basically says that a physician can't be prosecuted for CAM care if it works. My CAM care worked and I was prosecuted for it anyway. Section 230 subsection 6 of the Public Health Law states that my jury shall consist of two physicians and one lay member. The panel assigned to my case consists of two physicians and a physician's assistant. Public Health Law section 230 subsection 10aII indicates that medical experts who practice CAM shall be consulted during investigations. Only conventional physicians who have little understanding of CAM were consulted during my investigation.

My charges concern the care and treatment with nine patients with indefinite periods of time, but when it became obvious that my CAM care effectively treats human disease in six of the nine patients, the state has tried to block admission of this evidence and . . . charges as the case proceeds.

A recent article in the *Journal of the American Medical Association* suggested that conventional medicine itself is the third leading cause of death, resulting in approximately one-quarter of a million deaths per year, deaths mostly from mistake free medical interventions conforming to accepted standards of care. CAM is conventional medicine's answer, but what prevents conventional physicians from adopting technologies? The chilling effect of prosecutions like mine and the other panel members here is the primary deterrent to physicians. CAM will never be melded with conventional medicine till health care practitioners are free to practice CAM without fear of unwarranted investigation and prosecution. And even if protective legislation is passed, there must be provisions dedicated to upholding existing law with clear punitive consequences for health care regulators who place themselves above the law.

**GORDON:** Thank you very much. Serafina Corsello.

**CORSELLO:** Dear chairmen and honorable member of the CAM commission, I'm so sorry is an old CAM practitioner. Here I am talking about legality again. I tell my colleagues, this is the wounded soldier table. So I am glad to have been given the opportunity to present to you my 15 year long survival to keep my license to practice medicine.

I'm a 68-year-old physician. I came from Italy 39 years ago. And after the many steps to legally practice medicine in this country I began my wonderful journey as a physician. I've been practicing medicine for about 40 years, yet never harmed a patient. In 1992 I was one of the 25 physicians honored to be asked by the National Institute of Health to set the structure of what is now called the Center for Alternative Complementary Medicine. Twenty years earlier, in 1972 I had made the conscious decision to use as little pharmaceutical products as possible, in favor of nontoxic natural interventions. I then began to encounter the scorn of my colleagues, but nothing prepared me for what was soon to come. For 15 years organized medicine has brought me in front of their notoriously biased tribunal several times. I've spent untold amounts of energy and money to protect my patients' right to receive safe and effective treatments. I believe then, and still do, the synthetic chemical are often toxic and dangerous.

This past May, the OPMC went for my jugular. My attorney informed me they wanted to take my license. Since then the OPMC has done nothing but defy the 1994 New York State Alternative Medical Practice Act. They intentionally disobeyed the New York State law by going after a number of New York alternative physicians, including myself. They continue to defy the law when they had, amazement, physician who admitted to not understanding any of the alternative treatments review my case. When I requested review by an alternative physician they flatly refused.

Finally a supreme court judge alarmed by the lack of due process halted the OPMC trial with an injunction. The OPMC then tried to override the supreme court decision. The judge was shocked and outraged by the disobedience and total disregard for the law and reaffirmed the state order.

It is extremely important for all of you to realize that a stake is not only . . . practice nontoxic and effective medicine, but the ability of the consumers to access the medicine of their choice. The promise of access and choice is meaningless if thwarted by the state bureaucracy. I believe the OPMC is a runaway agency that needs to be reformed to comply with the intent of the 1994 health law. The purpose should be that of protecting the public against incompetent physicians, not to restrict the practice of medicine they do not yet understand.

Another compelling issue is that of the antiquity of the medical insurance industry against alternative medicine. I'm told they spearhead many disciplinary actions. Their minimalist approach to testing is in stark contrast to our comprehensive and humanistic view of medicine which Americans, much to the insurance company's chagrin, are willing to pay out of pocket. Thank you very much for your time.

**GORDON:** Thank you. Arnold Gore.

**GORE:** I'm Arnold Gore from the Consumer's Health Freedom Coalition. There are not enough doctors with an M.D. who practice complementary and alternative medicine. Although New York State has a law providing that doctors should not risk losing their license just because they practice nonconventional therapies, the Office of Professional Medical Conduct has not observed this law. Although the law has been on the book now for six years and should be known to the entire staff, this discourages the alternative doctors that we need. Diet and exercise have been shown to be effective in the treatment of diabetes. But it is not often used, and New York State regulators are currently violating the Alternative Medical Practice Act by bringing a case against a doctor for using this medically and scientifically documented treatment. You have just heard from that doctor. And outside on the table I have form letters to Governor Petaki which you can pick up, and I would please ask that you send in.

The *Journal of the American Medical Association* of April 15, 1998, published a study highlighting the dangers of prescription drugs. Research has found 2.2 million patients suffered adverse drug reactions requiring hospitalization. And of these, 106,000 patients who were admitted to the hospital died. Others did not even bother going to the hospital to report their adverse reactions. This is a tremendous understatement. There should be a source of information on natural vitamins, minerals, and herbal substitutes for FDA approved prescription drugs which usually have dangerous side effects and are usually not very effective.

The most significant advancement in the treatment of cancer has been made by Dr. Stanislaw Brazinski(?) of Houston, Texas. He has been in FDA clinical trials for over four years and has reported fantastic results. But FDA has not granted approval of his antineoplastins as a new drug which can be prescribed by all physicians. This fact is a disgrace to the integrity of the drug approval process. Something must be done to expedite this approval. Dr. Brazinski's most notable success has been treating difficult brain cancers. His antineoplastins are an FDA sanctioned clinical trials for varying cancers. And if you see his Web site, www.cancermed.com, you can link to protocols for the specific treatments.

The latest report that I have received in October 2000 of 35 valuable patients, 39 percent of whom had gleoblastemal(?) multiform, and 36 percent haniplastic(?) glioma, had complete response. Twenty-five point seven percent partial response, 22.9 percent stable disease, 31.4 total objective response of 48.6, and total positive of 80 percent. This is very consistent with his other reports, and something should be done to see that that is approved, even if it doesn't go through the regular process. Thank you.

**GORDON:** Questions from commissioners. I'd like to get a sense from those of you who are grappling with the Office of Professional Conduct what you think, you've spoken in your testimony about the issues. What do you think the dynamics are right now? Where do you see your cases going? And beyond that, what would you like us to look at more closely? What would you like us to consider in terms of recommendations?

**CORSELLO:** As I said, this is a runaway agency. And like any runaway agency, needs supervision. Why was the dynamics as a psychiatrist I can venture many many suppositions. I will spare you my suppositions. You're intelligent people. You can come to the same conclusions. However, the fact remains they don't know, they're not following the law. How can a government agency be scorned for, of the law, be scorned of a supreme court judge? The judge was so outraged that he screamed for five minutes on the phone. Bless his soul. He said, never in six years in his seat on the supreme court no agency, no district attorney ever dare to override his decision. So I am still now in the brief sending lawyers, God bless them, you know . . . forgive me for those of you who are lawyers. But nonetheless,

back and forth, back and forth. And every time they write a brief you know what that costs. And this is where we are. Telling the judge, who is a very fine judge, what are the points of law, because he doesn't want to make an unwise decision. So I'm in the hands of this brilliant judge who saw immediately from the initial brief that there was total lack of due process. What my destiny is in the hands of this judge.

**GORDON:** So you're essentially saying that the Office of Professional Conduct is not operating according to the law.

**CORSELLO:** Absolutely not. You hear . . . and you're going to hear more testimony about this. Absolutely not. I'll send you my lawyer's bills, and you have only three minutes, I didn't know if I could bring any more evidence. My colleague is already given you some very valuable points. The fact is, they must, there must be somebody above them to tell them, follow the law.

**GORDON:** Other thoughts, Dr. Daniels?

**DANIELS:** My first question is where I see things going in terms of my case. I'm not as affluent as some other people, so I am presently pro se, that is Latin for for yourself. That means I am legally representing myself. Now, the importance of legally representing yourself is not that I am any brighter than any attorney. None of them are . . . anyway, so how can I be worse? But you get to participate in these conferences with the judge, the prosecutor, and you're sitting where your lawyer would have sat. And you're hearing what's going on. It's appalling. I'd like to introduce this testimony and photographs which would exonerate me. The judge says, I don't think those are relevant. And the prosecutors are, oh, no no, we can't have those. What other evidence do you have, Dr. Daniels? Well, I'd like to introduce some research saying I did the right thing. The judge says, oh no, that would never do. And the prosecutor says, oh, we can't have that. What else do you have, Dr. Daniels? We went through my whole list of 19 exhibits just like that. And then they said, of course, Dr. Daniels, anything in those exhibits you may not refer to. So I'm telling you, I realize it's futile, and my plan is to cop a plea. I may get a license, I may not, but it will end the process. And my plan is to continue to do services in New York State, perhaps without a license and perhaps not even in the healing capacity. But I cannot do any more than what the law allows. And if the law is going to allow OPSC to do this, I have no way to oppose it, other than go to jail and fast.

**GANT:** I come from a family of lawyers, and I was kind of the black sheep of the family. Father, brother, brother-in-law, they're all lawyers. But they did impress me when I grew up that we are a nation of laws and not of individuals and not of ideologies. We are a nation of laws. And I was raised with that kind of respect. Having had that rug pulled out from under me, that total uncertainty, you don't know where you stand. I have unbelievable respect when I hear about dissidents in other countries who don't have laws to protect them, yet they stand up to it anyway. It takes unbelievable ego strength to be able to do that. I know doctors who have attempted suicide, left the country, have been forbidden to practice alternative medicine. It's very easy to give up, and I'm not going to. I don't think that other panel members here are going to either, because we're fighters.

One last thing I'd like to say is that this is not really about me or individuals. It's not about even our patients, because that's relatively few people in New York State. It is the deterrent effects of hitting one physician here or there which prevents the conventional doctors from emerging who want to step out and practice complementary and alternative medicines, that deterrent effect. And it's clearly set up that way. And I know of doctors and nurse practitioners who simply would like to, they've been trained, they've gone to courses, they're ready to do it. They're afraid to do it. And I can't blame them.

**GORDON:** Effie, David, and Linnea, quick questions and brief answers please, we don't have too much

time.

**CHEN:** Have you folks taken action to possibly countersue? I'm just interested in what the course of action is because I understand, for example in Vancouver, British Columbia, they were wanting to close down someone who was practicing Canatian(?) therapy and they sued the individuals, not the organization and they didn't hear anything more about them. I was just wondering what kind of strategies you people have taken, when you're saying that they're obviously abusing . . .

**CORSELLO:** Oh yes. There's no questions about it. I am told that civil servants cannot be sued. They have protection of the law. And in fact, the medical board that decides who to hit next is also exempt from lawsuit. So we are at a loss. I don't know if this is peculiar to New York State or is the law of the land. Right now I'm defending my right to service my patients. I'm 68, I can't go back to my country. But I love my patients, and they love me. And I'm not going to abandon them. So this is where my energy is going day after day, for nine months now. And for 15 years, but 9 months of intense. When I finish, however, I'll . . . for the sake, for the right of justice in this country, the possibility of a punishment, some kind of action. Perhaps patients. Patients have the right. Perhaps they should sue, because they've had much less of my time. This has taken two-thirds of my professional time. I'm a strong person, and I can function under fire, but no one can under the circumstances give full attention to patients.

**GORDON:** Thank you. David.

**BRESLER:** Yeah, along the same lines there's been some discussion in California that following malicious prosecution, if people are exonerated that those agencies reimburse their legal expenses, because you probably have no hope of recovering your legal expenses. Do you think that would make a difference at all?

**GANT:** I'm closing on over $100,000, and I wasn't that good a money manager to begin with, and so luckily I've been able to defer some of my debt, but boy, that would be, that would exert, that would bring some pain, some consequence, something, some ouch, some repercussion consequence that perhaps could have a rippling effect through the illegal application of these statutes.

**CORSELLO:** I have been to their kangaroo court just to be in the supreme court, I'm over $100,000. I owe already $6,000 more to my lawyer, so it's a strategy. I will send you . . . that will shock you. That is right in the Internet.

**DANIELS:** There is no hope of winning because the person who must exonerate you is OPMC itself in its own court in secret, free from the rules of evidence. So to have victory as a premise for malicious prosecution lawsuit means that no one will ever be able to file that suit.

**GORDON:** Thank you all very much. And I appreciate the recommendations that you've made. And if there are other ways you would like to elaborate on some of the recommendations for openness and accountability and inclusiveness, that would be very very helpful. So thank you all very much. We really appreciate you coming.

**Panel 6**

**Panel Coordinator, Corinne Axelrod**

**CHANG:** The next panel, could you please come on up. Janet Susan O Faolain, Vera Smith, Monica Miller, Philip Shinnick, Patricia Connolly, and Gary Wadler. Thank you.

**GORDON:** Janet Susan, how do you say your last name?

**O FAOLAIN:** Well, if you're going to say it the Irish way, it's O Faolain. But in America they'll say O Faolain.

**GORDON:** Okay. I wanted to check to get my . . . Please, O Faolain.

**O FAOLAIN:** Thank you very much. And it's wonderful to be with so many esteemed colleagues. It's good to be here. Thank you.

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 could buy. But ultimately it was my uniqueness and skills that would land me job opportunities. It was what I could do with my services primarily in teaching that made me sought after. No one ever asked to see my license to dance or to teach dance, for that matter. It was pretty much understood. So I've led the life that most Americans dream of. Absolute freedom of choice and pursuit of happiness in my work. That is, until now. Learning reflexology seemed a very natural extension of my dance career. I'm already in the business of adjusting bodies, strengthening muscles and postures through movement. I offer sound advice based on my experience in the trade. When I was informed that I would have to go to massage therapy school and obtain a massage therapist license to do reflexology, this, in addition to my years of study already in the field, I was really angered at first, the 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 healing practitioners, like reflexologists and polarity therapists, need not fear being accused of practicing medicine without a license. They do not claim to be medical doctors. We practitioners 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 penicillin coated, pharmaceutically 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 the situation is simple. Let the practitioners govern themselves. Allow them to provide full disclosure of their pertinent information to their clients/consumers. Perhaps their training was in an institute of higher learning or through time honored traditions passed from generation to generation. Let the professional affiliations where they exist and referrals lend credibility. Does it really make sense for me to get a cosmetologist's license to be able to perform reflexology? I guess it would if I wanted to paint toenails.

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

**GORDON:** Next is Vera Smith.

**SMITH:** Good morning ladies and gentlemen. I'm here as a private citizen who is very interested in complementary and alternative medicine. For the past three years I have been fortunate to participate in a health and wellness program on the upper west side. The emphasis of the program is to maintain well-being and to prevent, as far as possible, the effects of serious illness. More and more information has become available to help us maintain a healthy, productive, active life. Unfortunately, this information is not readily available to the public at large unless you have access to professionals who are knowledgeable about the benefit of exercise, nutrition and supplements. Many times information in

newspapers and on TV is superficial and conflicting. We need standards to evaluate products to know that they are accurately labeled. People who are suffering from serious chronic illnesses should have available at the treatment centers access to facilities that utilize exercises that will stimulate the immune system and supplements that will lessen the harsh effects of many treatments. Complementary and alternative therapies should be readily available for all to prevent the debilitating effects of aging. As the population ages, it is really imperative that the tools needed to achieve optimum health are at our disposal to counteract the negative forces that affect our health.

Some of the programs that I've participated in range from hands-on healing raki(?), meditation, reflexology, to exercises, chi-gong, modalities that would help improve the immune system. Awareness of these specialties and affordable access through appropriate information would enhance the well-being of all. These practices can and should be thought to health aid workers who can utilize the exercises to assist their clients become healthier and to function on a higher level. Thank you.

**GORDON:** Thank you. Monica Miller.

**MILLER:** I represent the Foundation for the Advancement of Innovative Medicine the preeminent advocate for alternative medicine over the last 15 years in New York State. I wanted to bring you something important, and so I brought you a bit of the past. This is information in relation to the 1994 law which the previous panel brought to your attention as the subject of scorn by the Department and the Office of Professional Medical Conduct. Section 4 of the law insisted that there be an evaluation of the use of nonconventional physicians in the investigation and hearings of doctors.

I have brought you the report that was conducted pursuant to the Act. I would bring your attention to page 4. Here the evaluation panel is discussing the prosecutions that had taken place at that time, mainly Revichi(?), Adkins, Gonzalez, and Warren Levin. And they say that the physicians practicing nonconventional medicine were not treated unfairly because the issues of these cases involved patient history, diagnostic procedure, record keeping, and referral to specialists. If you are at all familiar with nonconventional therapies you're probably aware that it begins with the patient history, how the patient presents the problem and how the problem is assessed. The homeopathic patient history will be very very different from the conventional patient history, to say the least. A homeopathic physician lost her license entirely over the issue of record keeping after the law was passed.

Advising patients, diagnostic procedures, referring to specialists, these all change when you're talking about nonconventional medicine. And it was Gonzalez one of the cases they're referring to when they talk about patient histories and record keeping, gives lectures at NCI on the proper record keeping of oncology patients. When he was evaluated pursuant to the charges of the board, the evaluation panel looking at him examining his practice over three days and over a hundred patient charts found no deficiencies.

I would like to read you something from a current case involving nonconventional medicine. The panelist is one of the three people, two doctors or a lay person. The witness is the witness for OPMC prosecuting a nonconventional doctor. The panelists' questions: Doctor, does that mean they are practicing bad medicine because they don't choose to follow the course of treatment that you and your colleagues who agree with you would choose to follow? The witness: In many cases I think the answer is an unequivocal loud yes. They are practicing bad, inadequate, ill advised medicine.

May I continue?

**GORDON:** Just for a few moments.

**MILLER:** Panelists: Am I to assume that there are other clinicians who are respected who would disagree with you? Yes. But he is the witness. He is the prosecutor of the case against the physician, and he is basically saying, I don't agree with it so it is bad medicine.

FAIM is undertaking reforms of OPMC. We are talking to legislative leadership. The name of our campaign is CPR, Crusade for Patient Rights, and we ask of you to please instruct the conventional community that CAM is not a speciality. It's not a sideline. It is a different paradigm, and it is different from the moment the patient walks into the room, for the benefit of all. Thank you.

**GORDON:** Thank you. And I have a strong sense that we'll be talking with you further, both today and as we move ahead, looking at these issues of credentialing and licensure.

The next group of speakers, I want to thank Philip Shinnick whom we heard in Washington for bringing these three, bringing this mini panel together to talk with us about some of the use of supplements to promote performance in sports and some of the issues they're in. So let's begin with Philip Shinnick.

**SHINNICK:** Thank you very much. And I'd like to address the panel on the whole question of policy and your mandate and your executive order and try to talk about some recommendations. I came to you before and I said that I challenge the idea of a good science makes good health. I said that sports has created a crisis in sport in the United States which undermines the development of the whole personality and health. And it's been a model for youth, but it perverts the historical process that brought meaning and health to millions of people. This is the anabolic steroids and these synthetic drugs. That it's synthetic drugs and steroids, and it's created sports heroes that are really a sham. And I suggested that yoga, breathing, biofeedback, visualization, tai-chi, kung-fu, chi-gong, acupuncture, herb, homeopathy, these are things that should be available to athletes.

I'm an Olympian myself, and I brought three time Olympian Pat Connolly. She's one of the founders of the Women's Sports Foundation. She coached Evelyn Ashford. Evelyn Ashford did not use drugs. We're going to talk about the necessity on social policy to project out the future. And we're going to, I'd like to ask the commission to think about recommending some sort of center that covers their mandates, a center that synthesizes existing information. Dr. Wadler will talk about this in his speech. Synthesize existing information to get into the educational process of youth, competitive athletes, and older people in sport and physical, cultural and arts.

We need to talk about more things than mind/body that synthesizes the whole personality to show how that can help in moments of stress and prevent disease and so forth. But what I'd like to do is I'd like to forfeit my time because Dr. Wadler has a lot of very important things to say. And I would hope the commission and the wellness panel will maybe address this issue and maybe ask to have some more people who are leaders in this field come here and talk about this and let us try to develop some social policy that will go into the future. So I'd like to forfeit my time for Dr. Wadler and proceed with Pat Connolly.

**GORDON:** Thank you. Patricia Connolly is next.

**CONNOLLY:** Thank you very much for listening to us. I'm looking at the questions and issues of this commission through my own prism of experiences. As an Olympic athlete, track and field and cross country coach, and my own business of exersage, which is a one-on-one approach to health and fitness to senior citizens that I learned while working with doctors, Buddhist monks, psychologists, athletic trainers, nutritionists, and chiropractors to help my elite athletes peak performances and world records.

I also am looking at the changing kaleidoscope of these issues as a parent of seven children who were in California schools during the deregulation of physical education that resulted in an energy crisis of its own. One full of hyperactive maladjustment, attention deficit disorders, obesity, early onset of menses, anger, and boiling point volatility in our youth. This time was filled with rolling blackouts of common sense and the profession of physical educators was trashed.

It was as a coach that I sought to use and coordinate every resource that might be beneficial to the

success of my athletes. In the early '70s it was a perilous path, a virtual tightrope between closed-minded medical professions who thought anabolic steroids to be nothing more than a placebo and snake oil practitioners.

There has been debate whether athletes should be role models for our society. But in reality they are a reflection of the society from which we come. A society that cannot watch five minutes of television without seeing a commercial selling drugs. A quick fix, no pain tolerance, pill popping society that wonders why the use of drugs by teens has increased in the past decade. However, athletes are a unique group of goal-oriented people who have a strong desire and need to succeed. It doesn't take long to separate those who must be well from those who use injury or illness as a break in indulgence and excuse to get workman's comp.

Top performance in athletes have tangible incentives to heal faster than predicted, and they do. They're willing to spend the time and endure the tedium of injury and illness prevention and rehabilitation routines. As a result, they are unique group of people for HMOs and other health insurance companies to study in terms of the efficacy of various healing art forms. Athletes and performers also resort to the quick fix of pain pills and succumb to the use of banned substances, as the show must go on. They will experiment with every word-of-mouth performance enhancing routine, some eventually dangerous to their own lifelong health and well-being. As risk takers they place themselves in a unique category, one that must be methodically studied before we use them as role models in the healthy life.

For about 20 years United States Olympic Committee and other sports federations have been conducting tests to detect the use of performance enhancing drugs and substances by their athletes. Most of these doping controls have been secretive and punitive with the pretense of deterring the increase of substance abuse and cheating. Millions of dollars have been spent on laboratory equipment, collection, and testing procedures.

And as my time is up, I am going to just condense to my two recommendations. That you look into the possibility of coordinating research with data that already exists from the last 20 years, a data that we, as athletes, have not had access to. As a coach I would like to know how many athletes in the Olympic games, the results, all the substance, how many were HIV positive. There's so much data that has been collected already. And to coordinate future research with these sports organizations for the ongoing programs that they are continuing to conduct. So this is stuff that's already funded. And if it's coordinated we can get the results. We can certainly learn a lot more about us.

And secondly, I'd like to encourage you to support Senator Ted Stevens Senate Bill 1159, that was also sponsored by the Women's Sports Foundation, which will provide grants and contracts to local educational agencies to initiate, expand, and improve physical education programs for all kindergarten through 12th grade students.

**GORDON:** Thank you very much. I appreciate. I love your metaphors too. Thank you. Gary Wadler.

**WADLER:** Thank you very much. I'm here today in a variety of roles that are linked by the relationship to the cascading problems of performance enhancing drugs and dietary supplements in sports. It's a crisis that observes no boundaries, as it ranges from the grassroots to the elite level. My testimony today is as an internist and sports medicine expert serving as medical advisor on drugs in sports for the White House Office of National Drug Control Policy. My testimony is also as a member of the White House Task Force on Drug Use in Sports and a member of the Health Medicine Science Research Committee of the World Anti-doping Agency.

For the past two decades I have worked to focus attention on the increasingly pervasive and multi-dimensional problem of drugs and sports, a subject of immense and ever growing scientific and ethical complexity. It is imperative that we recognize that the abuse of drugs in sports is not limited to individuals or the exclusive domain of athletes. It is a burgeoning problem that is threatening our youth,

and as such threatens the public health. Given the breadth of the subject, I would like to narrow your attention to the issue of dietary supplements, and particularly the so-called steroid precursor dietary supplements. Ever since Mark McGuire's home run record was clouded by the revelation that he had used a dietary supplement, androstenedione, known as andro, there has been a predictable explosion of the sale of andro and related substances, such as 19 . . . antisdine dione.

These so-called steroid precursors are not only a problem for elite athletes. Their use represents a far broader threat to the public health because the physiologic impact of steroid precursors goes well beyond their effect on muscle. To understand their danger, we need to understand that short- and long-term effects of all things, the female hormone estrogen. You may ask, why estrogen? The simple reason is that the human body converts andro into estrogen for both males and females alike. In fact, a recent study has shown that 300 mg a day of andro, the recommended dose on the bottles, can increase estrogen levels by as much as 80 percent.

Why should this panel be concerned about estrogen levels? The answer lies in the fact that just one month ago an expert advisory panel of the National Toxicology Program of the United States National Institute of Environmental Health Sciences recommended that estrogen be placed as a known cause of cancer in humans. That may put this estrogen/testosterone paradox in some perspective. Because andro is converted to testosterone, this dietary supplement . . . interest to athletes who are seeking to increase their levels of testosterone without purchasing anabolic steroids, and thus violating the very strict Controlled Substances Act of 1990.

As we all know, to athletes testosterone means larger and stronger muscles, less body fat, and increased assertiveness. To young men and women who are not athletes but are victims of our "perfect body culture" it means a leaner, more contoured or cut physical appearance. Alarmingly, recent studies revealed that as many as 3 percent of teenage boys and 3 percent of teenage girls have used controlled anabolic steroids, and the rate of increase among these teenage girls is particularly alarming. The marketing of andro is nothing less than a flying under the legal radar screen to achieve a steroid effect without violating the law. It is a dangerous loophole. There is no telling how many teenagers have used the over-the-counter dietary supplement andro and related substances, unknowingly placing themselves at the center of estrogen's carcinogenic effects. And who knows what other health threats the rest of their lives.

And here's another twist in the road. While andro has been primarily marketed to our athletes and young people, its immediate precursor, the hydroepiendrostrone(?), known as DHEA, has been marketed to the older population as yet another anti-aging miracle. Claims have been made that DHEA is the fountain of youth, able to turn back the clock to increase one's sense of well-being and boost, if I might have his extended time.

**GORDON:** We've given you Phil's extra time already. So if you could just conclude, real briefly.

**WADLER:** In fact, I'll just stop here.

**GORDON:** Thank you. Questions for the panelists. Joe.

**FINS:** For Ms. Miller, I'm concerned, as you must be, about the potential for conflict of interest where practitioners who practice a certain kind of therapy or promote a certain kind of drug are in the business of regulating their own business. We heard a lot about self-regulation. Is there any role for government, if you're critical of the OPMC, but how would you restructure it? What should be the role of government and how would that be fairer to the diversity practitioners that are out there?

**MILLER:** New York State differs from many other states in the licensing of physicians insofar as the disciplinary process is a peer review process. The intent of the legislature has always been that since

1927. And the intent, as you'll see at the back piece of the packet I gave you, was also greater peer review for CAM physicians. In the case of Dr. Serafina Corsello, if the investigator of her case had been knowledgeable of CAM the report would not repeatedly say, I don't know what this is. I don't have the time to look it up, so it must be misconduct. Peer review is the essence of licensure in New York State. It is the blending and the melding of governmental oversight, and collegial interaction. The law can be strengthened in regards to peer review, both in the investigative and in the hearings stage. But also rules of evidence have to be brought into play.

**FINS:** Just a quick follow up. My understanding is that OPMC changed some of its guidelines for the inclusion of pain specialists and parative(?) cure doctors to better inform the deliberative process about the use of opioids for pain management.

**MILLER:** That is correct.

**FINS:** Is that the sort of model that you would endorse or think should be endorsed?

**MILLER:** That is getting in the ball park, yes.

**FINS:** Thank you.

**TIAN:** Regarding sports medicine issue, and I'd like to ask whether you have some data or some information to show to professional athletes, like U.S. Olympic athletes and also amateur athletes, what do you recommend dietary supplement, the nutrition stuff, instead of drug related to other things. Because it's very important we need to provide the very important information to this very active few, because people do purchase a lot of things which is very important. We want to make athletes safe and also effective.

**WADLER:** There are a whole array of dietary supplements available. Of all of them there's probably more that has any benefit at all, but probably relative low risk ratio, and that's creatine. What I would ask the chairman specifically is to address the Dietary Supplement Health Education Act of 1994 and explicitly remove steroid-based supplements from that list. I don't think anybody envisioned what was going to happen with Mark McGuire. I don't think anybody appreciated the conversion to estrogen and testosterone and the effect on the public health. With respect to the others, it's catch as catch can. There's relatively little evidence out there. There was a dietary supplement that was used by a total of 12 people that became a hundred million seller over night. A product called HMD, with no evidence whatsoever. Athletes tend to look for the magic bullet. The assumption is, if it's a supplement and it's on the shelf, it must have been blessed by the government and it's safe. That is a very dangerous assumption.

**CONNOLLY:** In 1980 with a group of other Olympic athletes who were training, we did a study with Dr. Rob Krakovitz(?) out in California. And we tested all kinds of supplements, from vitamin C to ATP in terms of performance enhancement. Out of that study there were some things that we thought perhaps were helping us. But one thing I have had 100 percent help with my training of my athletes that we discovered in that process, and that was magnesium and potassium aspartate(?) when taken before heavy exertion and training we do not experience cramps or cramping.

**GORDON:** Doctor, I just want to add onto Ming's question, then we'll come to you, Effie. Are there recommendations that you would make, either about supplements or about the studies that need to be done?

**WADLER:** This is a problem and it transcends the United States. We have, there have been 343 cases of dietary supplements producing positive urine drug tests in elite athletes in the Olympic movement. And indeed around the world we have opened the pandora's box and enabled us to explode throughout the world. I think as one, that's a crisis issue. And that's the steroid-based supplements. I think the others can be dealt with in due time. But to me, that is absolutely a public health crisis, particularly now with the recognition of the danger of estrogen. And that's a sleeper because most people are worried about big muscles, and nobody has thought about the estrogen effect. And that goes for the older population in terms of DHEA, because it too becomes estrogen.

**GORDON:** I'm wondering if you could provide us with, I appreciate your testimony. If you could provide us with some more of the documentation in terms of either bibliography or even better from our point of view, some of the original papers on the subject.

**WADLER:** Certainly.

**GORDON:** Phil, you wanted to add something?

**SHINNICK:** You know, there's a lot of information available. And what I'm suggesting is that we have some sort of mechanism where we can synthesize the existing information and channel this into the educational process in high schools, grade schools, throughout the whole society. And that has to be systematically done through the existing association. And then there's a lot of questions that you probably personally would be interested in that have to be done too. And that is the mind/body sensitization, which is when a human being integrates the emotions and the feelings and brings together, that they go to a different level. And that different level can be defined by global physiology. You can define it by brain waves and so forth. And performance changes.

And I think the biggest frontier in all this is in CAM, where we have to take what's human about us and continue to develop along those lines and not in a mechanical way and not in a synthetic way, and it will benefit the health of all of our society. And I think this is where the commission should be looking for, is the health of the whole society. And of course this could possibly wellness, as you suggested before. But we need to have the commission help us to bring togehter in some form, maybe it's a center for performance athletics and physical arts. Because we're talking about dancers, we're talking about people under stress, we're talking about truck drivers, we're talking about anyone who performs. There's all sorts of things that CAM can offer them, and it's just not there. So this is more of a problem of bringing it together. And what you see here is the start of this. I've been doing this for 25 years. As I mentioned, I was in China in 1976 and had an NIH grant in 1970 on drug usage, and we still haven't gotten anywhere.

**GORDON:** Effie, you have a question.

**WADLER:** I just wanted to ask, I have one other . . . the whole issue of fedra(?) has met over 50 deaths reported several years ago and there's been attempts to remove that as a dietary supplement. That requires under law to be done, not by the government, by somebody bringing an action.

**Panel 6 – cont.**
**Panel Coordinator, Corinne Axelrod**

**EFFIE CHEN:** And similarly with the sports, are there studies that you have collected on the value of like yoga or Chi Kung (Chi Kung) and all these natural studies? How can you foster, so the next level is marketing, like fostering marketing of the sports person who is top notch and have used these methods, instead of just always the drug that was the negative part?

**SHINNICK:** Well, we really have two sides. We have the synthetic drug scene, and we . . .

**GORDON:** Phil, come closer to the mike, please.

**SHINNICK:** Actually, we have those two sides. We have the anabolic steroids and myself, who was an Olympian, only used yoga. And I still compete on a swim team and I'm fifty-seven and I still do yoga three times a week, and gung fu. There are studies, mind and body, doing yoga that are existing. I think that what we really need to do is to create some sort of mechanism where this information can get out to all the people and the public at large. It's a tremendous thing. Chi Kung (Chi Kung) is a tremendous thing for anyone at any field. I think that the whole area of CAM and this drug thing have to be combined. On the one hand, we say we don't like this. On the other hand, we're talking about the increase in human potentiality, which doesn't require anything more than synchronizing.

**CONNOLLY:** To partially answer your question, with the existing organizations that do test and have been collecting this data, we need to get them to publish it, but it isn't publishable because these tests were punitive drug testing. So I'd like to see that this information be publicized by gender, by race, by geographic area, not for the purposes of punitive testing, but just to know how many athletes in Sydney were using substances that looked like banned substances or were asthmatic or were using those things.

**GORDON:** All right, thank you. Thank you very much. Thank you all very much.

**Panel 7**

**Panel Coordinator, Kenneth D. Fisher**

**GORDON:** We'll begin with the panel now with Renate Siekmann. Okay, please.

**SIEKMANN:** Good afternoon. I come today as a mother of four children. All of my children . . .

**GORDON:** Come closer to the mike, please.

**SIEKMANN:** I come today as a mother of four children. All of my children have benefited tremendously from alternative forms of medicine, especially homeopathic treatment. One of my sons came down with a double ear infection and double conjunctivitis when he was just a toddler. He was given a powerful antibiotic by our pediatrician. The result was such bad diarrhea that he began bleeding from his anus. For a year and a half after that he had daily stomach cramps, diarrhea, and vomiting. My pediatrician had no solution. I finally found a homeopath who was able to cure him and return him to the old self he had been before his ordeal began.

Another one of my sons came down with a bad case of eczema as an infant. My pediatrician

suggested using hydrocortisone cream, an option unacceptable to me. I would not use that type of medicine on myself and I will certainly not put it on my three-month-old son. Again, homeopathy came to the rescue, and within ten days of treatment, all eczema disappeared. I would be happy to give you many more examples where homeopathy in particular has been a wonderful and effective form of treatment for my family and myself.

I feel that allopathic medicine is doing a wonderful job in trauma care, and we would certainly never want to be without everything it has to offer. However, there are many illnesses where treatment is either ineffective or can even be harmful. There are wonderful gentle alternative therapies, which have survived the test of time. Homeopathy, for example, has been used successfully in Germany for over two hundred years, longer than most forms of allopathic treatment. In Germany, as well as many other countries in the world, natural alternative forms of treatment are available to the patient by specialized practitioners as a compliment to allopathic medicine. It is up to the patient to decide which type of treatment he or she prefers. Freedom of choice is what it's all about.

I feel that it is important that the patients are given the choice. Let the different forms of medicine work hand in hand and allow the consumer to choose freely without breaking the law. Let the trained practitioners practice freely without breaking the law. This type of system works beautifully in many other countries, and it can work in this country as well. Let's all work together towards one common goal, a healthier population.

**GORDON:** Thank you very much, and thanks for the pictures of your children. If you don't need any of them, I'll be happy, oh, they're yours.

**SIEKMANN:** Was mine.

**GORDON:** I'll be happy to take those home. Sheldon Lewis.

**LEWIS:** Thank you. As a journalist, I've covered alternative and complementary medicine for more than twenty years. As a parent, I'm the father of an almost seventeen-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 syndrome, Turrets, ADHD, and many more. For seventeen 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, my wife and I sought help from other approaches to health and healing. Homeopathy, chiropractic, craniosteopathy, nutrition, environmental medicine, reiki, meditation, prayer, social therapy, movement therapies, and many others, most of which were helpful. But most parents don't have the resources, the knowledge, or the finances to get the help they need. Just as a medical model is limited, so, too, is a scattershot approach to alternative and complementary medicine. In both cases, you're searching for a magic bullet where none is available. In our case, conditions haven't been cured, problems haven't been fixed. What has ultimately been the most healing has been the journey, the conversations, the love, the interactions with caring people, and building a life for both our sons and our family.

Children don't develop medically. They don't develop homeopathically. And they don't develop 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 anti-developmental 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, 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 us to talk to and listen to our son. He is the one truly holistic member of our team. He talks to his doctors about prayer, amino acids, and blue green algae. He teaches his therapist and friends to do deep breathing and other mind body techniques, which 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 children and their families. 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.

**WOMAN:** Sally.

**EKAIREB:** I passed the photographs because I feel that I'm here in front of you as a mother of two children, but representing all children. And I hope that their image will give us a focus today for why we're here. I've added to what I have to say, the acceptance speech to the Swedish Parliament at the presentation of the right livelihood awards by George Vitholkiss(?). He is a homeopath with four decades standings and a world renown. I'd like to start with his definition of health, which is that health can be defined best by the word freedom. Freedom from pain on the physical level, having a feeling of well being. Freedom from passion on the emotional level, having a feeling of dynamic serenity and calmness. Freedom from selfishness on the mental and spiritual level, the individual having a connection with truth or God.

As I look at my background, I think of my grandparents, who were Christian Scientists and enjoyed the freedom of religion in this country. From them I learned that physical disease stems from an unhealthy mental state. I questioned whether we know look at the freedom to choose on medicine in this country. Because what happened in my history is my father developed fibromyalgia thirty-five years ago. He did not have choice. He did not have information. They did not diagnose it properly so they just medicated it. He went on a narcotic for over twenty-five years named Talwin(?), and about two years ago, as his body was breaking down from all of the medication and it was not working, they switched him over to methadone, which he now takes twice daily for the rest of his life.

I ended up marrying a man, who is now a recovering addict. He started with the antibiotics and other kinds of drugs, but his major drug of choice was marijuana. Why? He suffered from a restless state in his body, his legs and fingers, that always moved in a hurried mind. His problems have never been addressed. From this genetic background, two children were born. Rachel is now ten and David is seven. Rachel developed secondary infections with each viral infection she caught, virtually from her first year. By her third year, she was on antibiotics to such a degree that the pediatrician had me give her a daily dose throughout the winter months. I needed to find another solution.

I went outside the typical realm of medicine and I found homeopathy. I was drawn to it because homeopathy can cure viral infections and, therefore, before bacterial infections. She has now been free of all bacteria and strep infections for three years. I hope you'll listen for a moment for my son. My son David was born in a lower state of health than his sister. He had immediate lung and digestive and neurological problems. It was clear, from early on, that his neurological system had problems that resulted in strong over sensitivity to his environment, noise, touch, and light. Yet on other levels, he had no sense of boundaries or pain. From the night he came home from the hospital he woke screaming with terror. Holding him gave him no sense of comfort. Most often he would scream as someone tried to approach him, and then when they withdrew, he screamed louder as being alone was even more terrifying. There would be a wild vacant look in his eyes, and it would take about twenty minutes of just

being with him before he would become calm.

We started weaning him from naps at eighteen months because this transition from sleep to consciousness was so terrifying for him and so painful for us to watch. I felt so helpful to comfort him, and it was so clear that he did not have that sense of security and safety that is so vital to a young child. His deep state of mental terror was expressed physically by lack of impulse and hyperactivity. His emotions were extreme and easily triggered. He was crawling by five months and running by nine months. He was the textbook model of the difficult child, and quickly labeled by adults as ADD or ADHD. His behavior became more hostile. He became more difficult to control and hitting, biting, scratching, and screaming were daily events. He required enormous energy from me and his teachers. Keeping other children safe was often a major issue. There were days when I thought I would lose my mind. The constant stress of his behavior affected the entire family.

**GORDON:** Excuse me, I'm sorry to interrupt. But I wonder, I promise, and we all will read the testimony.

**EKAIREB:** May I just tell you that he was given a homeopathic remedy two years ago. You can look at this child today. His terror is gone. He remembers his dreams. In fact, this week, he dreamt of a little girl that he has a crush on. He is at the top of his class. He can behave like a normal child. Twenty-five percent of the children in my daughter's fifth grade class were tested for ADD and such things. Parents are looking for options and solutions. I can refer them to homeopaths, but these people are practicing outside the law. Please help us to get solutions for these children.

**GORDON:** Thank you. I appreciate the testimony, and when it comes time for questions, we will come back. I appreciate all of you, all parents, coming here and talking about these issues. And we want your guidance, and we will be asking for it when everyone is finished in what kinds of recommendations, what kinds of regulations, what kinds of congressional activity, which is really our domain, we should be encouraging to make it possible for your kids to receive therapies that are safe and are helpful for them as well. So, thank you. I realize the emotional power for everyone and for all of us as well. It's important that we hear the testimony and it's important that we try to formulate together ways to act. Thank you. Jordana Sontag.

**SONTAG:** Before I begin, I'd just like to ask the commission to take a peek at the back of the room and acknowledge my son, Jacob's, attendance. Of no insult to any of us, he's decided to take a nap, but I do want him to be acknowledged.

My story begins in 1996 when my son, Jacob, was born and then six months later diagnosed with Canavan disease, a fatal neurological genetic disorder. After being told Jacob would never hold up his head, sit, crawl, walk, or say a single word, I was horrified to further learn that he would develop seizures, lose his ability to see, hear, swallow, and would die within the first decade of his life. Even worse than the diagnosis was the reality that there was no treatment to save my baby.

What I thought would be an endless journey to search the world for any hope of a treatment was not that at all. Within a month I had located researchers from Yale University in the Auckland School of Medicine, who had successfully treated two Canavan children with gene therapy in New Zealand, and were planning to treat fifteen Canavan children in a U.S. phase one clinical safety trial. Jacob was enrolled. In January of 1998, after an extremely lengthy review process through the NIH, FDA, and the internal review boards at Yale, Jacob was finally treated and treated once more in September of 1998. Jacob improved dramatically, but most impressive was his ability to generate new white matter in his brain.

As I sit before you today, Jacob, again, waits for the approval of yet another gene therapy protocol that, according to the researchers, is safer, less toxic, and technologically advanced. Whether prior therapy

successfully reached a few areas of Jacob's brain, data indicates that the new procedures will deliver the gene critical in saving Jacob to all the areas of his brain. With the excitement of this potential treatment comes the reality that Jacob deteriorates before your eyes as we wait for a review process that began back in May. While I am told by FDA officials that the review process is to ensure the safety of my child, I often respond by saying why isn't the FDA equally concerned that Jacob could die because of lengthy reviews.

Because of the orphan disease status of Canavan, there is zero federal funding that supports research in this horrific disorder. In addition to the emotional and physical toll taking care of my child has taken, I've also been given the responsibility of raising the funds necessary to support research with the potential of treating Canavan. For an agency that prides itself on working hard to provide the public with safe effective treatments, I'm amazed at the snail's pace and lack of regard the FDA has for terminally ill patients and their families, who have no alternatives. They seem at rest with the fact that because they are taking an unethical amount of time to ensure safety, and patients may die while doing so, there is some sort of justification. I can assure you there is never justification for a parent who must bury a child.

In my summation, Jacob's ethical right to receive a treatment that may stop the progression of Canavan, improve his quality of life, and potentially treat or cure him is denied with each passing day he waits for an approval from the FDA. It is my belief that protocols involving terminally ill patients must be reviewed more expeditiously and with different standards. I would propose the following: for experimental research and preparation for clinical trials involving patients quickly deteriorating from terminal illness, there must be prior knowledge of the FDA's demands, a review process that begins prior to submission. Researchers and patients and patient representatives should be able to have open dialogue with the FDA to discuss protocol intentions, collection of data, risk benefit ratios. The FDA needs to have more interaction with the patients, or the protocols they're reviewing, to understand the magnitude and the necessity for treatment, the patient's knowledge of the alternatives, and the desire of the patient's choice of treatments.

Upon submission, the FDA should be required to respond within two weeks. If there are further requests from the FDA that the researchers and patients deem unreasonable, and we create an unnecessary delay, then the patients or family members should be able to waive the approval from the FDA and sign an informed consent to proceed with the treatment. An oversight committee must be created to protect patients and oversee the FDA. There must be a balance. As stated by our local congresswoman, Nita Lowy, if there is a level of comfort, parents or patients are informed and know the risk, and there are no other options, then we must move ahead and treat the patients. I thank you for this opportunity to share with you my precious Jacob and the struggles we live through every day. I hope that our testimony will make a difference and, most important, save lives.

**GORDON:** Thank you very much. James Navarro.

**NAVARRO:** Distinguished panel, if you will notice, there is nothing in front of you written from me, and I have maintained this posture even with Congress because it's very hard to put seventeen months of struggle onto paper. I will, however, be submitting a written testimony by e-mail later. I am Jim Navarro, the father of Thomas Navarro, who is a terminally ill five-year-old child suffering from medulloblastoma. And as I've listened to the speakers today, the one thing that keeps coming back in my mind is freedom. We have no freedom. As Americans, as occupants of the country that claims to be the bravest, the greatest, and the freest, we have no medical freedom.

We learned early on, in September of '99, when my son was stricken, and, by the way, only days away from death, that after he had been admitted to a hospital for treatment that we, as parents, had no legal right to be involved with the doctors or the treatment process. That, in fact, if we stood in opposition to a suggested treatment, or method that the doctors wanted to do, that we could be

imprisoned for child abuse and medical neglect, and our child taken and treated against our will. But the greater horror to this was the fact that if, in the process, our son died that there was no civil or criminal liability on the part of the doctors or medical institution.

I find it a great tragedy that today, with our abilities in technology, science, and medicine, that we are still administering a failed therapy. And I say failed therapy because of the fact that, for those of you that are doctors, if you have ever read the insert to the chemo drugs used on children, it says there, in plain English, that it has not been proven safe or effective in pediatric application. So I pose this question. Why, then, are we forced, why are we herded like cattle, to subject our children to these treatments that could cost them their lives? Who will replace my son when he dies? The question boils down to this. Who decides?

I've testified a number of times before Congress, and some remember that when I testified and the doctor from the FDA, who had sat in opposition to us, and, in fact, refused six appeals for Thomas to receive treatment, admitted that he didn't even have knowledge of my son's illness or any background history. And in that moment in time, I had greater understanding and knowledge of my son's disease than the person that were allowed to sit in judgment over us. So I think before we can embrace new veins of medicine, or types of medicine, we must first recapture our freedom.

**GORDON:** Thank you very much, Jim. Jordi Ross.

**ROSS:** I want to thank the commission and Jim Navarro for inviting me to speak here today.

**GORDON:** Come a little closer.

**ROSS:** I feel a little out of place among such a distinguished group of panelists, but I hope my perspective as a filmmaker can be of some benefit to your mission. For the last year, I have been working on a documentary about cancer. I call it The War. It is the story of how Jim and Donna Navarro have fought to keep their son, Thomas, alive. In my fifteen years in the film business, no story has moved me as much as the plight of Thomas. As a studio executive in Hollywood, I was involved with three films of which I am proud, Kundun, the story of the Dalai Lama and his struggle for his homeland, the Insider, the story of how tobacco executive Jeffrey Wigand testimony helped to break the tobacco lobby, and a Civil Action, the story of attorney Jan Schlichtmann's litigation against polluters in Massachusetts. I don't know if you have seen any of these films, but they share with the story of Thomas the belief that the courage of one individual can have a positive affect on the lives of many.

I believe the courage shown by Thomas Navarro and his family, their willingness to go up against the FDA, and the medical establishment will be seen as an important turning point in the project that brings all of you here today. I want to share a brief story with you. When I began filming this documentary, and I hadn't met Thomas yet, I used to do this little experiment. I would go up to random people in the street and ask them to do a word association game with me. I'm sure you're familiar with the game. I would rattle off a number of words, and about seven or eight words in, I would drop the word cancer. I'm sure you can guess what I got back in response. I would say that eighty percent of the time the word I got back was death or pain or dying or something to that effect, and I think that is significant.

Now, this was not a controlled experiment and it was not a random sampling, so I'm sure it's of no real value and it will definitely not get published. But as a filmmaker, I was intrigued. To me this meant that a large number of us are walking around, and when one out two or one out of three, or whatever it is, I don't know what the numbers are, are diagnosed with cancer in the future, many of us will believe that we have been handed a death sentence or at least a long period of time with a torture. I wouldn't say that this is a healthy state of affairs in a country whose medical expenditures dwarf the GNP of most other nations.

So when I first started the documentary, I said to myself that if I could change even one person's belief, that a cancer diagnosis did not have to equal death, I would have done my job. And then I met the Navarros and I realized that nobody could make my case more eloquently than this family, who have defied all the odds and who believe that the power of love and the power of a parent's love for their child, more than money and more than drugs and more than high tech cures, can keep a child alive.

**GORDON:** Thank you very much. Would any of the commissioners, yes, Joe?

**JOSEPH FINS:** Ms. Sontag.

**GORDON:** Joe, come close to the mike.

**FINS:** Ms. Sontag, it's a pleasure to meet you and I read the article in the *New York Times* magazine section a couple years ago, and it's nice to meet you and your family. What would you recommend as a policy or some sort of recommendation for the FDA? Should there be an ombudsmen, someone who could represent family interests in the federal bureaucracy? You know, when you have to interface with this massive building and no one knows what's going on, someone who can sort of be your advocate, the people's advocate in the face of the bureaucracy. What kind of concrete recommendations can you help us with so that you don't face an impersonal bureaucracy?

**SONTAG:** Well, I think your point is well taken. Since waiting since May for this review process, which, I will say, has been politically driven. There have been some recent events in the gene therapy field that have caused some delays, and my son is being tangled up in that tidal wave of a bureaucratic nightmare.

**GORDON:** Jordana, come a little closer to the mike.

**SONTAG:** I don't have anyone to turn to. I have nothing to do, but to wait. There is no agency. There is no commission. There is no parent representative. That is there is nothing set up to help patients that are fighting this fight and just simply trying to save their children's lives. So, yes, I agree with you. If there was some type of oversight committee that would keep the FDA in check and to watch over my son's ethical rights to a treatment, then, yes, I wholeheartedly agree with that.

**GORDON:** Thank you. I'd like to open the question that Joe just asked up to all of you. Are there other suggestions, Jim, or any of you might have for making it possible to have access to some of these therapies. Yeah, please.

**EKAIREB:** There has to be the freedom for people to be educated and to practice these disciplines with freedom in this country. Today we've just heard from a panel of what sound to be very qualified doctors, who have been persecuted for helping. I mean, the intentionality of these people was so strong, and yet what we're finding is there is something about the way the system is operating that they're being closed down. And I, as a mother, and I hear this, I am so lucky that I have the finances that I can go to a homeopath that is legal, but I talk to people. They can't afford $700 for an initial consultation. This should not be the way it works. We need to get good schools with licensing and certification. We need to have people be able to explore these disciplines with freedom the way they do in other countries. And the whole background of education because doctors are so burdened with what they learn. I mean, it's phenomenal the amount of information that goes into the medical community and into the pharmacology that we have today. But then there are whole other realms that are outside that domain and they need to be stimulated and flourished because the pain you heard from me is what I hear from too many other

parents today.

**GORDON:** Thank you. Jim, were you?

**NAVARRO:** Yeah, one of the things, Dr. Gordon, that I'd like to bring up is during this seventeen months with Thomas' struggle, I took the time to educate myself. I don't think it's an issue where we're denied access to education. I think what we have to do is break the chokehold of the old guard. If there's going to be any type of a review panel with the FDA, or even amongst yourselves, it must, in fairness, include parents like us that are living this nightmare. One of the things that changed the dynamics of my relationship with the FDA was the fact that I made it a point to bring Thomas to the doctor's attention. Thomas was no longer a number. He was no longer a name on a piece of paper. When I put Thomas in front of him, and there had to be physical contact and he had to look in his eyes, it changed the dynamics. So often they shield themselves. It's a disservice to those of us that are out there struggling. The panel definitely needs to be a reality, and it needs to happen now.

It's interesting that when Jordana and I first met, one of the first things you do is compare illnesses. And it was interesting that the common denominator between our children is that they're both terminally diagnosed. Also the fact that neither one of them, according to standard knowledge that is available now, will survive their illness. But I found myself becoming envious of her in that, whereas Thomas is alert and appears to function as a normal child that Jacob will live five times longer. Thomas is now in the last months of his life unless we change this.

**GORDON:** Thank you, Jim.

**LEWIS:** My wife and I were also threatened by a physician who was going to take legal action against us because we wouldn't let them cut our son open and insert a tube so that he could, because he wasn't gaining weight when he was very little. We had quite a fight on that, but we instead took him to someone who put him on an elimination diet, and we went to a homeopath, and he started gaining weight. We get, my wife and I get, calls from friends of friends of friends and relatives or relatives on an almost weekly basis asking for information. People don't know where to turn. We need to create some kind of parent information network or a way that parents can support one another because really most of the medical specialists that you go to when you have a child in a life threatening situation don't really have this information. The experts are really the parents and the complementary practitioners who have been working with children and their families.

**GORDON:** Thank you. George, I think you had a question. Did you have a question? I, on behalf of all of us, I really want to thank you all for coming. I think it's, my hope is that out of the pain that you and your families and your children have suffered and are suffering that somehow all of us will learn what we need to learn, and it will help us have the force and the energy and the wisdom to open this system up so that whatever we have available that may be helpful is available to everyone. Thank you very much.

**MAN:** Thank you for including us.

**Panel 8**

**Panel Coordinator, Dr. Kenneth D. Fisher**

**GORDON:** One thing I did want to say as we're getting ready for this panel is I do feel it's so important for all of you, not only who are speaking with us, but who are working to change and enlarge and improve the health care system to bring . . . real human face of these issues to the people who have power to make those changes. I'm definitely going to keep this picture on my bulletin board. So, thank you. Next panel, Robert Schiller. Hello.

**SCHILLER:** Thank you for this opportunity. I just want to comment on the previous panel, and I think, although I'm going to address certain issues related to larger systemic problems, I think it's important for all of us, either as practitioners or people who access the system, to understand that the driving force of a lot of this is what the people's personal lives and personal struggles around health care and how this country really needs to address these issues and involve all of us as people who have to use the system and suffer with its limitations.

I want to address the issue of public health and how we can try to heal the system, in addition to how we attempt to heal our patients. The recent expansion of complementary and alternative medicine to various medical settings has brought profound benefits to many sectors of the health care system. However, these achievements have benefited only a fraction of the population. People with inadequate health coverage have little or no access to these therapies. Ensuring equal access to CAM for all citizens should be of the highest priority for health care reform. I believe there is a tremendous opportunity to bring the reform of public health care policy, together with the expansion of the practice of CAM, in an effort not only to correct this inequity, but to address many of the other problems of the health care system.

As complementary medicine has reintroduced healing in the mind body connection into conventional medicine, so can these practices bring public health back into the sphere of the medical mainstream. The key to bringing public health and medicine together exists in strengthening the system of primary care and enhancing these services with the integration of complementary medicine. I am a family physician with over fifteen years of experience, mostly practicing in lower Manhattan. Although I've received training in acupuncture, I currently practice mostly homeopathy with general family practice patients. I have learned from various practice experiences that it is essential to build complementary therapies upon an existing successful primary care practice. Primary care is the most efficient and effective way that people access the health care system. A primary care team is a model of collaboration and integration of services. And complementary therapies can be part of the routine referral network for this practice.

From my early years as a resident until now, I believe that beyond broadening the therapeutic options for the patient, the real potential for CAM is in its ability to potentially radically transform the health care system. Many of us were drawn to learn about these methods because we knew of the fatal flaws in our training and in the practices where we cared for our patients. We hoped, even expected, that the widespread use of these therapies would promote a more caring system, one that would be devoted to healing and encourage the curious critical use of new or ancient unconventional therapies. The excitement, enthusiasm, and positive results of CAM practitioners experienced in the exam room need to be extended to the surrounding community in the form of health education, health promotion, and health care reform. Racial and economic disparities in providing even adequate care has been highlighted among the more important health care issues in this crisis. Now it is time to correct these disparities and access to CAM.

If I could just conclude with certain recommendations, I suggest that people without health insurance or inadequate coverage are entitled to equal access to CAM therapies. HCFA and state legislatures should provide a basic package of coverage. These basic Cam clinical services need to be defined and based upon principles that permit local and regional variation. Training of health care providers, both physician and non-physician providers in these basic therapies is essential. And financial support for this initiative is the most challenging problem. With a fixed health care budget other

services and training may have to be reduced and eliminated. This is a crucial role for public health care policies. Supporting programs that provide the greatest health care benefit to given communities will assist in these decisions. And I'll conclude. Thank you.

**GORDON:** Thank you. Ellen Paula Tattleman.

**TATTLEMAN:** Hi. I appreciate this opportunity to speak with you about medical education. I'm a family doctor working at Montefiore Medical Center and a faculty member at Albert Einstein College of Medicine. For the last fifteen years, as a clinician, I've been integrating a number of different CAM approaches into primary care, mostly with the medically under served in the Bronx and lower Westchester. As a teacher, I've been presenting these modalities and their underlying philosophies to residents and medical students. Presently, I chair a group on CAM for the medical school's Department of Education, and we've begun to integrate CAM education into all four years of the curriculum.

My experience has shown me that CAM education is critical to the education of health care professionals, but we must acknowledge that this education presents a significant challenge to our present medical and educational systems. Many schools now offer electives in CAM, but we need this training to be required and integrated into all areas of the curriculum. Often students here an introduction to CAM, but they may here this introductory talk many times without it going any deeper. We need to teach some specific techniques to the students. Which areas of CAM you choose to teach, whether it be mind/body or . . . or herbs, that is less crucial than approaching the techniques in a hands-on way, emphasizing self care is crucial to health and healing. Use the best teachers you have available and let them teach from their expertise.

What is really important is that we don't just substitute one of these techniques for a western medical one. We don't just use an herb in place of a drug. We need to integrate conventional and unconventional medicine, and we need to change the whole approach to patient care. We need to teach the deeper philosophical base of CAM. Teach about health and healing, about working with another person to let the body heal itself in order to reach the harmony of mind, body, and spirit. When we bring CAM to medical education, we need to bring a change in the paradigm of conventional medicine. We need to move away from the focus on curing diseases to one of healing individuals within the context of their community and family network. We should encourage research and evidence based CAM practices, but we also need to endorse the connection between patient and provider that many people seek when they turn to CAM practitioners. We need to emphasize, along with CAM techniques, the compassionate and loving embrace of each individual by the health care professional. This provides the basis for healing to occur.

In conclusion, we must acknowledge that we need to change the paradigm of conventional western medicine, and CAM education needs to be a required, not elective, part of health care professionals curriculum.

**GORDON:** Thank you. David Katz. You're not David Katz. Okay, William Prensky.

**PRENSKY:** That I am.

**GORDON:** All right. I got it.

**PRENSKY:** Thank you. My name is William Prensky. I am the director of the graduate program in acupuncture and oriental medicine at Mercy College in Dobbs Ferry New York, and also chief of the division of acupuncture at Sound Shore Medicine Center in New Rochelle New York. I'm here to speak with you not about a monolith of CAM, but about a discipline specific medical system, traditional, acupuncture, and oriental medicine.

Mercy College was the first regionally accredited comprehensive graduate institution to integrate the discipline of acupuncture and oriental medicine into its offerings in allied health and professional health sciences. In 1996, we merged that study into the general study . . .

. . . Vision of health sciences and began a collaboration, a unique collaboration, with Sound Shore Medical Center of Westchester, an accredited teaching hospital with five accredited residency programs, to educate and train acupuncture and oriental medicine licensed independent providers in a conventional hospital setting. 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. Chief amongst these barriers are the inequities and inefficiencies and insufficiencies in the education of professionals in all branches of medicine and health care. Isolation has been one of the major factors, which has prevented barriers from going down. Up until now, acupuncture and oriental medicine have been taught only in stand alone, small schools built upon a technical training model. There has been no strong academic infrastructure support and no buy in by academic medicine or by academic allied health care. That acupuncture and oriental medicine offer 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.

The students in our program earn a masters degree in acupuncture. And in order to do that, they must spend twenty months in education inside the hospital setting. And, in addition, they must complete a formal research thesis, which generally consists of designing and implementing an original research project. Because of this, they participate on an equal footing with gaining evidence, which indicates the efficacy of their own medicine within the hospital setting, and in creating relationships, which help to bring these barriers down. In order to complete that process, we are now beginning to develop a postgraduate fellowship program, which will provide clinical specialist education for the practitioners in our field inside the hospital setting.

So I'd like to give you a list of six policy changes, which I think would be helpful in helping to continue this process. We need enhanced federal support for acupuncture and oriental medicine education and other discipline specific education at the highest academic levels. We need federal funding for hospital-based residencies in other forms of medicine. We need federal support for research aimed at providing answers and innovative means of asking questions that are discipline specific. We need training grants, as well as research grants. We need the educational infrastructure of all other forms of medicine to begin to move towards the academic excellence which conventional medicine has attained. And we need federal policy which opens Medicare and Medicaid reimbursement to acupuncture and oriental medicine, and other forms of medicine, which are not currently practiced. Thank you.

**GORDON:** Thank you. Kenneth Gorfinkle.

**GORFINKLE:** Thank you all for giving me the chance to speak to you. I'm a pediatric psychologist working at the bedside of critically ill children. We provide treatment that is both alternative and complementary to allopathic, medical, and surgical care in a larger tertiary care teaching hospital. We do so with full cooperation and usually close involvement with the medical and surgical, as well as nursing, staff. For over twenty years, our field, in our field we have attended to children's quality of life needs. While our medical colleagues attend to pathogen and disease, we focus on pain, fears, and many of the unintended side effects of medicine, surgery, and radiation. This includes pain, nausea, weight loss, fatigue, immune compromise, not to mention loneliness and despair.

The tools of our trade are, unlike suture and scalpel, friendly to children. They involve harnessing the child's imagination and natural tendencies to joy and playfulness, and using that to

transform the meaning of the hospital stay from nightmare to feelings of mastery and understanding. Because we work elbow to elbow with medical and nursing staff and trainees, they, too, inevitably, adopt an increasingly integrative holistic approach to care. Our role in providing complementary care to sick children is hard won. We are committed to put our treatment methods to rigorous test and evaluation that you might expect of an intervention with any critically ill patient. That commitment has been instrumental in forging a working alliance with our medical colleagues. I'd like to see academic medical institutions welcome practitioners who wish to integrate traditional, naturopathic, and oriental approaches with our current technological focus.

But these approaches clearly, they offer a great deal to children, and they have not been available for a number of reasons. Some including that such approaches don't easily lend themselves to empirical examination. Two, there are few satisfactory ways to establish qualifications and standards of practice in most modalities. It's difficult, but essential, to question how a child can provide informed consent for alternative and complementary interventions. We're reluctant to lay our hands on other people's children, even in the hospital, and even when they're healing hands, lest someone interpret it as a breach of medical ethics.

In conclusion, child psychologists, pediatric psychologists, are uniquely suited to the task of bridging the gap between eastern medicine approaches and those of the American physician. Key steps to take include the establishment of qualifications of practitioners, in whose hands parents must place their children's care and safety. Better educational information is needed for parents and pediatricians alike to render informed consent on behalf of their minor children as they expose them to traditional and complementary medicine. And, finally, as a parent, I would wish to know a great deal about any method or approach employed on behalf of my own children. So I'll stop there. Thank you.

**GORDON:** Thank you. Constance Park.

**PARK:** I'm Connie Park.

**GORDON:** Connie, bring the mike toward you.

**PARK:** I'm an endocrinologist internist at Columbia, and also the education director of the Rosenthal Center. I just want to make one brief comment about research, which is that as part of a CDC grant looking for promising unconventional therapies for cure or life threatening illness, we, in interviewing practitioners, have found practitioners asking us to please help them figure out how to do case reporting. Which are the key features of the patient that are important, in terms of the illness the patient has? What's the burden of proof? What's the evidence they should have? This is the . . . how should they describe the intervention? How should they describe the effect? If people don't know how to report their own individual cases, then there's a lot of very lost information that's very important. And when we go around looking for those cases, it would be wonderful if people could just put them forward and eventually, perhaps, the commission could have a mechanism for case reporting that would partially relieve the burden, to some extent, from people like the parents we've just heard to feel that there is no mechanism at all to look for that one case that might have a meaningful impact for them. So that would be my first point that relates to medical education because we teach by cases, as you know. And the more interesting cases that we have that relate medicine in hand with biomedical, whatever, the better, more effective teaching they'll have.

As somebody who has been involved in medical education for twenty-two years, some with the nursing school, mostly with the medical school, I've always been bringing in the peripheral curricula on ethics, on patient interviewing, on whatever. So I can tell you that there is a growing body of information within medical schools about the importance of the total person perspective, and there are huge numbers of courses, as you all know who were in medical school, that at least address this. It's the low status

teaching. I have my high status teaching when I'm speaking about endocrinology . . . preferably molecules, and then my low status teaching when I'm speaking about human beings. But we have enormous amounts of curricular time from the point of view of the already packed curriculum that relates to those things, and it's very important for CAM people to recognize that.

So we would like people to build on what's already internal, and to eventually not have something . . . is the CAM practitioner with the CAM approach and the biomedical practitioner with the biomedical approach. But if they could together work on questions of basic epistemology, how do we know what we know? What are the rules of evidence? Basic definitions: what is health? What is healing? If we could present a case where we show the people going the healers going out into the rainforest in Costa Rica, collecting the leaves, bringing them back to the village. The leaf comes to the botanical gardens. It's ground up. It's put in the machine, an active agent is found. Pill bottles distributed in clinic. Many people feel better. We could see what the gradient is of what's gained as we go down this reductionist approach, but we could also see what's lost, and we could have a group of people, who are scholarly, and having open minds and intellectually creative rather than, and looking at the whole truth rather than having fragmented groups. These are the people I would hope to help train with trained medical students.

**GORDON:** Thank you. I wanted to ask one question, which is really in a sense turning a question back to you. Which is what are you all doing, particularly those of you who are working, four out of five of you, who are in conventional medical schools, what are you doing to help move ahead the agenda that you have, the perspective you have, within the community of medical schools, and particularly with the AAMC? What are your efforts? What are the difficulties? Where would you like to go?

**TATTLEMAN:** I have not gotten involved with the AAMC, but I know there is a group, a CAM group, at the AAMC. It's a special interest group. It isn't one that was sanctioned, but a small starting group that is beginning to look at this. I know a few people on that committee, but I don't think it has moved very far yet. They are looking at it, but it's slow.

**GORDON:** Let me ask you, at the risk of being personal or impertinent, but because it's really an important question. Why aren't you involved in that committee?

**TATTLEMAN:** It's mostly time. Just being pulled in many different directions. I think you're right. It is very important that we get there and we move this ahead and this be across all medical schools. But, at that moment, that hasn't been possible for me.

**SCHILLER:** I think that the participation in the professional organizations is crucial. One member of our faculty, Ben Klegler(?), was responsible for getting the Society of Teachers of Failing Medicine to actually pass a core curriculum in this area. However, it's my experience at the institution that I work, and also when I was previously at Montefiore, that what really gets physicians to change their mind are not blue ribbon panels, but the patients that they work with, getting their colleagues to begin to ask the questions. So when we started an acupuncture program in this clinic that served people in lower Yonkers, and started doing acupuncture, there was a lot of resistance at the institution. They were concerned about liability issues and exposing the residents and medical students to this type of practice that was unproven. It turned out that when these physicians heard about the results from these patients, those faculty members, who were the most critical, began to refer their most difficult patients to us.

So that's why I think although the work has to be done within the professional organizations, the resistance to change in those organizations, and the other issues they're faced with in their professions, really makes it difficult to get high on their agenda. It's really the bottom up effect, and that was sort of my point about public health, and particularly those of us in primary care are really in the best position. I

mean, family physicians across the country have really embraced a lot of these, much more than other disciplines. And I suspect there are a variety of specialty organizations have put CAM on their agenda, but not really focused on the practical ways in which you can introduce and implement some of these practices so that those practices become the laboratories for students and residents to learn.

**GORDON:** Connie, did you want . . .

**PARK:** Well, I think it is important to work within the professional organizations. Certainly, it shouldn't be ignored. The Society of General Internal Medicine has had large amounts of units related to total patient medicine, including forays into CAM, etc. The ACP panels last year, there were several related to CAM. And I think it's very important to acknowledge what's being done that can be built on for cross-fertilization. I think there is a huge danger with this term integrative medicine that CAM is saying this is health and healing, this is total patient medicine as if only people who come at medicine from that direction are doing that. There will never be any meeting of the minds at the medical center with that. There's a huge literature of patient centered medicine, the bio-cycle social model. There's lots of other literature that should be there, and this should be a meeting where eventually we look at the truth. We look at the issues. We don't . . . where they came from, and I'm upset by that, the integrative, the implication in there. We all are involved in health and healing, and we shouldn't see ourselves as one or another. I like to see myself as an open minded intellectually curious person trying to have intellectual honestly, humility, about the limitations of what I can do. And I would like to, as much as possible, instill that in students and then they would make choices among all the actual options that do exist, knowing limitations of certainty when they do exist.

**GORFINKLE:** I'd just like to highlight a research project at Babies and Children's hospital that was conducted by Dr. Kara Kelly, a pediatric oncologist, that has really had a grass roots effect that may or may not have been intended. And that was we questioned parents of all pediatric oncology patients, how much they were using alternative and complementary treatment approaches with their children. And a large sample showed that upwards of sixty seventy percent of parents were using these approaches, many of whom, unless we had asked them, weren't going to tell us. Weren't going to tell their pediatric oncologist or their nurses because they were afraid it would be disapproved of. One of the nice side effects of this research project was that it really has opened up a nice dialogue between the patients, their parents, and me, the clinical psychologist, and also the medical staff. I think that hopefully that will spread through the pediatric oncology group.

**GORDON:** I'd very much welcome a copy of that study.

**GORFINKLE:** I'll get that for you.

**GORDON:** I'll get that for you. Yes.

**PRENSKY:** In spite of the fact that I'm not teaching in a conventional medical school, Sound Shore Medical Center is a teaching hospital and a major teaching affiliate of New York Medical College. So I'd like to speak to the question if I might. Every aspect of the mutual respect, which needs to be built, is built upon relationship. So every resident, in the five residency programs at Sound Shore Medical Center, spends time with us in our teaching facility at the hospital in which discipline specific licensed independent providers of acupuncture and oriental medicine are educated. Every medical student who does any rotation through Sound Shore Medical Center, from any medical school, spends time with us in the same way.

We do in-service training for all aspects of the house staff, all elements of the house staff. And they, in

turn, do in-service training for us. Our students are paired with residents as preceptors, and residents come to us in order to learn about our medicine. So there is an aspect of this integrative education, which doesn't need to be formalized into the undergraduate medical curriculum, but into the relationship building that takes place in the graduate medical curriculum.

**GORDON:** Do you have a description of that, of the program, that you could give us?

**PRENSKY:** Yes, yes I do. Some of it is in what I have given.

**GORDON:** I'm just curious if you can tell us one or two of the most, how did this come about, especially, importantly, what does everybody else have to learn from your experience?

**PRENSKY:** It came about because we had the unique opportunity to pair two regionally accredited institutions that were similar in size and in academic point of view. So both institutions felt comfortable with one another. And there were faculty and personnel in both institutions who were pioneers in desiring to do this. So that's one of the key things. There has to be a champion in both institutions that wishes this. Some of the things that we've learned about it, however, are extraordinary. I can share a story with you.

Our students spend twenty months in the extended care pavilion at Sound Shore Medical Center, treating patients whom acupuncture and oriental medicine students almost never see, bedridden patients, terminally ill patients, chronically ill patients. At one point, one of the gerontologists was speaking with a patient, and said to the patient, well, I don't know what more you want us to try and do for you. We've brought everything we have. We have the anesthesiologist, the pain fellow. We have the physical therapist. We have the psychologist. We have the acupuncturist. They were all seeing you every day. And at that moment, we knew that we had entered into the tapestry. We had seamlessly integrated.

When we first began, in 1996, there used to be cartoons put up in the medical lounge and in the medical dining room about our presence there, and it was a tremendous resistance to us being there. I would say there were ten percent of the physicians who welcomed us, twenty percent who tolerated us, and the rest who actively disparaged us. At this point, there is no member of the admitting or house staff at the hospital who does not regularly refer to acupuncture and does not call for consultations.

**GORDON:** Thank you very much. That's extremely helpful. I think we'll be asking you for more information, especially for our February panel on education and integration and bringing together the different fields. Other questions? Charlotte, yeah.

**CHARLOTTE KERR:** Dr. Park, I appreciated your last comments. In light of that, though, I wanted to speak to Dr. Tattleman's comment about the need for the philosophical review in the education. You spoke of epistemology. And I'm wondering do you think we need to have more of an emphasis than we usually do when we're talking about the incorporation of CAM therapies? Would it help us in this paradigm shift you speak of?

**TATTLEMAN:** I believe it's really crucial. I agree with Connie that any physician can have a health and healing relationship with a patient, and can promote that. But I don't think our medical schools are doing a very good job of creating physicians like that, even as we've added patient centered talks and, you know, added other things, having artists come talk to medical students. It doesn't seem to be making the kind of change we need to see. I think that what you talked about, and what you talked about, the relationships are very important. But the point about the AAMC, I think it does have to come from a professional organization in order to see that kind of change, and it needs to be very deep. It needs to have the philosophy. It needs to, I happen to be in a medical school that is very open and has

embraced the idea of integrating CAM throughout the four years, but that's not true across the board, obviously. I've had no resistance.

So the professional organizations that really dole out the time for the different things that are required do need to get involved. And I think, as I said, it needs to be on that deeper level because these talks that we've had, that we've incorporated, people have been listening. They've been talking about patients and about listening to patients and interviewing patients, but it doesn't seem to be. The minute they get into the hospital and on the wards, where the things that are reinforced are not sitting and listening to a patient, but rattling off information . . . unless that changes and unless what is reinforced throughout the four years changes, we're not going to see the deep change we want to see.

**PARK:** That's definitely true, and that's really harks back to another involvement at the Rosenthal Center, where we have one of the NIH funded research centers. And part of that is supposed to be career development for research in complementary and alternative medicine. While we would be happy to take fellows who are going to, in fact, find that phytochemical and feed it to women and show that their bone mineral density has gone up. In reality, that person could have been trained strictly in biomedicine. So we, with our fellows, don't want to just put them into those kinds of projects. We want to have them exposed to other systems of medicine with other paradigms. We want them to have that type of open mind that looks at rules of . . . looks at ways of knowing just because there's not this type of evidence doesn't mean it's not a legitimate form of knowledge. But let's say what form of knowledge it is. If a healer wants to say that this is something that I just feel is right and, I'm sorry, I'm not interested in your randomized clinical, that's something to look at. That's not something to just set aside. That's a way of knowing. Patients have ways of knowing. Clinicians have ways of knowing. The dyad has ways of meeting or not that are subtle.

**GORDON:** Thank you all very much. It's very helpful for us.

**Panel 9**

**Panel Coordinator, Corinne Axelrod**

**GORDON:** Mark Hoch.

**HOCH:** Hi. Thank you for the opportunity and privilege to address you and for all the hard work that you are doing to advance health and medicine in this country. Very much needed. I'll focus my remarks on the education of physicians with regard to complementary and alternative medicine. Just as a way of background, I'm the secretary of the American Holistic Medical Association, and I have extensive practice and teaching experience, both in conventional and in holistic and complementary medicine.

From my perspective, I feel it's critical for physicians to be well trained in CAM. This needs to begin from the beginning of medical school. Students need to learn the history, and also the core philosophic constructs of various disciplines that make up CAM. And they need to know the diagnostic and therapeutic strengths of each discipline. It's also important for them to know the toxic effects of the therapies and the potential harmful interactions between mixing modalities. It's also important for them to be taught how to evaluate the literature in various disciplines and where to find that literature. And they need to have an understanding of the language of the discipline so they can communicate effectively with their patients and also with the other practitioners that they'll be working with in the system.

Also of critical importance is for much of their training to be given by teachers, who not only have a solid intellectual grasp of the above, but who can effectively practice those disciplines. This

means the students need to be afforded a meaningful clinical experience so that when they actually are trying to do something, they'll be effective at doing it and they're much more likely to put patients in harms way. However, I think the most important thing that I'd like to say today is that we need to go way beyond the common concepts of complementary and alternative medicine, and we have to be very careful not to CAM up the current fatally flawed system of disease management that we have.

If our goal is to really improve the health of this nation and the people that make it up, we need to build a new foundation and one that acknowledges, honors, and values health and the profound ability we have to heal ourselves and others. I think we need to teach this to our children and to society and especially to students of health professions. We need to empower people to be self-responsible and to learn to care for themselves.

Along these lines, I think it's very important for us to work with the pioneers who have already blazed the trail and not to dilly around here. We need to work with organizations such as the American Holistic Medical Association, which will be putting on its twenty-fourth annual scientific conference this spring, and has already co-sponsored several three and four day conferences in the art, science, and practice of holistic medicine with the departments of family medicine at several medical schools around the country, and with the newly founded American Board of Holistic Medicine, which gave its first national certification exam in December. These organizations are not only teaching positions about how to practice quality medicine, but also . . . beginning to set evidence based standards and guidelines of practice. And we also need to honor and utilize the gifts of the worlds many traditional medicines that have really brought high levels of care to us for a millennium.

And, in closing, just four points I'd like to make. One is that physicians need a thorough education in this area, and they need to get it in medical school. It's critically important that they get this education also with a clinical practical background so that they can actually go out and practice. Again, I think we need to build on the base of the pioneers that have gone before us, the organizations that we have now, and the traditional medical systems. And, most importantly, we really need to get to a health based system so that we're really meeting the needs of people and not, again, just throwing some other Band-Aid on the horse that already ran out of the barn, was lost, and sick and dying. Thank you.

**GORDON:** Thank you. Is Fran Catherine Starr here? Yes, okay. You confused me because you're sitting at that table. That's fine.

**STARR:** I'm sorry.

**GORDON:** That's all right. I'll get over my confusion.

**STARR:** I'm a holistic RN that practices, teaches, and develops programs on holistic nursing and medical Chi Kung. Medical Chi Kung, I have to say, medical Chi Kung being my first love. I had the honor of speaking at the World Congress on Chi Kung, organized by our esteemed Dr. Effie Chen, just recently and coming again in the spring. I wish to present three separate statements to the commission on behalf of a public hungry for access to alternative practices with integrity and freedom, and on behalf of nurses that want to heal the body, mind, and spirit with integrity and freedom, as one who personally benefited from complementary and alternative modalities myself.

Topic one in brief, promoting integration of CAM practices with traditional medical professionals, with the objective of educating and promoting CAM to allopathic professionals. There should be readily available concise scientific and factual based literature written in a context that would appeal to the medical professional. Some of the facts that should be included would be statistics on the popular demand of a complementary practice by the public at large. We also need more co-representative represented conferences, where CAM practitioners and traditional and medical practitioners can share information side by side, combining the best of both worlds and encouraging and

promoting the acceptance of CAM by medical professionals in a friendly setting. These conferences should be composed of well-known practitioners of both traditions.

Topic number two, the American Holistic Nurses Association was established in 1987 in an effort to organize and support nurses who believe in treating the body, mind, and the spirit, incorporating the various CAM practices, with the guidance and provisions to assist in providing and promoting the maintenance of professionalism that would uphold using these approaches, and provide guidelines for practice with integrity. We need more funding for individuals; financial support provided to aid and promote education in college courses about CAM within the institutions of higher learning. And we need more funding that would make it easier for nursing CAM practitioners to promote and participate in CAM practice models for research, without the criteria being attached to an established institution. In other words, funding for private practitioners to do research that can develop a comprehensive plan.

Topic number three, there is one brief statement I would like to have noted by the commission regarding practitioner guidelines. And that is simply that it does not take a bachelors or doctorate to practice CAM, but should involve some basic knowledge of anatomy, physiology, and simple understanding of the disease process of the body. There is so very much to consider in these processes. My proposal to you, in closing, is that along with considering all things, we need to bring CAM up to the acceptance level we desire. We also must consider that it should be done in a timely and expeditious manner. Thank you for your time and attention.

**GORDON:** Thank you. Sally Bishop. Bhaswati Bhattacharya.

**BHATTACHARYA:** Thank you for the right to testify. I have four recommendations on education and training, which come from my perspective as a public health professional, a preventive medicine doctor, and a holistic healer. My concerns are for the patients who are in the vulnerable position of having to depend upon another being to heal.

My first recommendation is for people who practice holistic medicine or integrative or complementary or alternative medicine to know the evidence that's out there. For the last ten years, I have been working to unite programs and educational courses, which are trying to teach that kind of evidence. There are databases, there are directories of databases, there are collections of directories of databases, and yet many patients and doctors and healers do not know the scientific as well as the anecdotal evidence that is out there. There are books. There are online written evidence based texts. And we need to make sure in our policies that those kinds of evidences are paid attention to, both for legal, medical, regulatory, insurance reimbursement, as well as educational purposes.

When a person does a Ph.D., they are required to take a qualifying exam, which shows that they have evidence in their field, they have knowledge of the evidence in their field, before they can even start doing a thesis. As far as I know, most MDs do not need to show that they have evidence and knowledge of CAM before they start to practice CAM. MDs are allowed to do whatever they like, in terms of practicing certain forms of CAM, and I have found doctors who barely know how to pronounce ayurveda who are calling themselves ayurvedic doctors. People who have just learned the difference between homeopathy and allopathy to say that they are practitioners because they have an MD. I happen to have the accolades and the trainings from the best institutions, and I've gotten that access so that I have the right to practice what I do. I do energy work, and my main work as a healer and as an educator comes not from the institutions where I've been granted my degrees, but rather from the forests and the bush and the mountains the places where the healers actually teach people who will sit at their feet and learn.

I would like for our second recommendation to examine how we decide who will teach us. Will we listen to the grandfathers who know how to practice holistic medicine, people at the AMHA, people who have been practicing for thirty or forty years? Or will we pay attention to the doctors who have just gotten two months certification courses and now decide that they can be the head of a department of

CAM?

The third recommendation is that we are vigilant on how we decide who is "good enough." And this requires us to look at how we credential, how we decide who is good enough. For example, a man who knows how to, a man who cannot sense Chi or disbelieves his existence can be a chairperson at a CAM center. And yet a cardiologist who couldn't understand how to hear a heart murmur would never be allowed to be a chairman of cardiology.

The fourth recommendation is that we include students and patients when we look at how we design our education policies because it is the students who know how they want to learn. It is the patients, and parents of patients, who know what evidence is really out there. Thank you.

**GORDON:** Thank you. Pamela Miles.

**MILES:** When I refer to . . .

**GORDON:** Come closer.

**MILES:** When I refer to traditional or natural medicine, I just wanted to clarify that I mean those medical systems and therapies that developed before science.

**GORDON:** You may have to bend a little.

**MILES:** I speak to you as a consumer who has used medical, natural medical intervention since childhood, as a mother who has raised two children with the required annual medical exams and occasional x-rays, but without ever having to use any conventional medical interventions, and as a traditional practitioner with thirty years experience, who only works with clients who are using medical care as well, and as an educator. I am the 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, myself, 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 techniques. I come from three generations of nurses. My parents used physicians, but never assumed that a doctor's visit alone was adequate to ensure health care.

Twenty years ago, when my son was born, 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 cared for properly. Over the years, I've developed good working relationships with my often-astonished pediatricians, who would acknowledge that we got faster results with natural techniques than they could have gotten with conventional ones. 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 that we depend on, and all of the services that I provide as a practitioner, are actually illegal because the government does not separate natural, noninvasive health care practices, many of which are really lifestyle interventions, from the practice of scientific medicine, which clearly requires a high level of expertise.

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. We need to be able to follow our passionate commitment. Most people who use natural therapies do so as a not 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. And I've attached specific recommendations in my written comments. Thank you for your time.

**GORDON:** Thank you. Brian MacNamara.

**MACNAMARA:** Hi. Dr. Gordon, commission members, and fellow citizens, I come to you today very honored, and I thank you for the opportunity, both as a consumer and a nutritional consultant, and I'm also a student. 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 that it was self-definitive. The authority for this Congressional legislation came from codified le scripta(?), the herbalist charter, under Henry VIII as common law. Both the SSA and the IRS recognized naturopaths as legitimate health care providers as federally defined in the Department of Labor's code #079101-014, continuously listed since 1939.

States must yield to federal law when in conflict. Subsuming naturopathy into medical regulation goes against Congressional legislation and intent. Integrating all modalities into the current system does not serve the majority of holistic practices. Traditional forms of regulation do not fit natural modalities, many of which reach proficiency through nontraditional methods, including practicums, apprenticeships, distant learning, and study with the masters. For instance, I had the privilege of working with world-renowned clinical nutritionist Dr. Bernard Jensen, actually studying with him on the tenants of replenishment, nutrition, and iridology. However, this experience won't show on any curriculum transcript. Distant learning courses offered by Westbrook, 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 and are seeking additional related coursework from traditional colleges.

In my opinion, 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. Physicians, naturopathic or otherwise, are already MDs and must adhere to current law and regulation. The government's acceptance of professional organizations, such as the ANMA, will allow consumers to obtain information about modalities and practitioners. To abolish the non-medical naturopath, nutritional consultant, or health counselors 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 9$^{th}$ Amendment's protection of enumerable rights we all hold precious. Thank you.

**GORDON:** Thank you. Questions from the commissioners? Any questions? Yes, go ahead, Conchita.

**CONCHITA PAZ:** This is to Dr. Bhattacharya. If you can tell us how you would go about trying to find a system for determining practitioners competence with their level of training would be real helpful, with the different types of therapies.

**BHATTACHARYA:** You and I both know that's a very difficult question.

**PAZ:** It is.

**BHATTACHARYA:** It depends who is sitting on the panel of judges. I believe that having a panel of judges that is more holistic, meaning MDs, RNs, all the licensed health practitioners, as well as patients, students, parents, consumers, regulators. That kind of panel is, obviously, difficult to assemble, but it's one which, I think, would be more objective than a group of doctors would be, or a group of any one particular type. There are certain baseline standards which have been attempted to be collected by groups such as, Rob Schiller mentioned there was someone, Ben Klegler, who had put together a core curriculum. Patricia Musim(?) at the AAMC has put together a group of documents. People at the APHA, which Joe Kaczmarczyk is involved with, have put together a group of recommendations.

There was a blue ribbon complementary panel. All these panels, there are about ten or fifteen that I've collected, that have put together a group of recommendations. Using those as a baseline would be a good place to start with a core curriculum. There are, obviously, going to be arguments about which of those things should be and should not be included, but at least people judging should know the basic terminology that is included in those basic recommendations. I'm sure that every member of your panel is not equally educated about CAM, but to have a baseline, well, maybe Jim knows everything. There is a baseline that I believe people need to know in order to consider themselves knowledgeable in CAM. Just as when I . . . my Ph.D. in pharmacology, there was a basic amount of pharmacology I needed to know, even though I didn't know the particulars of every single subdivision of pharmacology. That kind of basic level of complementary medicine needs to be known.

The one thing that I would say is mandatory is to understand what she is. There is someone amongst us, who has said commonly that he doesn't know what she feels like. For that person to be a director of a CAM center, I think, shows us that we allow doctors to not know the basic concepts and to still say that they are CAM experts.

**GORDON:** Any other questions. Okay, thank you very much. Thank you all. I'm going to take a brief break . . . ask Dr. David Bresler if he would chair while I'm gone. I'll be back in a few minutes.

**Panel 10**

**Panel Coordinator – Corinne Axelrod**

**BRESLER:** Okay, are we ready? Andrew Rubman, please begin.

**RUBMAN:** I'm, again, honored to address the commission on matters related to my profession. I'll briefly detail proposed steps to craft federal guidelines for curricula standards in education to apply to all medical training in the United States.

Individuals functioning as physicians in our society need to be formally trained in the sciences and philosophies, what Dr. Gordon refers to as the new medicine. As curricula at allopathic and naturopathic medical schools become progressively similar, our efforts need to focus on providing access to the philosophical differences in the disciplines that make these two branches of medicine inseparable, immiscible, and of equal value to this society. I submit for the commission's information comparative curricula and medical school data, generated by the AANP in 1998. As allopathic philosophy emphasizes the identification and suppression of pathology, naturopathic philosophy stresses the appreciation and enhancement of normal physiology. In order to understand the value of naturopathic medicine, allopathic basic and clinical medical science curricula need to be reworked to include these philosophical elements. In order to practice naturopathic medicine, these components need to be at the core of all formal medical education . . . that the new medicine include enough crossover within the two disciplines to allow both the appreciation of the value of the other and to allow for the seamless referral

and patient co-management. This should not encourage one to practice the others craft. To do so would be to act irresponsibly.

This conjoint approach needs to be available for the public in all medical delivery facilities, including primary care and hospitals. Allopathic medical schools need to have naturopathic physicians on staff providing curricula oversight and classroom instruction in the disciplines. MDs and DOs should not be asked to provide this component. David Studdart(?) of Harvard, writing in *JAMA*, emphasizes that patients need to be completely informed of the risks and the benefits of these alternative and complementary intercessions before the therapy is allowed. How can someone who is not formally trained do so?

The obstacles that exist to this necessary deregulation of medicine are those of ignorance, greed, and misconception. The appointment of naturopathic physicians to all agencies' committees' dealings with medical school curricula, hospital practice, and public health information dissemination will move to correct this. A good step might be to consider this commissions purview, that of traditional medicine not complementary and alternative.

In closing, I provide the commissioners a copy of a picture of the 1902 graduating class of the American School of Naturopathy in New York City. These were truly traditional naturopathic physicians practicing traditional medicines. Thank you.

**BRESLER:** Thank you. Mark Garber.

**GARBER:** Thank you. I'm a full time emergency medicine physician in Connecticut. I see patients every day and have for almost the last twenty years. I went to a four-year medical school. I went to a three-year residency in emergency medicine. And before that I was a human being and I was very interested in natural medicine, in the '60s, as many of us grew up. I got all the Jethro . . . back to Eden and I've never turned back. I've been interested in botanicals and herbal manipulation, and I'm self-taught and I've learned from others. So I incorporate these alternative therapies in emergency medicine, which is a strange thing to do. In the golden hour of emergency medicine, if you're having trouble breathing, you're having a heart attack, or you're really having a life-threatening situation, I do not use traditional alternative therapies so much as I use the traditional medical therapies. And most people would want someone to do that for them.

After that golden hour, my patients get alternative therapies as well as traditional ones. I'm faculty at the University of Connecticut Medical School, as well as being faculty at the University of Bridgeport Naturopathic School, and I teach students from the Canadian College of Naturopathic Medicine as well. I'm an allopath teaching at naturopathic school, and there is really no counterpart at the allopathic schools teaching people about natural or naturopathic medicine. So who is a doctor? And a doctor is a healer. A parent can be a healer. But who is a licensed physician in a first world country like the United States? And that's a medical doctor. As medical doctors, we have a responsibility to know about alternative therapies. I agree with everyone on the panel who said from day one of medical school in an allopathic or osteopathic school we need to incorporate these modalities. It has to be done, and I think it's being done, and there are good people to teach this.

However, again, my counterpart, I think, is a trained naturopathic physician, an MD. I am very fortunate because I live in Connecticut, one of the eleven states where naturopaths are licensed and they have a four-year school. I'm very involved in the four-year program that naturopathic physicians go through, and it's really quite similar to allopathic curriculum. I've been very impressed with that. One of the problems is that my students don't get enough clinical training with sick patients. And what we worry about is can a naturopath, who is using alternative therapies, and usually won't hurt someone if they know about drug interactions, and I've got to reiterate for the community everything you get is a drug. A botanical, everything you do is a drug that has side effects and can hurt people. But if someone misdiagnoses someone and treats them with so-called alternative therapies, people can be hurt.

The naturopathic physician, in one of these fortunate states where they're licensed and trained adequately, really has a good background to work together with the MD as either consulter in a primary role doing alternative therapies to get us together to go ahead and treat these people. And I feel like naturopathy really has a future in the licensed physician stage. I think working together and integrating these therapies we can do very well for the public. The public demands these things. They're going to a health food store, which, to me, is a pharmacy where everybody can get any drug they want without a prescription, and that's what a health food store is, and these drugs are dangerous.

One quick anecdote, when I give somebody antibiotics, and I don't do it very often, they get a prescription to go to the pharmacy and get the antibiotic. I give them a prescription to go to the health food store and get probiotics at the same time to not ruin their immune system. And we can all do these things. Thank you.

**BRESLER:** I agree. Thank you very much for your comments. Bronner Handwerger.

**HANDWERGER:** Yes, I'm delighted to address the commission today on matters concerning licensing and naturopathic education. I'm a fourth year medical student at University of Bridgeport College of Naturopathic Medicine, which is a regionally accredited four-year post-graduate medical program with admission requirements comparable to those of conventional medical schools. As primary care physicians, we are rigorously trained in basic medical sciences. Our clinical training, in part, includes the study of acute and chronic pathology, clinical physical diagnosis, minor surgery, emergency medicine, medical genetics, and laboratory diagnosis. Instructors of conventional medicine from Yale and University of Connecticut teach many of our required courses, and we spend time at local hospitals.

The Council on Naturopathic Medical Education recognized by the U.S. Department of Education, accredits our program at University of Bridgeport, as well as those offered at National College, Bastille University, and Southwest College. In order to sit for licensure, naturopathic medical students are required to have graduated from an accredited program . . . completed all appropriate board exams and clinical residencies. Naturopathic medicine is at the forefront of the alternative and complementary health care movement as it evolves today. Naturopathic physicians are the most comprehensively trained doctors of natural medicine, and are thus the most suited to help integrate the health care industry in the transition to what Dr. Gordon refers to as the new medicine.

Because currently naturopathic medicine is not a regulated profession in thirty-nine states, some individuals who call themselves naturopaths in those states do not meet our professional standards of education. Such individuals often obtain degrees or diplomas from correspondence schools or weekend seminar programs. The public needs to be protected from the consequences of misdiagnosis, non-diagnosis, and inappropriate medical treatment that may be offered by such individuals calling themselves doctors. Without standardized laws, individuals are being denied their basic freedom to access responsible health care of their choice. Untrained or under-trained persons calling themselves naturopaths may put individuals at risk by delaying the diagnosis of a critical condition needing conventional care. The science-based medical school trained naturopathic physician uses standard diagnostic methods and is taught when it is appropriate to refer to specialists.

Licensure of naturopathic physicians throughout the country would ensure public safety by requiring the highest level of education, training, and accountability. As more consumers turn to natural medicine, they need to be assured of the standards of care and practice. Globalization of health care information, due to the Internet, has raised some interesting questions and challenges as to how we may protect the public from misrepresented health care claims. It is difficult for the average consumer to navigate this increasingly complicated maze. The naturopathic model of health and healing incorporates conventional diagnosis and treatment with the understanding of the clinical use of preventive medicine and natural pharmacy from a philosophical perspective of enhancing wellness. It will be well to recognize this training as the experts standard within the so-called CAM disciplines. Thank you.

**BRESLER:** Thank you for your comments. Jonathan Daniel.

**DANIEL:** Thank you for having us appear here. First of all, I would say about, I'm a practitioner of Chinese medicine and I'm also a chiropractor, and I'm a teacher at the Pacific College of Oriental Medicine here in New York. First of all, I would say that Chinese medicine works within its own paradigm, and it's best that it works within its own paradigm. I heard, in the telephone conversation that we had before this panel began, that the standard was going to be western medicine, the standard for working with CAM. But I think it's very important that Chinese medicine work within its own paradigm. It developed its own modalities to fit within that and it has its own understandings of how diseases divide it. If that is not applied, then you don't get the same kinds of results.

However, at the present time, we are also trying to develop some kind of integration . . . taking place both in China and in the United States. There is an attempt to integrate western understandings with traditional Chinese medical understandings. I think this is a possible thing to do, but I think that this is a very long and difficult process. And to practice Chinese medicine this requires an understanding on the part, a long understanding on the part of those who are trained for it. At the present time, in the United States, the training of a Chinese medicine practitioner in most, if not all, schools requires more than three thousand hours, over an average of four years. This training includes not only courses in Chinese medicine, but also western physiology, anatomy, biochemistry, and pharmacology. At PCOM in New York, these courses are taught by professors who are medical doctors, chiropractors, and others who hold Ph.D.'s in chemistry, anatomy, and microbiology. One of our professors has actually been selected as teacher of the year at Cornell University Medical College, where he continues to teach. Any educational standards, which are set now or in the future, should be established by the schools and not by an external body. The minimum criterion is the ability of the graduates to pass the national certification exam, which is administered by NCCAOM, but most of . . . schools do exceed this minimum. Also, I would say that it's important to realize that, with herbal medicine, in most states herbal medicine is not regulated. But I think it's important to recognize that in the controversy that has arisen over the use of certain herbs, that most of the time when this has happened this has been using the herbs by people who are not qualified to administer those herbs. If the herbs are administered by a qualified practitioner, then the results have not been bad, most of the time. Thank you.

**BRESLER:** Thank you for your comments. Steven Schenkman.

**SCHENKMAN:** . . .

**BRESLER:** Microphone, please.

**SCHENKMAN:** Good afternoon. Thank you for the opportunity to speak.

**BRESLER:** Could you move a little bit closer, so that the back can hear, too.

**SCHENKMAN:** My name is Steven Schenkman, and I'm the president emeritus of the New York College for Wholistic Health Education and Research. I'm here today to speak very briefly, based on my experience as president of a CAM college for twelve years and a CAM practitioner for more than twenty years, on what I see as the main difficulty of integration with conventional medical institutions and practitioners.

Conventional medical intervention, while giving people the opportunity to live longer lives, increasing quantity of life, rarely guarantees a better quality of life. Conventional medicine excels in many procedures for acute and emergency health care, as well as in its advanced diagnostic techniques.

However, when it comes to preventative medicine and the treatment of chronic degenerative diseases, more often than not, CAM medicine is better suited. And this is exactly what consumers have begun to slowly discover for themselves, and why the White House Commission was formed.

I believe that the greatest potential for the future of medicine may be the true integration of these two fields. However, as leaders in institutions of conventional medicine seek to adopt different CAM disciplines, they cannot continue to ignore learning its theory, principles, philosophy, values, and the rich histories of these systems. Although there has been some positive movement of late to understand, I have, for more than twenty years now, experienced the so-called growing interest of university and private hospitals and their conventional medical faculty and practitioners miss the mark because of their true lack of understanding of the foundation of CAM systems and their disciplines, and the profound healing they provide to their patients. This had led to ignoring and minimizing valid results gained by thousands of patients of CAM practitioners, often relegating these powerful and valid CAM techniques and disciplines to trivia.

Until there is some real effort on the part of conventional medical practitioners and their educational institutions and organizations to really study and understand the foundation and underlying theories of CAM practices that have proven successful, and come to value them on their own terms, there can never really be a true marriage, and patients will never reap the possible benefits of such an integration. And by study, I'm not referring to research, which I believe should also be occurring. I'm referring to the undertaking of formal study of these areas, at least by those who will be in a position to make the decisions and policies, so when they are made, they are made from a foundation of understanding.

I believe that such decisions in policies would be much different than those which result from the conflicted position of conventional medical practitioners without any, or only a trifle, understanding, trying to decide on policy about the future of their own field by listening to the input of CAM practitioners. Without true understanding of all sides, how can it really be possible, at least on a grand scale, to come to an understanding of how these different worlds of medicine can properly be combined to the best interest of the patient rather than for ones own personal interest? It would seem that there need be some serious efforts made in conventional medical schools to educate future practitioners to a depth of understanding. I have something about policy recommendations, which I'll submit.

**BRESLER:** Great. Thank you very much for your comments. Commissioners, questions?

**XIAO-MING TIAN:** Question for Dr. Daniel. In your recent testimony, you . . . that most states regulate practitioner of Chinese medicine. What do you mean by that?

**DANIEL:** What I mean is that there is licensure . . .

**BRESLER:** Microphone, please.

**DANIEL:** What I mean is that there is licensure for acupuncturists inmost states at the present time. That's in comparison to, for instance, naturopathy, which I think is licensed in eleven states, whereas for acupuncture, it's licensed almost everywhere now, thirty-five states. As far as herbal medicine goes, though, it's only licensed, Chinese herbal medicine is only licensed in, I think, three or four states at the present time.

**TIAN:** In which state?

**DANIEL:** California, Oregon, Massachusetts, and that's it I think, maybe Connecticut as well.

**TIAN:** Is that regulated as a medicine or herbal remedies?

**DANIEL:** As a profession.

**TIAN:** As a profession. Do you believe that there must be a regulation better for . . . or medical professionals to . . . herbal medicine and herbal remedies?

**DANIEL:** Absolutely.

**TIAN:** Thank you.

**BRESLER:** Other questions from commissioners? You know, one of the things that would be helpful to us as a commission, we've heard from a lot of different advocacy groups who say that mental health professionals would be good people as sort of gatekeepers, naturopaths, nurses, acupuncturists, and so forth. And we know that, to a large extent, it's a matter of risk benefit. We want to provide the greatest benefit to the public, but we also want to protect them from risks. And I wonder if you could provide us, just your opinion or recommendations, as what the unique benefits of having naturopaths involved in triaging and screening, and what also some of the potential risks might be, in terms of what they might miss and things of that sort? If you comments now, that would be helpful or you could submit that to us later on . . .advocacy group.

**RUBMAN:** Very very briefly, we have the benefit of being classically trained in medicine in the same basic and clinical sciences that are provided in medical schools of all denominations in the United States. And part of that is recognizing acute pathology, the necessary for heroic(?) intervention, the necessary to refer to EMS, what have you. That's core to our discipline, and we believe if we're going to consider ourselves physicians, then the public needs to have that sort of understanding with the kind of service that we provide. But perhaps over and above that, we're also educated at the same time in the philosophy of enhancing human physiology. In other words, trying to educate people in terms of improving their wellness to decrease their illness, and in doing so, we are quite dissimilar from the allopathic profession. I'm not suggesting that we replace the allopathic profession. I'm suggesting that they don't try to do what we do better. I'll give that over to Dr. Garber.

**GARBER:** I think . . . a well trained naturopathic physician, who is licensed and has taken a four year course of study, has taken many of the same courses that the medical students do to become licensed physicians. In terms of clinical training, they don't have the exposure to the acute patients in the volume that a medical student does. Remember, in healing, in traditional and any type of medicine, it's an apprenticeship. You learn by seeing patients. What you learn is what you should do, what you should not do, and, frankly, we learn a lot by our mistakes as well as we learn from our mentors. And in naturopathic medicine, I think what they're trying to do in the licensed areas with the registered schools is that these are people who are working along with the same basic background that the MD has, where they can go ahead and expand on this background.

We're at a crossroads now. Should MDs do a residency in natural medicine, and will that make them qualified to do this? Is their training based in medical school enough? I don't think it is. The naturopath, who has all these modalities together can help us. When I want, I know how to do manipulations. I know botanicals. I know homeopathy, but . . . I really want to use these things in the hospital, I refer to the person to the person I think can do it best. I'll refer to an acupuncturist. I'll refer to a naturopath. I'll refer to a chiropractor. And we all refer to other specialists. I think a naturopath is another specialist, and the question right now is I don't think the allopathic community should try to take over natural medicine. That CAM should not be the purveyance of just the allopathic community. I

think we need these other people to work with us.

**BRESLER:** Comment? Yes, Effie, and then we'll need to stop.

**CHEN:** I like your cooperative exchange ideas very much, and you talk about the medical doctor and the naturopathic medicine practitioner or others. How do you see the role of other health practitioners, such as the nurse or physiotherapists and all the other . . . being part of this interchange?

**GARBER:** We're all healers to some extent, from parents to family members. The title doctor, although in the United States and in other so-called civilized countries, has a unique connotation that it doesn't in other less civilized countries. But in terms of reimbursement and licensure, the physician is usually the person who is the originator of most health care policy, who really does most of the health care treatments, and usually gets the best billing for it. Now, how do we do this? We have a bi-level society, where people who are wealthy can access the Internet, find out information about alternative therapies, and go to these people. And if they don't get reimbursed, they can afford to get these treatments, but the huge bulk of society cannot. We've got to try to remedy the system by utilizing every member. And, as I said, I'm more than happy to consult an acupuncturist, a massage therapist, all the time, and these people are wonderful in healing my patients. They do things I can't do. So we need to work together . . . ensure that the federal government and at the state level everybody is reimbursed for their services, so not only the wealthy are getting the benefit of these therapies.

**CHARLOTTE KERR:** The last, Steven, I wanted to speak to you. At the last panel I was talking about philosophy and the epistelogical underpinnings of the CAM therapies. You spoke about the need for the emphasis of the foundations of CAM to be taught. You have a sense of history here. You have twenty years of commitment. My sense was you didn't see it not only getting better. It might either be the same or getting worse. How much should we emphasize that in our recommendations? Is it imperative? Can we slide? What's the deal?

**SCHENKMAN:** On one hand I was glad to hear today that there was at least a theme, where more and more education was being done. But my experience, over and over again, as an educational institution specializing in these areas, we were approached over and over again by interested colleges and other hospitals and universities to do some kind of collaborative effort. And, usually, it was with some of the administrations of those institutions and perhaps maybe it was just because it was cutting edge and they were looking to be different than other hospitals. But once we began the negotiations, we continually ran into road blocks with the medical boards and with the so-called, I think one of the other doctors earlier had leaders of their complementary and alternative medicine program . . . who had perhaps the two month training, and literally had no real understanding. So, over and over, we run into the issue of trying to put something much bigger and squeeze it into this box. It won't work. It hasn't worked.

A large university on Long Island, Public University, one of the top in research, had created a complementary and alternative medicine center. It was done after a survey on Long Island to look at the interests of the population. And within about, the hard, who I consider pretty, someone who is pretty adept and well trained in the area of CAM, and within a matter of probably a year and a half, the faculty of the medical institution, the faculty of the hospital, became such a political hotbed it just closed. So, there you have it.

**BRESLER:** I want to thank all of you for being here today and for offering your comments. We're, again, very open to additional recommendations or suggestions that you have. Feel free to forward them to us, to the commission. Thank you so much for being here today.

**Panel 11**

**Panel Coordinator, Geraldine Pollen**

**BRESLER:** Kathleen Ann Golden, please start.

**GOLDEN:** Good afternoon. Welcome to New York. I will offer testimony on the topic of standards of education and the profession of acupuncture and oriental medicine. I think some of this may be slightly repetitive of what we just went through, but I think it's important to go over it again for the commission.

The national minimal standards for licensed acupuncture training require a three-year masters level professional program with at least one thousand seven hundred and twenty-five hours, passage of the NCCAOM national exam in acupuncture or Chinese herbal medicine, demonstration of competency in point, location, and clean needle technique. In New York and many other states, schools exceed the one thousand seven hundred and twenty-five hours. In many cases, the training will approach three thousand hours. These accredited programs draw on an international pool of the world's most experienced talented acupuncturists and herbalists, educators, and clinicians.

The profession is proud of the level of education it provides for the practice of acupuncture and oriental medicine in this country. The profession is constantly striving, through internal discussion and dialogue, to enhance the level of education available to the student of acupuncture and oriental medicine. The profession has currently evolved in creating the requirements for clinical doctorate in acupuncture and oriental medicine. The commission may hear testimony from other health care providers in this country that given a professional education in biomedicine, chiropractic, nursing, physical therapy, or podiatry, and the many hours spent practicing the chosen medical art, that this is a basis for taking abbreviated training programs in acupuncture, and incorporating it into an extent practice of medicine. This is simply not true.

Acupuncture is not a single or simple technique or modality that can be added to a health care practice with an abbreviated survey like course. It is a health care system with detailed complexity and subtlety requiring long and serious study. I find it professionally and culturally insensitive that abbreviated training programs publish these words in their brochures, "by eliminating the multitude of superfluous non-practical concepts surrounding the myth and folklore, which abounds in the usual acupuncture program." This reference to myth and folklore is an implication that the medicine, so generously shared by the Chinese, and carefully cultivated over thousands of years, has no basis in theory. This insults a complex form of medicine, based on the dow(?), and their early observation of nature and the interrelatedness of all things on this earth.

I've encouraged Ms. Tsao-Lin Moy to testify here today. Ms. Moy presents a unique opportunity for the commission to gain insight into the specifics on an education in acupuncture and oriental medicine. It is clear from the many hours of study Ms. Moy and her fellow students invest in their education that this is not an educational process that should be abbreviated. To do so insults the profession and destroys the integrity of the medicine. I believe it also inhibits the hope of the students to help . . . medicine, to look forward to practicing with equal opportunity for an equitable livelihood.

**BRESLER:** Thank you. Donald D'Angelo.

**D'ANGELO:** Mr. Chairman, fellow commissioners, thank you for being . . .

**BRESLER:** Please come close to the mike, okay.

**D'ANGELO:** As a physician and board member of the American Society of Acupuncture, I would like to briefly comment on . . .

**BRESLER:** You've got to come much closer and speak a little louder.

**D'ANGELO:** As a physician and board member of the American Society of Acupuncture, I would like to briefly comment on the education and training of health and care practitioners in complementary and alternative medicine.

As part of a physician's education, they complete four years of graduate level medical training and four years of postdoctoral training. This amounts to a minimum of thirty-five thousand hours studying the human body and its processes, based on a conservative estimate of twelve hours a day over a period of a year. Additional continuing mental education credits are also mandated by state and local agencies as minimum requirements for maintenance of good standing in licensure. Furthermore, physicians and dentists are required to complete three hundred hours of training as a minimum for certification, specifically in acupuncture alone, as well as recommendations by . . . for ongoing continuing education.

**BRESLER:** I think you're going to need, you're going to have to get a little more, little more . . .

**D'ANGELO:** It would be somewhat disingenuous to think . . . prior medical training is without significance with regard to the understanding of practice of complementary and alternative medicine. New York State was the first state to set . . . regulating the practice of acupuncture for physicians and dentists. And, in 1972, the New York Society of Acupuncture was the first professional organization designed to provide comprehensive training in acupuncture, both . . . and clinical, to physicians and dentists who wished to incorporate this modality into their practices. Therefore, I feel that physicians, who have completed . . . training are more than qualified to provide not only safe, but efficacious, care in the area of complementary and alternative medicine, and are able to bridge the gap between eastern and western medical practice, which, when used in concert, provide the most comprehensive approach to medical care with the greatest benefit to society. Thank you.

**BRESLER:** Thank you. Tsao-Lin Moy.

**MOY:** Hi. Good afternoon, members of the commission. Thank you for your attention today. My name is Tsao Moy. I am a second year student at Tri-State College of Acupuncture. I will be offering the commission testimony and insight on the standards of education in an accredited acupuncture and oriental medicine program.

What has been most challenging for me, as a 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 program is three to four years, approximately twenty-two hundred hours of study and training. More than fifty percent 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. First year lectures in Chinese philosophy provide the philosophical basis of acupuncture and oriental medicine. Describing and distinguishing which of the five filters a practitioner uses for arriving at an acupuncture diagnosis.

Skills review and hands-on contact include palpation of meridians, point location . . . evaluation, tongue and pulse, in small supervised groups with practiced basic techniques of needling, moxibustion, wasa(?), cupping, ariculotherapy, and clean needle technique. As part of our clinical experience, we observe and learn from senior acupuncture practitioners treating actual patients. At Tri-State, we are exposed to a

unique synthesis of various traditions in acupuncture from Dr. Mark Seem(?), Kiko Matsumoto(?), Aria Neilson(?), David Legae(?), and Dr. Richard Tan(?). In the second year, 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 from a textbook pattern.

During the third year, training, knowledge, and experience comes to fruition. 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. The Tri-State's 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 in acupuncture and oriental medicine.

I recommend that the commission look to the existing credentialing bodies for guidance and support the standards of education in acupuncture and oriental medicine that have been established by the NCCAOM, the ACCAOM, and the state education department of New York. I recommend that the commission not support abbreviated training programs, and 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, and I'm available if you have questions.

**BRESLER:** Thank you very much. Huaihai Shan.

**SHAN:** My name is Huaihai Shan. And I'm very pleased at . . . giving opportunity to speak . . . Chi Kung and psychiatry. I'm a psychiatrist, so, right now, I'm a visiting professor at UMDNJ, and I'm from China. Today what I'm going to say . . . how to application of traditional Chi Kung in China. As we know, that's complementary and alternative medicine, including . . . therapy and some . . . techniques, and also some . . . that has been used for many many years in psychiatry. For example, you can use acupuncture for depression . . . other methods. But, so when I'm . . . to United States, so I . . . about promote the traditional Chi Kung because I have practice Chi Kung in China for about thirteen years. I've been treating traditional university in China. I . . . involved in the research about psychiatry and traditional Chi Kung for about fifteen years. So when I . . . China . . . concern. So we have been considered. So in order to properly . . . of traditional Chinese Chi Kung is psychiatry.

The first question is . . . right now many Chi Kung masters. They don't know what is the disease. They don't know what's acknowledge(?). They're using the Chi Kung to treat the medications, and that's the same in China. The second problem is, so right now some medical . . . evidence of fixing, it's not accepted by conventional medicine because it makes the . . . especially in the United States, also in . . . China. The third problem is what I'm concerned. That is so Chi Kung . . . the name has been misused in all of the world . . . for example, when I come to the United States, see, I found some lots of Chi Kung master come to the United States. The establish . . . a Chi Kung company. They treat some patients. But right now you can't do it in China. That's a different tradition . . . I'm sorry. That's different than traditional . . . traditional . . . that is my body . . . that is my body . . . that is the traditional Chinese medicine. So something like this . . . included . . . still Chi Kung . . . Chi Kung masters . . . working in United States, though that's different. So that's what I'm saying.

So I hope . . . three things. The first thing is I hope to . . . United States . . . establish a Chi Kung research center and to we give . . . some patients for some practitioners training of . . . community and in the school. So . . . right now we don't have . . . for this. Thank you . . . thank you very much.

**BRESLER:** Thank you. Christopher Kent.

**KENT:** Good afternoon. My name is Christopher Kent. I'm a chiropractor and I'm president of the Council on Chiropractic Practice. The Council on Chiropractic Practice is a nonprofit apolitical

organization, committed primarily to the development and distribution of clinical practice guidelines. The clinical practice approach that we elected to use was evidence based. An evidence based clinical practice is defined by Saket(?) as the use of the current best evidence in making decisions about the care of individual patients. It is not restricted to randomized trials and net analyses. It involves tracking down the best external evidence with which to answer our clinical questions. This concept was embraced by the Association of Chiropractic Colleges in their position paper, which states chiropractic is concerned with the preservation and restoration of health, and focuses particular attention on subluxation. A subluxation is a complex of functional and/or structural and/or pathological auricular changes that compromise neural integrity and may influence organ system function and general health. A subluxation is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence. And, indeed, that was the challenge.

How can we acquire this evidence because much of it was not available on computer databases? Much of this evidence is not available in . . . journals. Some of it is privately published and some of it is simply passed on by word of mouth. So we used the following methodology. We began with a comprehensive computer and manual review of literature, using such databases as Index, Medicos, Mathis . . . etc. We had a technique forum, where we invited developers of chiropractic techniques to present oral evidence and any written support for their procedures, and the panel members had an opportunity to question these individuals. We then held an open forum because we found the practitioner acceptance of clinical practice guidelines was very poor unless they were actively involved in this practice. So to involve them in our process, we held an open forum where anyone who wished could present oral testimony, could present written evidence, and could interact with the panel.

The panel itself was multidisciplinary in character. It consisted primarily of chiropractors, but also included medical physicians, basic scientists, attorneys, and a consumer member. The important thing to remember in the guideline development process, in my opinion, is that it must be open. It must examine the best available clinical evidence, not placing itself in a sort of epistemological straightjacket by limited the work to randomized clinical trials. And it must be designed to empower the individual clinician by providing the best available information and not serve as a replacement for clinical judgment or a default to a cookbook type clinical approach. I've provided copies of the guidelines to the various panel members, as well as some resources, and thank you very much for your time.

**GORDON:** Thank you. James Dillard.

**DILLARD:** Dr. Gordon, esteemed members of the commission, as an acupuncturist, chiropractor, and medical doctor, I've had the opportunity to teach, the privilege to teach, in all three training programs over the last ten to fifteen years. And I think I've been able to see some things that are a little unusual. I think that CAM and non-CAM schools have a lot to teach each other. I think that the CAM trained professions have a lot to remind us, and I would agree with Dr. Park that this literature does already exist, has a lot to remind us about patient centric treatment, about the relationships of the heart, and about connections with patients, about resisting depersonalization. Likewise, I think that medical schools can teach CAM training programs a lot about the pursuit of scientific rigor, case reporting, vigilance for adverse reactions, and recognition of treatment failure. I'd like to make a few comments about that.

You know, when I was in chiropractic school, I was really taught to be a lone wolf. I was not taught to be a team player. I learned to go out and start a practice and see my patients. They were my patients. I didn't really want to work well with other; I didn't want to play well with other students. I would not have gotten good grades in Kindergarten. And I think that that's part of the attitude about being able to teach CAM practitioners to work more as team players. I certainly didn't learn that in chiropractic or acupuncture school as well as I did in medical school, and that's one aspect, I think, that can certainly make a difference.

The other thing that I see in teaching in CAM schools is I think there can be a lot more emphasis on looking for adverse reactions. You know, when I was in chiropractic school, one of the senior chiropractors said to me that he was pretty sure he got all his patients well because, after a few visits, they didn't come back anymore. They either felt much better or they just didn't come back, which meant that they were cured. This is a true story. Likewise, my acupuncture students are still looking for the right Chinese diagnosis, changing the position of their pins, still trying to find the thing that's going to cure them. I recently reviewed a case in which there was actually a loose body . . . being treated with multiple acupuncture modalities.

So I think we need to be a little more careful with looking for adverse reactions, looking for treatment failure, and what are we going to do with treatment failure because that's not being recognized enough. I do not believe we should medicalize CAM schools, except for the issues of basic patient safety, and I do not think that we should CAM-ify medical training, except for issues of heart, which the CAM movement should remind us of those things. Thank you very much.

**GORDON:** Thank you very much. Questions from the commissioners? Yes, George.

**GEORGE DEVRIES:** Dr. Dillard, would you expand upon your comments that we should not medicalize the CAM schools, I believe you said, or CAM-ify the medical schools?

**DILLARD:** I'm sorry, I don't want to try to create . . . here, but I think there have been a number of other speakers that have addressed you all today that have made this point. And that is I would not like to see a big sort of a glob made of medicine and the CAM professions together. I think that they have to be, indeed, separate individual training programs, which gain the strengths of the other forms of training programs. So I think that there needs to be more exposure in acupuncture schools to what chiropractors do. And I teach this class right before these acupuncturists graduate. What do chiropractors do? What do nurse practitioners do? There needs to be more communication between the training programs, but I also don't think that you can train medical doctors to do a lot of this stuff. God knows it's hard enough to be a competent medical doctor, with the ever-expanding amount of technology that we have and the medications we have. We can't train all these people to do all these things.

So it doesn't make sense to try to make too much of a crossover between the CAM professions and the medical professions. Rather sharing students, sharing faculty, I think this is where it can be valuable. Where you have faculty that will be shared between these different institutions, and students that could attend lectures. I know Yale, David Kass was not able to present to you today. He brings . . .

. . . Into the lectures at Yale. I think that's the model.

**GORDON:** Thank you. Effie.

**EFFIE CHEN:** Thank you so much. I have a question to Dr. Huaihai Shan. Thank you for your comments on Chi Kung. I think it's very important. Perhaps, you know, anything new, Chi Kung is sort of the new baby of Chinese medicine in the west right now. It was acupuncture and then herbs and now Chi Kung. We do have to watch its introduction to the west. It's very powerful, as you say. So are there models in China that you know of that can be served as models here, one for research and then setting up as a center, as you mentioned?

**SHAN:** . . . Students . . . from China for research.

**CHEN:** Yes. There has been lots of research done, and, of course, research . . .

**SHAN:** I remember we have tremendous research . . . Medical University. There's a Professor . . . she

has . . . she has . . . twenty years for . . . hypertension. There has been vast research has been published . . . but that is research . . . so interest in . . . Chi Kung . . . research . . . that's a problem. But especially for what we . . . right now . . . including the United States. There's a few psychologists and a psychiatrist involving the research . . . Chi Kung. So if we need more, if we lost the Chinese, lost the psychologist, and a psychiatrist . . . involving the Chi Kung, so we can avoid . . . mistake something like China . . . United States. That's my question . . .

**CHEN:** Thank you.

**GORDON:** Ming and then Veronica.

**XIAO-MING TIAN:** Regarding the Chi Kung, regarding the Chi Kung research. Definition of the Chi Kung you are talking about Chi Kung basic learning, teach patient . . . Chi Kung, or you're talking about external Qi, which study should be done?

**SHAN:** Okay . . . in order to research what is the Qi, what is the Chi Kung, and that is . . . we want to individually . . . traditional . . . Chi Kung . . . conventional medicine . . . acupuncture or . . . herbs . . . to we want Chi Kung . . . as we have to use it so conventional. Modern scientific methods to research for what is the Qi. So what is the Chi Kung? That's what we have to interpret. That's the traditional Chinese medicine and then combined with conventional medicine. That's very important to research for Chi Kung.

**TIAN:** Thank you. I'll talk to you later because too many details.

**VERONICA GUTIERREZ:** My question . . . comment to Dr. Kent. I want to thank you for bringing the subject of guidelines to the table. We have not, to my knowledge, had any testimony on that, and there is a lot of professions that have been presenting information that don't have guidelines yet. So I'm wondering if you'd comment on the implications, reimbursement, legal, any other applications that the guidelines have been helpful with.

**KENT:** Absolutely. In other words, to me, the primary value in the guidelines is not to tell a person how to practice, but to provide them with resources that allow them to make more effective clinical decisions. Byproducts of guideline development include defining research objectives. By identifying areas where, perhaps, the evidence based is weak, but could be improved. Another is to help . . . define public policy in terms of what procedures might be reimbursable and what's the level of the evidence based for those various procedures. I think that the basic methodology that we employed could be used by a lot of CAM procedures because they suffer from many of the, I won't say shortcomings, but let us say cultural characteristics of the body of evidence in chiropractic. And that is, for a long time, we had few, if any, refereed peer review journals. We're just beginning to see those journals appear in the indexes. We're just beginning to centralize the availability of these bodies of knowledge. For example our guidelines are online on the National Guideline Clearinghouse, and they're available to other practitioners and individuals outside the profession as well. So they help to define the level of knowledge and nature of contemporary clinical practice as well. So I think a lot of folks could follow our methodology. The thing that I would want to emphasize is that it should be an open process, that your goal is to find the best available clinical evidence, and you should arbitrarily exclude evidence because it doesn't meet a preconceived threshold.

**GORDON:** I wonder, somewhat along that line, if you've developed some ways of collaboration among CAM professions?

**KENT:** We haven't as yet, but I think it's a great idea. In other words, we've learned a great deal in this process because I've been involved in, I think, five different guideline development processes, and learned a lot from the mistakes of my predecessors and my own earlier mistakes. And I think that that basic process, that basic procedure, could be essentially cloned and made available to other professions. I'd be more than happy to do that, as would the Council.

**GORDON:** That would be very helpful for you to share that, share at least an outline of that process with us.

**KENT:** Yes. In the guideline document itself, we go over the methodologies. So I provided the panel with various Web sites, including the full text document, a print copy of the full text document, and an outline of the methodology, which is in the beginning of the text.

**GORDON:** That's great. You ought to come back more often. Thank you very much. We really appreciate all of you coming. We're going to take a fifteen-minute break at this point. So it's now, by our clock, twelve of 3:00. So two minutes after 3:00 we'll begin the next panel.

**Panel 12**

**Panel Coordinator, Geraldine Pollen**

**GORDON:** We'd also like to ask, while these panelists are coming up, if the speakers, future speakers, if you could sit in the first few rows, that would be very helpful to us. This is panel twelve, and we'll begin with Barrie Cassileth.

**CASSILETH:** Thank you, Dr. Gordon. Good afternoon everyone. It really is a great pleasure to see so many old friends, and a pleasure to participate in this very important meeting. I'm happy to describe the program at Memorial Sloan-Kettering Cancer Center, which is called an integrative medicine service. The service is quite new. We have been seeing patients for approximately one year, and the first question that you posed to us was to describe our treatment program.

Our treatment program is one of four major activities in the integrative medicine service. We offer a wide range of complementary therapies, both on an inpatient and outpatient basis. I'd like to make a distinction, however, between alternative and complementary therapies because we offer a wide variety of complementary therapies, but no alternatives. In cancer medicine, this distinction is particularly crucial because there are so many unproven methods that are promoted as cancer treatments and cancer cures. We do not use those. In fact, we encourage patients not to get drawn into them. Instead we offer adjunctive complementary therapies, which are used along with, not instead of, mainstream cancer care. These include mind body therapies, many different kinds of massage, acupuncture, classes in yoga, meditation, tai chi, pilates, mat(?), chair aerobics, and a variety of music therapy, art therapy, and a variety of other things.

Our inpatients are generally interested primarily, remember our inpatients tend to be very sick, and they are interested primarily in music therapy and sometimes massage. Our outpatients are interested in almost everything that we offer it. That's why we offer it. We are very responsive to patients needs. We will drop particular therapies that patients are not interested in.

The other point I'd like to make is about research and the importance, from my perspective, of

conducting very methodologically sound good research in CAM. We need it very much. We need it in order to be accepted in mainstream medicine. We need it in order to be respected by scientists and others who provide care to cancer patients and other patients who are ill with various diseases. I would encourage the commission to think about this as a very major issue, not only research, but high quality research that we can proud of and that people will not quarrel with. I thank you very much for your attention.

**GORDON:** Thank you very much, Barrie. Is Ray Chang here? I saw him earlier. We'll move on then. Janice Pingel.

**PINGEL:** Thank you. Good afternoon members of the commission. My name is Janice Pingel and I am from Scarsdale New York. I have had two bonafied cures with the help of acupuncture. 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 acupuncture. I turned to it, but with very little expectations of success. Six sessions later, I left that office pain free. I have never had another seizure, and that was eleven years ago.

In 1996, I suddenly developed severe leg pains. This time I went directly to acupuncture and to my present doctor. Dr. Doreen Chen. After eight treatments and consumption of Chinese herbal tea, I left her office healed with no further problem.

Now, to my present situation. In 1997, I was diagnosed with incurable neuroendocrine cancer of the lung, with metastases to the liver. I began very aggressive oncology treatment with Dr. Sarah Sudan and, at the same time, I 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 occurred and I was out of treatment for about six months, but I continued with Dr. Chen and was now able to drink her tea, since I was no longer taken this extreme oncology medication. And that was in 1998. In October of 1999, I returned to Dr. Sudan for weekly treatments of taxol, which continues to this day. At the same time, a new tea, cordiceps militares(?) was released in China for treatment of lung, liver, and kidney cancer. This time I prevailed upon Dr. Sudan to allow it to be part of my treatment. She was very open minded to this request and agreed.

CAT scans are given every three months. In September of 2000, my scan showed all lesions in the lung are gone, and cancer growths, which had covered the liver, were decreasing. Both Dr. Sudan, 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 10$^{th}$ CAT scan also showed very positive results in tumor stabilization. Thank you very much for allowing me to share my story.

**GORDON:** Thank you very much. Raymond Chang.

**CHANG:** Commissioners, ladies and gentleman, appreciate the opportunity to give testimony here. I am going to specifically comment on, I think, what some of the hurdles are for complementary and alternative medicine practice and what some of my proposals would be, but in a very general way.

In practice, I find that in order to enable complementary and alternative medicine to become more accessible and transparent, we really need to win the complete trust of the conventional medical community, as some of the previous testimonies have indicated. There is still, I feel, widespread suspicion, if not outright hostility, in many instances and on many occasions. And, personally, since I work with many conventional physicians who will refer patients to us, I sense that degree of resistance, and that hampers quality care. It needs to be clear to the conventional medical community that although CAM practices may be considered unconventional and the mode of action in many cases, such as acupuncture or certain herbs, the principle of action may not be fully accountable by current biological

sciences, but we should pay attention to outcome and results. Quality clinical data is extremely costly to come by. I feel that because of the trickle of public and private funding that's available for formal trials that the data will not be available any time soon.

Another important issue is that of education. Although basic introductory CAM education has been introduced in most medical schools over the past five years, it is sorely lacking at the postgraduate level: internship, residency, and fellowship. I think that it is important that appropriate rotations in CAM during postgraduate training be introduced to allow younger physicians to appreciate and to develop the consciousness of what CAM practice means at a deeper level. It is imperative, then, that the new generation of doctors develop this awareness in order for them to learn, accept, and practice it for the health and well being of the patients.

**GORDON:** Thank you very much, Ray. Joan Runfola.

**RUNFOLA:** Thank you. The remarks I'll be saying today are based both on my experience as an oncology social worker at Cancer Care, of having counseled patients about medical decision making for the last twenty plus years, as well as my experience as a breast cancer survivor, where I used integrative medicine. In fact, I saw Dr. Chen over there.

We all know that the reported use of CAM ranges up to eighty to eighty-five percent, and that information about CAM is highly available to the public these days, particularly through the Internet. However, one of the concerns I have is I have people come to me, trying to make decisions about CAM as well as conventional treatment, is that a lot of times their decisions are not based on having all the information. Very often they are going based on anecdotal evidence, hearing information from family and friends. They have complete or inaccurate information, which is not evidence based in any way. And sometimes they solely base their decisions about CAM use on personal beliefs or preferences. This is compounded by the fact that thirty-five to seventy-two percent of people don't discuss their use of CAM or intended use of CAM with their physicians, and that most physicians, as we've discussed, lack adequate information to be able to guide the patients through the decision making process.

So what I propose is that the commission advocates the use of a Web site, either its own, something like its own or that of the Center of Complementary and Alternative Medicine, which includes a listserv where physicians, other health care professionals, and the public can have ongoing access to a variety of different pieces of information. This would include the latest facts about the proven effectiveness of various CAM modalities, including the type of research that has been done to reach these conclusions, the methods by which the treatment or modality is administered, any potential risks, and indications and contraindications.

Secondly, the site or the listserv could also include questions that one can ask a practitioner when considering a particular CAM approach. And you see in your packet there a sample brief about making decisions about CAM. And, also, information about practical considerations that one should look at, such as cost and impact on lifestyle.

Thirdly, I suggest listing resources where one can locate qualified CAM practitioners. You can see the handout I've given you is as a sample of national organizations that will describe what qualifications one should look for in a practitioner, as well as referring to qualified practitioners.

And then fourthly, listing guidelines for both health care professionals and patients to use to communicate with each other about the use of CAM.

Because we've talked about the medical profession not being as involved as we'd like with the CAM information, I also recommend that states are urged to revise their continuing education requirements to include CAM, and that there is consideration of instituting a standardized model, such as the EPIC(?) program, which is used for end of life issues, which would be about CAM. Thank you.

**GORDON:** Thank you very much. Barbara Sarah.

**SARAH:** Hi. I address you today wearing three hats. One as the co-chair, with Joan, of the National Association of Oncology Social Workers' Complementary Alternative Medicine Special Interest Group. My second hat is as the chair of the complementary medicine committee and coordinator of the oncology support program at Benedictine Hospital, up in Kingston New York. And third as an eight and a half year breast cancer survivor.

It's getting late in the afternoon, so this is my first afternoon. Thought we'd have a little fun here. It's all so heavy. Wearing my first hat, I'm in contact with professional oncology social workers from around the country, who are flooded with questions from patients about what CAM treatments and procedures to pursue. This is especially true at that point in time when they have to make decisions about whether to conform to conventional treatments only, or after conventional treatment is finished and they want to be able to do something to maintain good health.

In my second hat, I'm working at a small upstate New York hospital, where doctors and patients alike need more information to stay up to date with current research and practice. Our hospital wants to set up a CAM center, and we want to be able to offer our patients reliable services to help them stay healthy. Consistently, the most popular of my support group programs is our regular complementary medicine discussion group, where patients share information and practitioners come to make presentations. People are hungry for information, yet I have to post disclaimers before our presenters speak because I cannot necessarily endorse the information that is offered.

In my third hat as patient, I made a decision following my lumpectomy and axcillary node dissection, and after doing research, and asking a lot of questions, not to do any conventional . . . treatments of chemotherapy radiation that were recommended. I did do acupuncture and yoga, mistletoe and supplements, all out of pocket costs. I began to meditate. I got involved in an immune system study at a medical center. I altered my diet. I changed jobs and began working as an oncology social worker and became a passionate breast cancer advocate and activist. I became a personal example of the use of CAM.

In all three roles, I face daily a quagmire of information about complementary medicine. Doctors, patients, other health care professionals, and I myself have questions about the reliability of information flooding us from all sides. We need to have regular contact with a trustworthy scientific national source that evaluation promulgates this information and makes it available to us on a regular basis. We need doctors who are educated about the use of CAM and can spread the word to their colleagues. Patients are reluctant to tell their doctors about their use of complementary medicine because so many doctors have insufficient training on the subject. We need updates on CAM through the Internet or hard copy bulletins to other health care professionals, such as social workers and nurses. They are the people who are in daily contact with patients.

I propose that we have a complementary medicine advocate corp. be established . . . composed of designated, educated, and trained representatives from the above mentioned groups, who would then be regularly updated by the national office on CAM. These people could then disperse this information to their respective networks, through existing publications, e-mail . . . gatherings of their special interest groups. Let's enlist those of us on the front lines to get that accurate information out to the public through an organized system of networking.

**GORDON:** Thank you. Virginia Mae Langley.

**LANGLEY:** Thank you for allowing me to speak here today. I am both a certified nutritionist and a cancer survivor. I am not a guinea pig. I am not a statistic. Being told that a blood test indicated a second bout of cancer was upon me led me to study nutrition. Putting this information, the information I obtained during my studies, in to practice saved my life. No allopathic treatments were used or to accomplish this. I share the reason for my good fortune, the macrobiotic diet and lifestyle, 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 Rodgers, 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 biased arrogance, bordering on criminal behavior. If my source of information is correct, cancer is the number two cause of death in the U.S. 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. My own daughter's elementary school psychologist recommended my daughter be put on Ridlin when she had a hand eye coordination problem, which was cured by doing eye exercises. No drugs were or are being taken 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 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. For 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 healthy diet and nutritional supplements. Ideally, nutritional education should begin in elementary school. School lunches should reflect the 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 cannot be legislated or drug induced. Without question, the medical profession does an excellent job when it comes to dealing with acute 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 therapies can provide what is needed. Thank you.

**GORDON:** Questions from the commissioners? I have one question; actually I have several. I'll start with one and then see if others have others. Several of you, Barrie and Ray in particular, and Janice Pingel talked about issues related to combinations of chemotherapy and Chinese herbs, or the possible combinations of chemotherapy and Chinese herbs. You didn't speak specifically about it, Barrie, but I'd like your thoughts about it. In a number of the Chinese studies, in particular, show very good results with combinations. And I'm wondering if you have proposals, and the reason I'm bringing up this specific issue is because I think it's an important issue specifically, but I also think there may be some general principles involved. So I'd appreciate any of your comments about the kinds of studies that should be designed, the kinds of services that either you're providing or thinking of providing, and what your concerns or considerations are about it.

**CASSILETH:** Well, you have hit upon what is closest to my heart. We do two types of research in the integrated medicine program at Memorial Sloan-Kettering Cancer Center. One is quality of life evaluations of benefits of acupuncture, massage therapy, and other type therapies, and the other is a study or primarily Asian botanical remedies. We already have a program up and running. We work in collaboration with various senior investigators, both basic science and clinical researchers. What we have done is to go back to the Chinese literature and, fortunately, we have several Chinese physicians with us who can actually translate this. And we have picked up those herbs or combination of herbs that have been recommended for use over a long period of time and that logically seem worth pursuing. So we have started out with laboratory test tube investigations, where we take these herbs, usually one particular herb in its entirety. We don't look for an active component necessarily because we believe in the synergy of the various components of a particular herb. And put that herb into several dozen test

tubes, each one containing a different cancer cell line. So one would be breast cancer. One would be color cancer, etc.

In doing this, we have found six or seven botanicals that are so exciting looking that we are going to bring them to clinical trials, and we're in the process of doing that. I think that this is the kind of thing that needs to be done. I think before we start doing clinical trials and experimenting with botanicals, along with chemotherapeutic agents in people, we need to do it at a test tube level. It's very easy to screen and find out which ones look really promising and which ones don't. But this is an area that I would hope the government would look at and be willing to fund more research in because I think it's tremendously exciting and potentially very very powerful.

**CHANG:** I think one, again, cost effective area because, as I said, I think good clinical trials are expensive to run, and without clear backing from drug companies, etc. good quality trials and results are expensive to come by. Without reinventing the wheel, there is a huge literature already available, and a lot of research has been conducted in China, Japan, Korea, and the rest of Asia, Taiwan, Singapore, and now in Hong Kong. It's very useful. A lot of it, unfortunately, is published, like the Japanese literature is usually published, a lot of it is published in . . . in Japanese cancer literature. And the same thing with the Chinese. There may be methodological issues. The quality may not be as rigorous as we would like to see . . . RCT trials, etc. But a lot of work has been done, both at the in vitro level, at the pre-clinical animal testing stage, and also clinical trials have been conducted, which would lend a lot of insight. So without totally reinventing the wheel, it would be very cost effective to try to obtain that information either through meetings, conferences, translations of existing literature. Although it's not in the English language, it's not abstract . . . etc., but there is a huge body of literature.

**GORDON:** Thank you. Other questions from commissioners? Charlotte, yeah.

**CHARLOTTE KERR:** I'm not quite prepared to ask my question, so first I'd like to acknowledge the three-hat lady and say please talk to the parents about the networking. I'm so edified when all of you speak. I'm breathless. I want to talk about nutrition and the role of the commission. When we talk about public health, which we've done this morning, we understand that's treating the body politics. So we're talking about air and water and food. And no matter what anyone is doing, we often talk about food, but we're not actually talking about it all the time. We know that children having Pop Tarts all day, and sodas, aren't going to have quite a healthy brain. Where do you think, what do you want us to say about it? What can we do? And I open this to everybody because I'm sure all of you would be talking about this in your care. So that's the best I can get on my question.

**LANGLEY:** That's a very good question. I've done a lot of thinking about this issue, and my feeling is that you have to start at the very bottom. Instead of having women sit in a gynecologist's office waiting for their turn, which I've been in that experience, it takes two or three hours. They will put a video in front of you to watch that will sell Pampers and all sorts of different things for babies, but they don't address the issue of properly feeding your child from the beginning. A lot of research has shown that children are getting asthma, very very large numbers. They're getting diabetes. They're getting blocked arteries, and this is ridiculous. It's absolutely ridiculous. You didn't see this a hundred years ago. You didn't see it fifty years ago. I blame the food industry. I'm sorry, but I think that's where it lies. That and the fact that we are not educated, as I said in my speech, we're not educated in nutrition at all. My daughters go to school, and I've questioned them about what they're being taught in school. There is no nutritional training at all. But my daughters have learned through me that things like dairy products are being pushed, and dairy products do not provide the body with calcium. Dairy products are very harmful to the breast. Very harmful to the prostate. Very harmful to the heart. And yet we continue to allow the dairy industry to be in your face. It's the milk mustache. Every child in school has to drink

their milk. It's these types of issues that we need to address. We need to address the fact that the mothers don't know how to start out with feeding their children. They don't realize that whole grains and beans and minimize the meats. Get the junk food right out of the kitchen. Don't even buy it. Don't allow it in your house. Obviously, they're going to get it when they go to school, but if you start them out with a taste of what's healthy, then they're going to be a little bit more likely to lean that way, I believe. And then when they get in school, don't offer them French fries. Don't offer them cookies and puddings and things like that. Offer them the healthy foods.

**GORDON:** Thank you.

**LANGLEY:** Thank you.

**GORDON:** Joe.

**JOSEPH FINS:** Yes, for Dr. Chang. It's good to see you again. Drawing upon your experience having worked, I believe, at Memorial in the past, and knowing that kind of culture of an academic medical center, perhaps you could say something about delineation of the scope of practice, privileges, and how do we delineate who does what when so many different practitioners may be providing the same service, such as pain management, which could come in from anesthesiology, a pain . . . care service, an alternative practitioner? And maybe Dr. Cassileth could also comment on this, but how do we delineate, in a complicated environment, scope of privileges and practice?

**CHANG:** I think that is an evolving issue for most institutions who have to enroll and place in practitioners who were previously not in the system. And how do you accredit certain practitioners? There are formal national organizations and certification processes for certain arts, such as acupuncture, whereas there is state licensing requirements. But for other things, it's more, I think the institution will have to evolve its own rules. In some places, for example, where acupuncture can be offered on an inpatient service, perhaps they cannot do it as, I meant on the outpatient service. They may not be able to offer it to inpatients. And there are issues like that. I think each institution will develop such credentialing processes within itself, and insurance companies, as they look to cover some of these services, will have to do the same. A similar issue will be related, I think, to herbals. How do you standardize? How do you introduce it to the formulary, etc?

**CASSILETH:** I think the issue of accreditation and credentialing of practitioners is really a national problem. Right now, we have a number of bizarre situations . . .

. . . We are doing it because Kimora(?) was very committed to having an integrated medicine service. But I get calls from people all over, frequently, that this is a very serious problem. They can't figure out how to fit someone, like an acupuncturist, into the mainstream of the practice of that hospital. And I agree with Ray, this is going to be a matter for individual hospitals to figure out, but it would be greatly aided if the commission could push whomever to help us get to a more similar series of practices and credentialing approaches across the board, across all states, or perhaps some national procedures.

**GORDON:** I just wanted to be clear on that. So you think it would be helpful, generally, Barrie, as you've gone around looking at other programs, for us to help establish some national guidelines.

**CASSILETH:** I think it would be enormously helpful to push the states to be consistent in their guidelines and for them to have guidelines. You know, there are some guidelines that are in existence, which I think are terrible. For example, in acupuncture, if you are an American physician, you can take two or three hours of acupuncture study and you're an acupuncturist. That doesn't quite cut it when

acupuncturists trained in China will train for years. There is a vast difference between the two. Those kinds of discrepancies and absences, I think, are very problematic. And I think anything that the commission can do to help alleviate the problem and encourage states to produce seriously rationale accreditation concepts would be helpful.

**JOSEPH FINS:** Could you also follow up on the question of herbals and on pharmacy and therapeutic committees and formularies?

**CASSILETH:** I'm not sure how to answer that. I mean, I know what we do, which is we have a variety of people, including basic scientists and a pharmacist, look at herbs when they haven't been so examined in their country of origin. I think that's going to have to be done until we reach some different level with some of these herbal products. Even those that have been carefully studied in Asia have not necessarily been studied for a long enough period or in quite the way that is acceptable in this country. And we are actually working with some groups, some pharmaceutical companies, I don't know if you call them pharmaceutical companies, but companies that manufacture a botanical product, in China, on products that have been in use there for a long time, to bring them into the mainstream of analysis here so that they can then be properly utilized.

**GORDON:** Thank you. We're going to have to end the panel now. I just wanted to say to Joan Runfola and Barbara Sarah that I personally look forward to talking with you more about some of your efforts and what you're doing in terms of education and networking. We look forward to hearing more about how your work develops as well. Thank you all very much. I just want to put in a thanks to you, Michelle, for assembling the panels. Once again, I see a wonderful coherence.

**Panel 13**

**Panel Coordinator, Dr. Joseph Kaczmarczyk**

**GORDON:** Because Robb Burlage is on a mission of mercy, picking up four children, we're going to ask Sezelle Gereau-Haddon to speak first, if she would, and then hopefully Robb will come and we'll have him speak at the end.

**GEREAU-HADDON:** Thank you. I'm a physician. I'm currently the coordinator or the Wellness Center at the Riverside Church. The Riverside Church is an interdenominational church that is on the upper west side, West Harlem and Morningside Heights community. We offer a number of complementary and alternative modalities for our parishioners and people in our neighborhood and participants of our programs.

**GORDON:** Sezelle, come a little closer.

**GEREAU-HADDON:** I am also currently an associate fellow, going through a program, the first ever program offered by Dr. Andrew Wile and the University of Arizona in integrative and complementary medicine. Thank you for listening to my comments today.

With millions of dollars being spent every year on alternative medicines, this is fast becoming a field that is affordable only to the very rich. Complementary and alternative medicine, though, has much to offer those who can't afford to pay out of pocket for these modalities. In these less affluent communities, there are high death rates from cancer, heart disease, and other chronic illnesses, in which

lifestyle plays a great role in their cause and treatment. Complementary medicine often begins with healthy lifestyle changes and emphasizes maintenance of health by changes in diet, exercise, stress reduction, and use of supplements. Once disease does occur, use of alternative modalities can often be cheaper and its effects more generalized to overall good health and well being than allopathic remedies that are aimed at specific illnesses. As such, use of alternative therapies in poorer communities could result in general better health at less cost. Here, indeed, an ounce of prevention is worth a pound of cure.

The question then becomes how to provide access to complementary and alternative medicine in the most cost effective way, one that will reach many people in need. I sit before you today to propose that faith-based communities are well suited to assist in this regard. Here are some of the factors that make these communities prime for this role. Congregations begin with the same premise that drives alternative medicine, that the patient is intrinsically a curable entity and that access to this cure stems from within the patient themselves, not from an externally applied medication or treatment. Alternative medicine seeks, in many instances, to balance imbalances and, as such, restore an individual to wholeness and health, not solely to cure a disease. Churches, synagogues, and masques, in many ways, do the same in addressing the person as a whole entity, mind body and spirit, in the context of a community.

Second, faith-based communities have a wide audience of individuals that use the facility, from parishioners to people who access these for social services, such as food, shelter, or clothing. They also provide an environment in which the patient feels safe, unlike hospitals, which can be stress inducing in and of themselves. Here is a captive audience in a space that lends itself to healing. Thirdly, congregations have their own resources that might be used to offer alternative therapies to patients. Riverside offers a variety of modalities: meditation, massage, therapeutic touch, support groups. I could name a number of them. Also, many congregations have parish nurses, who serve in various capacities.

If alternative medicine is the new wave, let's not let this wave pass by some of those who could use it most. I encourage you to consider using faith-based communities as allies in this quest. Thank you.

**GORDON:** Thank you. Swami Sada Shiva Tirtha.

**TIRTHA:** Mr. Chairman, commission members, my name is Swami Sada Shiva Tirtha. I'm the president of the Ayurveda Holistic Center and the School of Ayurveda on Long Island. I hold a doctorate of science in ayurvedic medicine. It is the spirit that I come to talk to you about today, not herbs, not drugs, not medicine. Spirit is the core therapy.

Ayurveda, unlike other sciences, offers a spiritual dimension. Love, care, compassion are the essence of ayurvedic healing, more than mundane therapies. Health care must fit into a spiritual paradigm. We cannot mold traditional medicines into the allopathic system without destroying its spiritual effectiveness. Therefore, it's crucial that an ayurvedic expert be represented on the commission, or at least on a secondary panel. If you're to be effective, the commission must include representatives of the original healing sciences or run the risk of overlooking the essences of spirituality in health care.

Along with love, come care and compassion. Ayurveda contains a complete and profound science. It diagnoses the root cause of illness with unique pulse taking methods. It treats individualized therapies with herbs, nutrition, aromatherapy. And there are more than two thousand research studies done throughout the world on ayurveda, proving it effective, safe, and inexpensive. In our center, we have consistent success in many areas: for OB/GYN with PMS, menopause, bone loss, hormone balancing; for seniors with age reversal memory loss, brittle bones, and arthritis; and with special conditions, such as Parkinson's, MS, and fibromyalgia.

Ayurveda is cost effective. Medicare and Medicaid patients won't have to choose between paying for food or for medicine. In my pilot research study on seasonal allergies, we found a savings of $2 billion

for just a six-month seasonal allergy period in one year. If you apply the ayurvedic cost comparisons to just digestive disorders, we could save hundreds of billions of dollars in a year.

There should be as much press coverage for alternative medicine as there is on allopathic drugs. Pass an equal airtime bill. In a time when western medicine has no answers for many diseases, causes deadly side effects, and exorbitant pricing, it's a crime that people can't hear more about alternative medicine successes. Create a proactive holistic health care law. Don't just fight unfair labeling and freedom of information law attempts, but try to create bills that punish the truly criminal injustices of current health care. Set up a Web site database for practitioners to submit their case studies and research findings to inform practitioners and citizens. And use these databases to report to the press.

I encourage a national and state practitioner regulatory committee based on the Minnesota model. In New York State, we're not allowed to practice ayurvedic massage without a license, without undergoing lengthy costly study in Swedish massage, but a Swedish masseur can practice ayurveda with just a little bit of training. Thank you.

**GORDON:** Thank you. Ellen Schaplowsky.

**SCHAPLOWSKY:** Yes, thank you. My name is Ellen Schaplowsky. I'm vice president of the Traditional Chinese Medicine World Foundation and executive editor of our newspaper. Our goal has been to build bridges of understanding between the east and the west in the areas of authentic, beneficial, and sound traditional Chinese medicine. And we do this through a variety of means. We have a newspaper, which I believe you have a copy of, which looks like this, called Traditional Chinese Medicine World. This paper now has a circulation of approximately two hundred thousand people. It's in three hundred and fifty hospitals with complementary and alternative practices. It is in libraries, the Yale Library, Indiana University, and Stony Brook, and it's in all the New York public service libraries.

We've produced three books on traditional Chinese medicine. One with Dr. Nun Lu(?), who is our founder, one on breast cancer, one on menopause, and one on diet and stress. The hunger for this information is tremendous, as evidenced, on the Barnes and Noble Web site, there are seven hundred and seventy-seven books on breast cancer. We are number twenty-five. We are the second book in traditional Chinese medicine.

It is critical that we provide authentic traditional Chinese medicine information to the general American public. We cannot feed them the short form answers. They have to understand the difference between western medicine and Chinese medicine. It is the difference between quantum physics and science. It is not an either or, but an and, and it is very important that we shy away and discourage the suspicion, the fear, and the aversion therapy that goes on in western medical offices when women who are dying for this kind of treatment, and I mean literally are seeking help, kindness, nurturing, and loving attendance to their health and not to the financial bottom line.

One of the things that we know is, in our next issue, we are producing an article by a highly regarded researcher at Mt. Sinai, who will publish a landmark study in a prestigious western medical journal about asthma and TCM formulas for asthma, which have been in use for centuries. She has produced a remarkable piece of work.

I suggest to the panel that you support public service announcements, in general. I suggest you do syndicated radio programming, which you fund and . . . the quality of. And I suggest that you personally take an active role in ensuring that the finest quality of educational material gets to the American public. I think this is essential, and I think that east and west can coexist beautifully together for the preventive good health of every person in America. And I thank you so much for listening to these comments.

**GORDON:** Thank you as well. Ming Jin.

**JIN:** My name is Ming Jin. I'm a licensed acupuncturist in New York and New Jersey. I'm a medical

director of the MingQi Natural Health care Center. So I present here for AAOM, advisory board member, and I also present for the National Association of TCM. Here, because there time limited, I think of the major concern . . . talking about the Chinese herbs. Chinese herbs, I think, I spend eleven years in China in our college, you know, university, study for Chinese medicine. I think now all the, in this society, all the people will know the Chinese medicine already. They will use it for all different . . . preventive care. The major part, I think, Chinese medicine for treatment . . . we need more research and . . . for support all evidence. Just like we heard about the Chinese herb that treated cancer, Chinese herb lower the PSA level. Chinese herb, like myself, I do the research for Chinese herb to shrink the uterus of fibroids. We have so many cases in the clinic already, but we cannot say, you know, we cannot publish it . . . just need more evidence, more research, and then the lab research here to support us to say this . . . for the treatment. So I think there will be the chance to tell, you know, present our ideas. Say we need like more support from the NIH, from the White House, from you all commissioners give us, and more . . . funding to do this kind of research to make it like really . . . to approve that.

And, also, I want to talk about the Chinese herb is so many . . . for the Chinese herbs. There are side effects, like Mahwah(?). Mahwah is a very important herb of . . . to treat the asthma, but because we didn't use it properly and then you have a lot of problem here. So usually in the . . . eight hundred years documenters say the Mahwah cannot use as a simple herb. It cannot overdose. It has to be preserved with honey. They have to use . . . certain herb as their formula. And, also, for the patient . . . like heartbeat too fast, they have the bleeding problem, over sweat. They all cannot use Mahwah. They're all documented in our book for over, like almost a thousand years. But here they use the Mahwah for simple, you know, the concentration for lose weight. Of course, there will be the problem. I just used this as an example to say maybe if we can have the, like a panel, really have some professional doctor can handle this kind of problem and can make an herb work better in this society. Thank you very much.

**GORDON:** Thank you. Thomas Leung.

**LEUNG:** My name is Thomas Leung, and I stand here today, or sit in this case, representing the Association of Chinese Herbalists of New York. Our organization has been in existence for over twenty-five years, and has a membership of over three hundred TCM . . . practitioners. I would like to begin by thanking the commission for the hard work and making today possible. In particular, Commissioner Tian for encouraging traditional Chinese medicine organizations, such as ours, to participate in this movement.

The Association of Chinese Herbalists would like to address the 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. There 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 the 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 or she does not have to have any training in the discipline of acupuncture. Therefore, it would not be in the public's best interest to have practitioners of either discipline to treat patients in the modalities to which they are not trained. I would urge that licensure in the use of herbs be implemented in all states to ensure that their usage will be by qualified practitioners of oriental medicine, who have been trained in their use. This will ensure the public's

safety. 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 TCM, traditional Chinese Medicine.

The second subject is the importance of recognizing the roles of Chinese herbs in traditional Chinese medicine and Chinese cultural 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 are 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 interests of the public. Thank you.

**GORDON:** Thank you very much. Are the children okay, Robb? Robb Burlage.

**BURLAGE:** Thank you. This is the way I wanted it anyway. My colleague, I think you've heard, Dr. Suzelle Gereau-Haddon, who I think has made some specific observations about the needs of our communities and congregation based health and wellness programs. So I want you to permit me, not only to be late, but to give a more global testimony from my position and experience with the National Council of Churches Health Justice Ministry . . . consultant to the . . . Church Health and Wellness Ministry.

The National Council of Churches and the Riverside Church share a strong faith-based advocacy of universal health care as a human right and system efficiency. We also have been part of the spiritual, scientific, and policy quest for a truly holistic health care and integrated medicine. We hearken back to the pioneering sermons in the 1930s and 1940s of Riverside's founding senior minister, Dr. Harry Emerson Fosdick(?), on religion, science, medicine, health, and mental health, as well as our senior minister, Dr. James Forbes, who shared his pulpit a year ago with the surgeon general, Dr. Hatcher, about the blending of the spiritual, the medical, and public health.

Former Congressperson, NCC president, Reverend Dr. Andrew Young, of Atlanta, is a member of the surgeon general's steering committee, the campaign against racial and ethnic disparities in health and health care. The moral disgrace, human suffering, and social cost of forty-five million Americans and more without basic health care coverage, including complementary and alternative medicine and holistic modalities, and a hundred million more vulnerable and at risk . . . seriously under insured, is an international scandal. As representative of the National Council of International . . . are constantly confronted throughout the world. We should consider the fact that the U.S. is the only industrialized nation in the world without such universal health care coverage, including at least some complementary and alternative and holistic modalities. Even a unit of South Africa, with a heartbreakingly widespread epidemic of HIV AIDS, and a bitter history of Aparteid, and severe research shortages have made that commitment.

The interfaith health seminar, co-sponsored monthly by Riverside Church and the National Council, has emphasized, over the last five years, topics regarding the politics of universal holistic health care. Our recurrent theme is our community's right to universal holistic health care. The underlying quest is for community congregation based action to improve public resource support and scientific development toward access for all, to the emerging integrative medicine holistic health care, with an emphasis on the truly holistic, including spiritually linked prevention, health education, and public health.

As a health care systems analyst teacher and researcher, with training in public health and urban planning, I believe we need a major and expanded U.S. public resource commitment, both to ensuring

universal access to holistic care and a scientific evaluation of the effectiveness of all health care modalities. Even more serious funding for the Center for Alternative Complementary Medicine Research . . . health is required, effectively to encompass all utilized and potentially useful modalities. Yet, in fact, the major cost danger and unfulfilled benefit of health care today is the global monopoly of clinical, primarily allopathic, prescription drugs. Research, production, marketing, and pricing, and the lack of effective coverage in the U.S., and particularly with the tens of millions of our Medicare eligible older adults and people with serious chronic illnesses and disabilities. Over forty percent of the cost increase in health care overall in the U.S. last year was due to the price of prescription drugs.

The major scientific health care evaluation gap, as well as socioeconomic coverage gap in the U.S. and internationally, is not regarding complementary and alternative medicine and holistic modalities, but is in fact . . .

**GORDON:** Robb.

**BURLAGE:** Cut, okay. Can I conclude?

**GORDON:** Yes.

**BURLAGE:** Let it be stated that the quest for our community's right to universal holistic care, particularly from across the hundred and thirty-two thousand American faith congregations and communities, encompassing an overwhelming majority of Americans, requires comprehensibly vigilant action for better public policy and resource support. The mission of this White House commission we salute and promise full partnership.

**GORDON:** Thank you very much. Ming.

**XIAO-MING TIAN:** I have a question for Dr. Ming Jin regarding your treating OB/GYN disorders with very successful rate, eighty percent, using Chinese herb. I just wanted to understand, have you published those data with your OB/GYN collaborators?

**JIN:** Yes, I do publish this report, but this is in China, where I study for Ph.D. This is a special study for Chinese herb treating uterus fibroids. Also, it's for ovarian cyst. I do publish for that, yes, in my research. Yeah. That's why I said, but this type of material I cannot use here because I just want to say I would know this type of medicine, or herbs, use very well, but we need the more labor research, everything, can work here and then get all this done and get approved. So this is, I think, not only for my study. I think of for all the professional Chinese and medical doctor, so for this kind of study can make so many different things get approved. We need NIH to give more whatever the funding or the supporting for this kind of research.

**TIAN:** So you also have successful case in this country, too?

**JIN:** Yes, especially for the uterus fibroids. We have almost like eighty percent. Yeah.

**TIAN:** Thank you. The second question is for Dr. Leung, if I may. You mentioned that, I understand your group, your profession as a traditional Chinese medical doctors, you practice herbal medicine that's called herbal remedies. And the people purchase from your store and also your clinic. May I ask number, every year, and how many buyers that buy, or patients that buy your herbs and what is percentage and you might have a complaint. Have a complaint means some patients took your herbs . . . report and I don't feel well, side effect . . . toxic . . .

**LEUNG:** Let me start by saying that there is a good, we have a good number of patients who are Chinese, as well as non-Chinese, and I would have to say that most of the, we have very few complaints of people, of patients complaining that they don't feel well after taking remedies. I think when herbs are being given by practitioners of, you know, trained professionals who study herbal medicine, the chances of complaints, or the incidents of complaints, should be very low. It's usually the problem is when practitioners who are not trained in herbal medicine, and they'll . . . practice traditional medicine. That's when usually problems occur.

**TIAN:** Let's see if I want to buy some aroma . . . from your store, what kind of advice you could give me?

**LEUNG:** First of all, we would probably discourage the sale of Mahwah, discourage you from buying it. I think it would be bad business practice to sell it. In the long run, it would cause more problem. It would not be good business practice. It would not be good for the field to sell Mahwah because I think it's one of those herbs that should not be used by the general public indiscriminately. I think it should be used by practitioners who have training in herbal medicine. There are certain herbs that are very strong, the dosage range is quite, the window is small, and should not be used by the general public indiscriminately.

**TIAN:** Thank you.

**GORDON:** I have a question for Robb and Suzelle. Having spent some time at Riverside Church with you all and seen the program, and having a sense of how it's developing, I'm wondering what the response is as you contact other church groups. Is there interest or are there developing programs in other faith-based organizations? And if so, or even if not, are there efforts you're making to organize and to bring people together to take a look at what faith-based communities can do?

**BURLAGE:** There actually are two organizations. One that has existed for a long time . . . Harlem Congregation for Community Improvement. But especially in dealing with HIV AIDS from treatment and prevention has relied increasingly on holistic modalities as part of that practice and support. The Harlem directors group endorses this. And they are beginning to bring that to the front of their agenda, and we're trying to get them involved in our seminars. Dr. Forbes has actually formed or helped form an organization called The Harlem . . . Community Health Alliance, which is organized essentially by clergy and by congregation leadership across northern Manhattan, which is half a million people. And I'm talking about Harlem, or we're talking about west central and east Harlem, Washington Heights. And that organization is committed to doing outreach and in-reach congregation based community . . . outreach workers that will have training . . . holistic modalities as well.

**GORDON:** If there is any kind of information you have about those efforts, we would really appreciate that. How about nationally, is there an attempt to reach out nationally as well?

**BURLAGE:** Well, I mean, the National Council of Churches, we realize that there is incredible activity across the country in congregations, very little of it coordinated . . . communication . . . and by different denominations and, indeed, Jewish Synagogues, even Masques, obviously, behind other religious faiths. However, to correlate that, and to communicate that, I think is an important task. We've been trying to develop, even catalog, what some of the activities are by denomination.

**GORDON:** Thank you. Joe.

**GEREAU-HADDON:** Can I comment on that, also?

**GORDON:** Yes, please.

**GEREAU-HADDON:** We have thought about more recently than whether or not this is a "clonable concept," and have just started dialogues to reach out to a church in the south Bronx that works with at risk youth. And Columbia Presbyterian has been helping us to make inroads to that to see whether or not this is something that we really can put into action in other faith-based communities. So, on the global level, yes. And on the smaller level, we're also working on that.

**GORDON:** Great. Thank you. So we'll have Joe and Effie.

**JOSEPH FINS:** Dr. Burlage, just a quick question on the disparity issue from the other side of the equation. Do you have any evidence that the lack of insurance, that moral outrage that you eluded to here in your written testimony, has any impact on people who are in the underserved communities, using CAM modalities as an alternative, a low cost alternative?

**BURLAGE:** There's not enough evidence, I don't think. There is certainly plenty of evidence about lack of coverage in general. The uninsured, especially those who have more health problems, more at risk . . . lot of demonstrated lack of . . . of that. However, I think holistic modalities haven't been evaluated enough in that sense, but I would actually urge that there not only be this emphasis on evaluation of modalities, but on utilization and what its impact is.

**GORDON:** Effie.

**EFFIE CHEN:** Hi. My question borders on a spiritual and cultural aspect. Chinese medicine, whether it's herbs of acupuncture or ayurveda medicine, it's a practice from a different country, and coming to this country, do you find that you have to adjust some of your thinking and your approach to the population because of our lifestyle and so forth? Adjustments to the practice here?

**TIRTHA:** Yeah, there's quite a big difference between the way ayurveda is practiced in India and the way it's practiced in America. Ironically, in India, it's practiced very much with an allopathic mental think. The patient comes in, they take the pulse, they write a prescription of herbs, and send them on their way. Partly that's because their lifestyle is already, their nutrition is very similar to what we have to educate people who are in this country. But in this country are really more about education, education about nutrition, education about lifestyle, education about life purpose, and we spend much more time. We'll spend half an hour or an hour or longer with a patient for that.

**SCHLAPLOWSKY:** Yes, I'd like to make a comment on that. If Dr. Nun Lu was here, he would say definitely without knowing and understanding that the basis, the fundamental basis of Chinese medicine is how vital energy or chi moves through the body, you simply do not understand Chinese medicine. And everything ensues from that philosophy, and that obviously accrues to the herbal and the acupuncture and the acupressure. And to mistake acupuncture for the totality of Chinese medicine is something that we do here in the west, and we must broaden our purview and understand what is Chinese medicine before we can successfully apply. We cannot try to catch up and pretend that it's as good as western medicine. It is equal to and in some cases far outstrips the ability because it is dealing with the intangibles of wellness. I think that we have to incorporate that into our thinking when we are educating the American public.

**GORDON:** Okay. Thank you all very much.

**Panel 14**

**Panel Coordinator, Dr. Joseph Kaczmarczyk**

**GORDON:** We'll begin with Frances Brisbane.

**BRISBANE:** I am a passionate advocate for CAM becoming its own mainstream and for CAM not standing for co-opting alternative medicine. On November 2, 1999, there was an advertisement in the *New York Times* by one of the major insurance companies that said alternative medicine has been around for over five thousand years. Isn't it about time someone made sense of it? I thought how arrogant. I reflected on my grandparents and how they had made sense of so-called alternative medicine and therapies more than two thousand years before they became known as alternative to modern medicine. And, of course, many decades before, while they were still in Africa, they used medicine from the land, which my ancestors call root medicine and teas. The name herbal medicine was not part of their language. That, too, is a modern day adaptation. They also fashioned all manner of lying on of hands to make people in the villages well.

I refer to CAM as ancestral medicine, as a way to preserve the intellectual property of many things my ancestors and the ancestors of each one of us in this room used decades, and in some instances, centuries before modern medicine came on the scene. I have heard some people call CAM granny medicine, including the esteemed Dr. James Gordon, when on March 26, 1999 he said sixty percent of my practice was composed of granny medicine. I believe that his success and the success of everyone who practices CAM or granny medicine, especially among African ancestral people, must have a one hundred percent granny attitude. One of caring, concern, and commitment to a relationship with his or her patients.

African ancestral people find ancestral and granny medicine appealing because for us it is based on relationships and faith. Something I'm not quite sure double blind studies and the rigors of research will be able to prove CAM effectiveness among African Americans if the research blindly focuses on the product, such as St. John's Wort, Echinacea, garlic, etc., rather than on the mind body connection as a major cause of effectiveness. Our faith and, yes, our religious backgrounds, among perhaps the majority of African ancestral people make it easy for us to believe in energy medicine. For example, Chi Kung, therapeutic touch, massages, meditation, and acupressure among other things. But none of this will work with us unless we have a relationship with the practitioner and faith in her or his ability to bring healing and health to not only our bodies, but to our lives. When we are sick, our lives our sick. And the rest of my comments, oh, you have them.

**GORDON:** Thank you, Frances. I can't think of anyone I would rather by quoted by. Ora Bouey.

**BOUEY:** My name is Ora James Bouey. I'm a nurse practitioner and faculty at the University of Stony Brook. I thank you for the opportunity to present testimony regarding the complementary alternative medicine or traditional integrative health care therapies, as it is also known, which, to us, is ancestral medicine.

My experience is that of a health care provider and user of traditional medicine. I was employed for several years in an emergency department of a major teaching hospital is the Nassau-Suffolk County region that treated, then and now, more patients in the emergency department than any other hospital in

the surrounding area. According to data collected year 2000, the same hospital had over eighty thousand patient visits. While I do not recall exact numbers of patient visits annually while I was there, it was proportional to the population at the time.

I began the rudiments of data collection regarding the use and efficacy of traditional therapies, ancestral medicine, from information elicited from taking a health history. My sample size was huge because of the patient population. Patients were from a multicultural and ethnic population. My questions were basic so as to be understood with minimal clarification to the patient and/or to the historian or significant other. The questions that I asked then, and the questions that I ask now are what is the problem as perceived by the patient or the historian, may it be parent, guardian, significant other. What did they use to resolve the problem? How was the ailment treated? It was significant to ascertain why they used what they used when they used it. Also significant to understand how they used it. It's very easy for us to ask the question about their usage without fully understanding the reasons behind the usage.

For example, asking a patient if they use, a patient what they use, and they said they use tea bags with water. Tea bags with water may be used as a drink, but it also may be used as a . . . where they used it was equally as important. Was it by mouth? Was it by inoculation? Was it a salve? A liniment? Or was it the famous vapor rub that we now see in strips that are being sold to place across your nasal bridge of your nose to inhale and to open your bronchials, if you will? When did they use it? For persons with a history of using traditional medicines, there are select times to use intervention. So chronobiology and chronotherapeutics are equally as involved here. What made it better, what made it worse, was my way of ascertaining not only the efficacy of the treatment. It was also my way of seeking information regarding therapies that augment or serve as antagonists to the treatment that will be ordered by the physician. Am I towards the end?

**GORDON:** A concluding thought or two.

**BOUEY:** Okay, I did submit a paper. If you will indulge me, I offer to you what can be done to expand the current research environment so that practices and interventions . . .

. . . Conventional science adequately and appropriately addressed. I have been collecting data, anecdotal reporting, since 1954, when I went into nursing practice. I teach my students to collect the data while taking a health history. This can be systematically incorporated in data collected by health care providers throughout the country. Retrospective studies may be employed, especially examining what treatment is effective for the little people, pediatrics, so that we may begin early in life with prevention, promotion, and maintenance of health. I thank you for your attention.

**GORDON:** Thank you. Elsie Owens.

**OWENS:** Thank you for inviting me. My name is Elsie Owens and I'm the chairperson and founder of the Elsie Owens Health Center in Suffolk County on Long Island. I know that there was a need for health care and so I worked very hard to get health centers for all of the people on the Island, but I never forgot about growing up with a mother of twelve children, with no family doctors to attend our needs. No matter what the health needs were, my mother was able to take care of them with her herbs and her homemade remedies. I remember I had a fall, and I fell and had a very bad cut on my leg. My mother used something called a butterfly to kill the . . . to cure the wound, and it healed leaving very small scars. As I got older, I got high blood pressure and I had very bad arthritis.

I have a family doctor at my health center, and I really love her. I trust her very much, but I never forgot about my mother's remedies. They don't have doctors like we used to have that would sit and listen and talk to you about your family problems. As I grew older, I began to feel tired and lost my energy. The pains was gone, but I always was tired, and I remembered my mother's remedies. So I visit a CAM

doctor center. I started to take vitamins and herbs, and I began to feel better. My pressure was lowered. I felt better. I'm able to walk two or more miles a day. I'm not feeling tired at the end of the day. I'm seventy-three years old, able to do and to be active in my community.

Many people in my community visit my health center, but they do not tell the doctors that they're taking herbs or vitamins. And the reason for that is that they do not want to be cut off from a health center. And so I think that it's very important that people know that we will take those vitamins, most of us, because we're old and we know that it's active, but we also will visit our doctors when the pain is too pressure. Thank you.

**GORDON:** Thank you. Eliza Townsend.

**TOWNSEND:** Thank you. My name is Eliza Townsend MD, proprietor of the . . . a holistic practice located in Wyandanch New York. As an alternative health care provider, I teach lifestyle change and recommend the use of all forces, which are found in nature, such as light, water, air, plants, and food to stimulate the body's natural healing abilities. These services are not medical, nor are they intended to replace medical treatment. My practice, primarily, is word of mouth, referrals from alternative care practitioners, and sometimes medical doctors for a special need. I do not advertise or solicit. I receive calls from people when they feel they have run out of options. My clients do not tell their primary care physicians that they are seeking alternative services due to often negative feedback and warnings that these services have not been validated.

Why do people come to me? When asked this question, one of my clients responded I feel very comfortable with your services. I get results. You spend time answering my questions. After the cleansing, my skin cleared up. As an American citizen, I have the right to make choices about my health care. We're all aware of the fact that natural remedies have been part of our culture for hundreds of years without side effects. As a practitioner, I bring a valuable service to the table, and I should be recognized as a valid acceptable service provider.

The challenges I face as an alternative . . . provider, number one, constant criticism from the medical profession. Number two, lack of health insurance company coverage. Number three, to publicly advertise my services as an acceptable alternative cure service. The federal and state government should provide policies that are inclusive and not exclusive in providing alternative health care to our ever-changing society. Thank you for listening.

**GORDON:** Thank you. Charles Robbins.

**ROBBINS:** Thank you for this opportunity. I'm the associate dean of our School of Social Welfare at Stony Brook and chair the Center for Health Promotion and Wellness. I'm also the director of social work in our academic medical center and co-chair of our institutional ethics committee. There are several areas in which the federal government has responsibility to act as it impacts public health education. The first of these is to ensure that the public has access to the information that's currently available about the products and services which they are using. It is the government's responsibility to see to it that individuals have the necessary information to make an informed decision. The government must ensure that allopathic physicians and health care providers are aware of the practices that individuals from different parts of our country and from throughout the world are likely to be utilizing. They must be educated about the importance of engaging in non-judgmental communication about these practices.

Allopathic physicians, and other health care providers, must be educated to understand that their way is not the only way. Likewise, the public must be educated that simply because something is said to be natural does not mean that taking it is without consequence. Individuals would not take substances that they believed to be inert, as they would produce no effect. Therefore, the government must provide

accurate information for the public on the risks and benefits of so-called natural substances.

There are two additional areas in which I urge the commission to take action. The first has to do with the regulation of the supplement industry. I am not suggesting that the government dictate what supplements are available to the public or even evaluate the outcome claims made by the manufacturers. What I am suggesting is that the government does have a responsibility to ensure that what is on the contents label of a supplement package is in fact what is in the package. Today one does not know anything about the strength or purity or even if the substance they are ingesting is in fact the product on the label. It is time to tell this multimillion dollar industry that acceptance of this minimum level of regulation is simply part of the price of doing business.

And, finally, an issue that is potentially a huge public health problem in this country. This has been highlighted by Dr. David Eisenberg, in his two national studies, as well as in virtually all other professional literature in this area. I am referring to the lack of communication between patients and allopathic health care providers about CAM practices they are utilizing, as well as lack of communication between CAM providers and their patients about allopathic treatments they are using. As we see an exponential rise in the use of what we refer to as CAM practices, there is going to be an unfortunate explosion of negative drug supplement interactions, as well as unforeseen consequences on specific health conditions by taking supplements.

There are two areas in which I believe the government must act if we can head off this crisis. The first is to require that all allopathic health care providers are educated about the supplements and practices their patients utilize. The next step would be for the government to launch a public health education campaign utilizing public service announcements, television commercials, and print media to underscore the importance of patient and practitioners communicating. Thank you.

**GORDON:** Thank you. Dan Kamofsky.

**KAMOFSKY:** I represent Care for the Homeless, a nonprofit organization that sponsors health teams that provide medical and social services to twenty-four outreach sites in New York City. We cover a wide spectrum of facilities, including family residences, single adult shelters, soup kitchens, and drop in centers. In 1999, medical care was provided to approximately ten thousand clients, of which over three thousand were children. Fifty-five percent of our patients had no medical insurance coverage, forty-three percent had Medicaid coverage, one point three percent had Medicare, and zero point five percent had VA insurance. Clearly, Medicaid is a major determinant of what kind of medical care our clients received.

Medicaid restraints often make providing alternative or complementary treatments a challenge. For instance, I recently evaluated a forty-year-old woman for Puerto Rico, who lives in shelter with her four children. Leaving out the clinical details, this woman presents with a classical case of seasonal effective disorder, which is a pattern of regularly recurring episodes of winter depression, seemingly caused by the dearth of sunshine in winter. Significantly, I believe this disorder led to the loss of her job, her husband, and, finally, her home. There is a very broad consensus among psychiatrists that the treatment of choice for seasonal effective disorder is light therapy with a light box. However, New York State Medicaid will not pay the $200 needed to buy it. The only state Medicaid program which will pay for a light box is Maine. Medicaid did pay for the antidepressants, Effexor and Prozac, which gave some minimal relief and cost a little less than $200 per month. Thus, we have Medicaid spending almost $200 a month to provide an inferior treatment, when the same $200 could provide an alternative treatment that is universally accepted as the preferred one and which could assist not just for one month, but for many years.

Other examples of New York State Medicaid not reimbursing effective or promising alternative or complementary treatments involve the prescription policies for nutritional supplements. Although Medicaid covers many supplements, such as Vitamin C, folic acid, and calcium, it will not pay for many

others, such as Vitamin E, omega three fatty acids, and magnesium, even though there is good evidence that these supplements can, respectively, be useful in slowing the progression of Alzheimer's Disease, stabilizing a manic depressive disorder, and treating diabetes. Efforts to more favorably affect Medicaid coverage will permit much more of the homeless population access to alternative and complementary approaches.

Finally, more attention needs to be focused on the thousands of children living in homeless shelters, many of whom remain in the system for more than a year. These children may have nutritional deficiencies, learning problems, and psychosocial injuries that might be amenable to alternative or complementary techniques.

**GORDON:** Questions? Well, I'll go ahead with one I have. I was intrigued and disturbed and, unfortunately, not too surprised by your saying that if people talk about using some of these therapies, traditional therapies, they might be cut off from their health center. I wonder if you could, any of you, Elsie, you were the one who said this, I believe, but I wonder if you could talk about it and if others could talk about it as well?

**OWENS:** Well, I remember when I did tell my doctor, although my pressure had lowered a lot, that I was on vitamins and taking herbs. And she kind of said that maybe I had better stick with my traditional medicine rather than to do that because she was afraid of what might happen, and I think lots of people feel that way. They come to health center and you talk about using vitamins and herbs. I don't remember them turning anyone away, but that might happen. And the fear of that is that they won't tell.

**GORDON:** Anyone else?

**BRISBANE:** I've not seen anyone actually turned away, but I have seen individuals "shut down." Patients, parents, guardians, historians, or especially people of certain ethnic groups are natural storytellers. We have limited time to elicit a health history from a patient, given the reimbursement code that we currently have. If a person starts telling a story that's going to take more than a few minutes, immediately the patient, the significant others, can see that the shade has been pulled down and they've been shut out and you're no longer listening to them. That, in and of itself, is a turnoff. Much of the information, of course, that they're willing to share is information that could be helpful to them, and certainly very helpful given whatever it is that the physician is going to prescribe.

**GORDON:** I'm wondering, based on your experience, if you have any suggestions about ways to change the situation, change the lack of receptivity either to traditional cultural forms of healing and/or traditional forms of expression. What would you suggest as a sort of policy recommendation that we could think about?

**OWENS:** I think one of the most important things is in every clinic and every place that we can possibly have an integrated team, and once the team is integrated, then that symbolizes to the person who comes that there is a healthy respect for both forms of medicine. I also want to just mention about the earlier question that you asked. I remember telling someone that I had a prayer vigil, and African American people often have what we call prayer vigils when you have an illness. I told this to my doctor and I said that my kidney really was fine since I went to the prayer vigil. And before I could leave, she worked around to tell me I should see a psychiatrist, but I was strong enough not to let her throw me, but there are too many people who would not have even said that to her. And I said it because I'm an advocate for CAM, and I was really trying to educate her, but so many people would never have said that.

**GORDON:** Thank you. Effie and then Joe.

**EFFIE CHEN:** Thank you, SUNY Stony Brook and also Center for Homeless. Our concern has been that CAM may be just reaching the upper middle class, and the cultural and deprived financially, and I wonder if you would speak to that. How can we reach out more to that population? What is some resolution?

**KAMOFSKY:** I think the reality is that all of the studies that have been done and the data that has been collected have been collected on a very middle class, very white, or upper middle class population. And I think the reality is that the practices are going on in the communities, particularly in communities of color, but they don't consider them complementary or alternative. They're, in fact, traditional medicine. So when you start collecting the data and using the language, I think that part of the problem is that we're talking about one thing and then the folks we're talking to are talking about something else. I think that understanding what we're trying to collect data on, again, public education as well as practitioner education about what people are doing, and particularly as people from throughout our country settle in different communities, people from throughout the world settle in different communities, and bring those practices with them, it's critically important.

In answer to Dr. Gordon's first question, I think there are two other factors that play, too. One is that, particularly in communities of color, there is a general mistrust of institutions, including health care institutions. So we have to understand that and then first deal with that before we're going to get to the next step. And the other thing is that when you go to conferences and meetings and professional sessions, there is, more often than not, nothing on culture. Somehow there is a belief that what people are now coming up with as complementary and alternative medicine is something new. And I think that we need to begin to build into the national conferences, to build into the educational sessions an understanding that, as Dr. Brisbane said, that the intellectual property rights of this really go back a lot further than most of us are willing to give credit for.

**BRISBANE:** One of the things, too, that I think is real important is the fact that we believe that the answer to do we use these things is no because we don't want to be seen as not having respect for conventional modern medicine. So the answer is no. So even when you ask us, so if you're going to get a true picture of our use of it, which is very very widespread, you've got to have people asking the questions that are answerable and they have some faith in. And we don't respond well to any telephone. So most of the studies have been done through the telephone. We don't know who you are on that telephone. So if we don't have a face to face with you, we have every reason in the world to be suspicious.

**ROBBINS:** With regard to this issue, I think more research needs to be done in certain areas. For instance, with the many children that are in the shelter system. I wonder what sort of, what their nutrition is like, whether they have nutritional deficiencies. For instance, a pet project that I'd have an interest in is, let's say, to look at omega three fatty acids, vitamin A, and vitamin D to do blood levels for this. We hear that rickets, now, the prevalence is going up because children are drinking less milk products and they're spending less time in the sun, and we're just beginning to learn how important omega three fatty acids for the development of the brain. Well, let's say we look for those three nutrients. We find amongst the children in the homeless shelters. Perhaps we could treat those individuals very simply by recommending an old supplement that was given by our grandmothers, simply cod liver oil. So it's things like this. I do think that some basic research could be very helpful in this area.

**GORDON:** Joe.

**JOSEPH FINS:** Dean Brisbane, as a social work educator, and I was really struck by this notion of ancestral medicine. It puts it back into the heart of the person and their history and all. One of the, perhaps, failings of allopathic medical education is the failure to get to know the person as a person. We get to know your biology, but not you as a person. What lessons are there from social work education for allopathic training, vis-à-vis what we can do to get that richer history about CAM therapies the meaning of these modalities and ones spiritual and family life?

**BRISBANE:** What we do, at our school, we teach exactly what we're talking about. We have a whole curriculum around this, and I lose no opportunity to be on every national social work conference talking about this issue as an advocate for maintaining the intellectual property of this, as a part of what your ancestors brought to this country and brought to this particular subject, and my ancestors, and so forth. And we also teach our students how to help their clients to know the options that they have, and to also talk to them in ways to elicit from them some of their beliefs about ancestral practices, and to let them know, because they respect us, to let them know that we respect what they do and that it is all right. So we also use them to teach other people in their communities about these kinds of things. That's why we stay abreast of it.

**FINS:** If you could share that with us, because we have to make recommendations about medical education across the board in this arena, if you could share that curriculum with us, we'd be most grateful.

**BRISBANE:** We'd be delighted.

**FINS:** Thank you.

**GORDON:** Thank you. Thank you all very much. It was very important for us to hear from you today.

**Panel 15**

**Panel Coordinator, Corinne Axelrod**

**GORDON:** A panel of old friends, at least some very old friends. Maria Josepher.

**JOSEPHER:** Jim, I just want to say I really thank you for the single pointedness of your vision. I've known you sixteen years and this is all I've ever heard you talk about. My name is Maria Josepher, and I'm the deputy executive director of Exponents Inc., an organization which is dedicated to serving substance users, their families, the homeless for twelve years now. As an organization, we have attempted to create and conduct stress management education, meditation and conscious breathing sessions in the Rikers Island prison, one of the largest jails in the United States. And we had incredible benefit that we saw in rage reduction of the inmates, but we had to stop those classes because we could not get any cooperation with the prison escorts, nor could we get any private training rooms, because we were working with HIV positive inmates, and we really needed their confidentiality to be maintained. So that had to be stopped.

As an organization, we're very committed to utilizing the person with the history of addiction to provide direct client services. And doing this really led us to have to deal with the conditions which present themselves as an aftermath of addiction in our employees. Things like HIV, hepatitis,

depression, diabetes, and that if we really wanted these individuals to be giving care on any basis, that we would really need to deal with their wellness first. And that is what we have done. We have created not only programs for our employees, but policies such as catastrophic sick time, and utilizing sick time for well visits to their physicians.

Our offices are also equipped with CDs and audio equipment, and many of our staff utilized CDs, which are embedded with brain synchronizing technologies, and they've had great benefit from that. We've also addressed the smoking cessation among our staff, and by doing this, just by educating them, half of our staff has already quit smoking, and that has just happened through an education process. I see CAM as the cost effective way of dealing with prevention and illness, and we do need policies, which will help our prison system to cease being a warehouse of humanity and start becoming a center of re-education for a very captive audience.

**GORDON:** Thank you. John Tribbie.

**TRIBBIE:** Good afternoon. My name is John Joseph Tribbie. I'm the assistant vice president of Greyston Health Services in Yonkers New York, where we are entering our fourth year of providing medical and social services, including a wide array of complementary and alternative therapies to persons living with AIDS.

As the AIDS epidemic enters the 21st century, persons living with AIDS, through increased education about their illness, are making more informed decisions about their course of treatment. Approximately twenty-five percent of our patients consistently access holistic services on a weekly basis. While approximately fifty percent access these services at least once each month. Medicaid, which is our primary funding source, does not cover these sources. Therefore, additional funding sources would enable programs such as ours to enhance service provision and increase our research efforts to report more precisely the effects of complementary and alternative therapies on special populations, such as persons living with AIDS.

It is expected that enhanced treatments, vaccines, and, perhaps one day, a cure for HIV and AIDS will be the result of western based medical research. However, the person living with the virus cannot be ignored. In utilizing holistic therapies, we work with the body, the mind, and the spirit to restore and strengthen the whole person, whereby the immune system, along with other bodily functions, is better supported. Our patients often comment on the healing component of alternative health care, and it's ability to promote wellness, to relieve stress, which studies have shown can weaken immune response, and to assist the body in stabilizing and managing an impaired immune system.

Through a partnership involving both holistic and standard medical approaches, we address not only HIV infection, but other health issues affecting persons living with AIDS, such as hepatitis C, depression, fatigue, physical rehabilitation, substance use, and cognitive skills. As a result, we have seen increases in T cells and decreases in viral loads. We have seen a lessening of anxiety and stress. We have seen a decrease in drug use. We have seen patients, who have an inability to trust and difficulty in being consistent in their treatment, come back again and again and again. And we have seen a community form, and we continue to see this community grow and flourish.

Now, how much do alternative therapies play a part in this development? Well, we know that our attendance is higher on days when we offer alternative therapies, so we know our members believe in the course of treatment they have chosen, which is a core issue in learning to care for ones self. Learning to take better care of your own well being. The healing process begins in the mind, moving into a contemplative state, and from there into a position of action. Our experience has shown us that the integration of standard medical procedures, with complementary and alternative care, can greatly enhance a person's ability to move in this direction. To continue to enable our patients to get to that point, we must provide them and ourselves with the largest array of ammunition possible. Thank you.

**GORDON:** Thank you. Anthony Vera.

**VERA:** Good afternoon. A funny thing happened to me on my way to this forum. I forgot the statement, but someone brought it in. So I'll pass . . .

My name is Anthony Vera. I'm a director of planning and development at Betances Health Center. And I'm really here to express the sentiment, not only of our executive director, Wanda Evans, but also our management team, who endorsed the statement you have been given.

Complementary or alternative medicine, in the form of home remedies or use of care discoveries amidst the cultural diversity of New York City has for generations been the first line of care for the many Latinos and African Americans served by Betances Health Center. We're located in the lower east side, New York City's traditional settling community for new immigrants. Betances, therefore, provides health care with thirty years of service commitment to integrate the healing wisdom of eastern and western cultures. Ninety-one percent of our three thousand eight hundred and forty patients are Latino and African Americans. And our experience has been that all have utilized at least one complementary care remedy for acute or chronic conditions. Last year, one thousand ninety-six patients made an estimated three thousand eight hundred and twenty-two visits for acupuncture, massage therapy, and nutrition counseling that included dietary supplementation.

These visits, however, were made for medical necessity, and only two percent of the visits were paid directly by patients out of their own pocket. That is to say that the bulk of these services were paid for either through grant sources or just the sweat of our staff to give extra time to provide services because, as I'll indicate later, Medicaid is not very helpful in this area.

Betances also provides primary care services to approximately four hundred Latinos and African Americans with HIV and AIDS. About four percent of our HIV patients have opted for complementary care for a variety of reasons. For many African Americans, choosing a complementary care is their way of responding to medical treatment fears rooted in the legacy of the Dashiki study. Among a significant number of our HIV patients, complementary care is consistent with a belief system that embraces holistic health and self-healing. Our experience with complementary care also confirms the finding, by they way, it's one of your commissioners I'm relying on here for this information. The findings that Latinos adopt traditional patterns of use when it comes to herbal remedies compared to the faddish appeal such remedies have for non-Latino white populations. Among Latinos, for examples, the botanical continues to be more than a place for spiritual healing. One where herbal remedies are intricately connected to belief systems that are only now being uncovered by conventional medicine to be a critical predictor of positive medical outcomes.

It is, therefore, very easy for Latinos to accept healing practices, such as acupuncture, massage therapy, or therapeutic touch along side conventional medical remedies. Regrettably, the barriers posed by western medicine are complicated by a marketplace culture that unrelentingly promotes complementary care the way it peddles beauty and fashion. There is no scientific method behind culturally driven remedies that show the . . . with the power of tradition and countless use over countless generations.

**GORDON:** I'm wondering if you could move directly to

**VERA:** Let me just summarize by saying that if we're going to make any meaningful change in this area, with this paradigm shift that's required with the dominance of western medicine, it is that there be two systemic changes brought about. One is that standards of care should be established that will permit patients to receive acupuncture, massage therapy, nutrition therapy, and other remedies as medical services within state licensed medical care facilities with adequate Medicaid and Medicare reimbursement rates. And, secondly, managed care plans should treat complementary care services as a carve out product that supports self care and wellness benefits such plans promote as health maintenance goals. Thanks very much.

**GORDON:** Thank you very much. Anne Markowitz.

**MARKOWITZ:** Hi. I'm a therapist in two grant programs at Harlem Hospital. I work with abused women, sometimes abused men, and their families. It's a very high stress population. There are four points I'd like to raise about which I've become increasingly concerned over the last twelve years.

The first area of concern is nutrition, which has been mentioned before, but I think there is a particular race and money issue involved in the way our society distributes its food, although the entire country seems to be going in the same downward direction. The hospital is a designated heart center, Harlem Hospital, because the 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, patient 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 an inordinate number of black boys, ages five to fifteen, are being diagnosed with attention deficit disorder or other related disorders and prescribed Ridlin 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 five or seven percent. 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.

The third are of concern is the widespread use of antidepressants 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 anymore. They are often depressed. However, when they're referred to psychiatry, they are usually given antidepressants, little or no therapy, and sent on their way, often with a referral, but without follow up or outreach. Several women, who came into our program after a referral from psychiatry, were on antidepressants, but stated that they were numbed and mentally a little unclear from the drugs. It's very hard to compare cases, but if I could generalize about the women I've seen, those who arrived depressed, but unmedicated, made faster and better progress in therapy than those who were on antidepressants.

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.

And one thing I wanted to mention just on one of Ms. Brisbane's points was that a lot of the home remedies that we see in the older population in Harlem have been completely lost to the younger generation. The younger generation comes in and they have no home remedies, even though they are close with their grandmothers or whatever. They are just turned off to the whole idea. And it seems to me that that could be worked out within the community. That there could be encouragement of intergenerational . . .

**GORDON:** Thank you. Questions from commissions.

**EFFIE CHEN:** My question is . . . we talk about other people using CAM therapy. What you people