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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	WHCCAMP roster (partial) (2 pages)	02/16/2001	b(6)

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

OA/Box Number: 43238

FOLDER TITLE:
WHCCAM Commissioners' Briefing Book, February 22-23, 2001 [1]

2011-0568-S
kc892

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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White House Commission on Complementary and Alternative Medicine Policy

February 15, 2001

Dear Commissioners:

Welcome to our February 22-23, 2001 meeting on **Education, Training, Licensing and Credentialing of CAM Practices**. This briefing book is a result of your efforts over the past few weeks, and is an impressive array of information!

The first set of tabs will take you through the Plenary Sessions on Day One. Where available, biographical sketches and written testimony from the invited speakers have been included. Missing information will be provided on-site, at the meeting.

The second set of tabs will take you through the responses that were provided to each Discussion Group by our deadline; others that are received after the deadline will be provided to you on-site, at the meeting. You may already have seen electronic copies of the responses provided to your individual Discussion Group; the briefing book provides an overview of all the responses received. Please take some time to review all the submissions to prepare you for the Full Group Discussion on Day Two.

We do recommend that you bring the briefing materials with you to the meeting for your reference during the breakout sessions and Full Group Discussion. We will be happy to ship the materials BACK to you after the meeting.

Please note that we will have a brief media training session during lunch on Day One. We hope this session will make you more comfortable and available for media opportunities as we approach the interim report deadline. Materials for this tab will be provided on-site, at the meeting.

Under the General Information tab, we have included the final Calendar of Proposed Meetings, and updated Biographical Summaries and Rosters for your review. We also have included a copy of the Draft Report Outline. We may take some time at lunch on Day Two to review our status with the interim report recommendations and process for the development of the final report.

As usual, we will arrange for a No-Host dinner on Thursday evening at Donna's restaurant in the St. Gregory Hotel. Hopefully, Doris Kingsbury will have already contacted you by Friday, February 16 regarding menu choices and payment. If not, we will make those arrangements with you on-site.

Enjoy reviewing the briefing materials and have a safe trip to Washington, D.C.

Sincerely,

Stephen C. Groft
Stephen C. Groft, PharmD
Executive Director

Michele M. Chang
Michele M. Chang, CMT, MPH
Executive Secretary

David Becker - Callan Fellowship to Discuss
- Cracking the Shell to get into the Org Box
Conventional + CAM

General Info

General Information

White House Commission on Complementary and Alternative Medicine Policy

Proposed Meeting Schedule*

DATE	SITE	TYPE	TOPIC
February 22-23, 2001	Washington, D.C.	WHC (4)	EDUCATION/TRAINING
March 16, 2001	Minneapolis, MN	Townhall (4)	
March 26-27, 2001	Washington, D.C.	WHC (5)	INFO DISSEMINATION and WELLNESS
May 14-15-16, 2001	Washington, D.C.	WHC (7)	RESEARCH II and REIMBURSEMENT
July 2-3, 2001	Washington, D.C.	WHC (8)	REVIEW INTERIM REPORT DRAFT
October 4-5, 2001	Washington, D.C.	WHC (9)	PROGRESS ON FINAL REPORT
December 6-7, 2001	Washington, D.C.	WHC (10)	REVIEW FINAL REPORT
March 2002	Washington, D.C.	WHC (11)	CLOSING EVENT

*This information, including dates and locations, may change based on recommendations from the Commission. Updates are posted on our website: http://whccamp.hhs.gov as soon as they become available.

DRAFT

Report of the White House Commission on Complementary and Alternative Medicine Policy

Letters of transmittal
- The President
- Congress
  - President of the Senate
  - Speaker of the House
- Secretary Department of Health and Human Services

Prologue – Chairman's Summary – 1 page vision
Acknowledgements
Commission Members
Commission Staff
Working Groups (Planning)

Executive Summary (10 pages)
- Conclusions
- Recommendations (a) Administrative Actions
  (b) Legislative Proposals

Table of Contents

DRAFT

Part III. Historical Perspective **(Jim Swyers)**

(A) Legislative and Executive Actions
(B) Other Federal and State Activities
(C) CAM Integration Efforts to Date

Part IV. Coordination of CAM Research
(Gerry Pollen)

(A) Current Efforts and Status of CAM Research

(1) Federal Efforts
(2) Private Sector Initiatives
(3) Not-For Profit Support of CAM Research

(B) Barriers to Progress
(C) Public Input to Identify Research Opportunities
(D) Interface Between CAM Research and Regulatory Agencies
  (1) Practice-Based Research
  (2) CAM Research and Experimental
  (3) Research in the Regulatory Framework
  (4) Facilitating CAM Research and Regulatory Challenges
(E) The need to Coordinate CAM Research and Development Efforts
  (1) Collaborative Efforts
  (2) Research Areas in Need of Coordinated Efforts
  (3) Underutilized Coordinating Bodies
  (4) Evaluation of Interventions by non-traditional Research methods

(F) Support for Research
  (1) Basic Research
  (2) Clinical Research
  (3) Health Services Research
  (4) Epidemiological/Follow-up Long Term Studies
  (5) Existing Sources of Funding
  (6) Research Opportunities In Waiting
  (7) The Research Community; Perceptions and Realities of Support for CAM Research
  (8) Peer Review of CAM Research Proposals

Part V. Gaining Access to the Delivery of CAM Interventions and Products
(Dr. Joe Kaczmarczyk)

(A) The Availability of CAM Interventions and Products
(B) Concerns About Liability
(C) CAM Delivery Systems
  (1) Private Sector
    (a) Private Practice Based
    (b) Community Hospitals

(c) Academic Health Centers
(d) Managed Care Organizations
(2) State and Local Government Supported
Washington
Minnesota
Ohio
(3) Federal Sector Activities

(D) Cost Effectiveness of CAM Interventions

Part VI. Reimbursement for CAM Interventions and Products **(Maureen Miller) (to be expanded after meeting)**

(A) Financing CAM Interventions, Services and Products
(B) Medical Insurance Industry, Criteria for Reimbursement
(C) Eligibility Requirements for Medical and Medicare
(D) Reimbursement/coverage in the Managed Care Setting
(E) Gaps in Reimbursement and Coverage

PartVII. The Education and Training of CAM Researchers and Health Care Practitioners **(Dr. Joe Kaczmarczyk) (to be expanded after meeting)**

(A) Attracting and Retaining CAM Research Investigators
(B) Research Training and Career Development of CAM Practitioners
(C) Emerging CAM Professions
(D) Introducing CAM Intervention Theory to the Research Community and to Healthcare Practitioners
(1) Undergraduate Education
(2) Graduate Education
(3) Continuing Education of Health Care Providers
(E) Licensure, Certification and Credentialing of CAM Practitioners

Part VIII. Development and Delivery of Information on CAM Interventions and Products **(Corinne Axelrod) (to be expanded after meeting)**

(A) The need for Information
(1) Public
(2) Patients
(3) Health Care Providers
(4) CAM Practitioners
(B) Sources of Information
(1) Public Sector
(2) Private Sectors
(C) Access to Information
(1) Media, (a) TV (b) Press (i) Professional (ii) Public
(2) Internet

Part IX. A Vision for the Future

(A) Building the Scientific Basis of Understanding CAM Interventions
(B) Overcoming the Bias against CAM Practices

White House Commission on Complementary And Alternative Medicine Policy

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Commissioners' Biographical Sketches

Dr. James S. Gordon, of Washington, DC, who will serve as Chair of the Commission, is currently the Director of the Center for Mind-Body Medicine. Previously, he chaired the Program Advisory Council at the Office of Alternative Medicine of the National Institutes of Health. In addition to maintaining a private practice in Psychiatry and Medicine, Dr. Gordon has been a Clinical Professor at the Georgetown University School of Medicine in the Departments of Psychiatry and Family Medicine since 1980. He is a member of the National Institute of Health's Cancer Advisory Panel and was the Director of a Special Study of Alternative Services for the President's Commission on Mental Health. He has written extensively on the subjects of psychiatry and alternative and holistic care, and serves on the Editorial Boards of Alternative andComplementary Therapies and Alternative Therapies in Health and Medicine. He received his A.B. from Harvard College and his M.D. from Harvard Medical School.

Dr. George M. Bernier, Jr., of Galveston, TX, is a hematologist/oncologist and is currently the Vice President for Education at the University of Texas Medical Branch. Previously, he was Vice President for Academic Affairs, Dean of Medicine, and a Professor of Medicine at the University of Texas. Dr. Bernier has held academic appointments at the University of Pittsburgh, Dartmouth-Hitchcock Medical Center in Hanover, New Hampshire, and at Case Western Reserve University in Cleveland, Ohio. He has published numerous articles and abstracts, and several books. He received a B.A. degree from Boston College and a M.D. degree from Harvard University.

Dr. David E. Bresler, of Los Angeles, California, is one of the first contemporary American scientists to study and research acupuncture, guided imagery, and other mind/body approaches. As a professor in the UCLA Departments of Anesthesiology, Gnathology/Occlusion and Psychology, he applied his findings to treating clinical problems that did not respond well to conventional care, beginning with chronic pain. As the Founder and Executive Director of the UCLA Pain Control Unit, he and his team created the first multi-disciplinary, university-based chronic pain program in America. Dr. Bresler has authored or co-authored numerous publications, as well as twenty books and workbooks. Currently, Dr. Bresler serves as Associate Clinical Professor of Anesthesiology at the UCLA School of Medicine, Executive Director of the Bresler Center, Clinical Consultant to the UCLA Pain Medicine Center, Dean of Mind/Body/Spirit of the University of Integrated Studies, and Co-Director of the Academy for Guided Imagery. Dr. Bresler received his B.A. from Brandeis University, his M.A. from Bryn Mawr College, and his Ph.D. from UCLA. He received his Certificate in Acupuncture from the Institute for Taoist Studies.

Mr. Thomas Chappell, of Kennebunk, ME, is the co-founder and CEO of Tom's of Maine, which he co-founded with his wife Kate in 1970. It is a company that produces innovative, natural personal products and natural wellness products in a caring and creative work environment. Mr. Chappell is founder and CEO of the Saltwater Institute, a learning institute of leaders seeking to integrate their values into their personal and professional lives. He is active in many philanthropic organizations, among them an Advisory Council member for the Center for Study of Values in Public Life at Harvard Divinity School, Harvard Divinity School Dean's Council, and a Board Member of the Nature Conservancy of Maine. He has written two books, The Soul of a Business and Managing Upside Down. Mr. Chappell received his B.A. from Trinity College and his Master's in Theology from the Harvard Divinity School.

Dr. Effie Poy Yew Chow, of San Francisco, CA, is the founder of the East West Academy of Healing Arts in 1973 and, more recently, The EWAHA Qigong Institute, the American Qigong Association, and the World Qigong Federation. She is the recipient of over twenty awards including "The Humanitarian of the Year 1999" and the "Visionary of the Decade 2000" awards. She has been the only Qigong Grandmaster and acupuncturist involved in the development of national health policies within DHHS. She was also involved in the first Ad Hoc Advisory Panel of the Office of Alternative Medicine at NIH. She has made over two hundred and fifty media appearances and interviews in the area of complementary and alternative medicine. Dr. Chow received her training in Traditional Chinese Medicine and Qigong in China, Hong Kong, Taiwan, Canada, and the United States. She is a registered public health and psychiatric nurse and has received a Master's degree and a Ph.D.

Mr. George Thomas DeVries, III, of Rancho Santa Fe, CA, is Chairman, President, CEO and co-founder of American Specialty Health, Inc. and its subsidiaries, American Specialty Health Plans, American Specialty Health Networks, American Specialty Health Systems, and Healthyroads.com. In his position, he manages complementary and alternative health care benefits, networks and services for over 100 health plans covering over 40 million Americans. American Specialty Health Plans is a licensed specialty health plan covering over 4 million Californians for chiropractic and acupuncture. American Specialty Health Systems is a health services intermediary in over 20 states serving over 1.7 million members. American Specialty Health Networks is a national health services organization serving over 35 million Americans and offering a national provider network of over 19,000 chiropractors, acupuncturists, massage therapists, dieticians, naturopaths, and fitness clubs. Healthyroads.com is a complementary healthcare consumer products company offering e-commerce and mail order. Mr. DeVries was the National Entrepreneur of the Year for Health Sciences in 2000. Mr. DeVries has published a number of articles and has lectured on alternative health care in managed care and third-party reimbursement. He received a B.A. from the University of California at San Diego.

Dr. William R. Fair, M.D., of Longboat Key, FL, was, until recently, the Florence and Theodore Baumritter/Enid Ancell Chair of Urology, and was Chief of the Urology Service at Memorial Sloan-Kettering Cancer Center in New York City. Currently, he is Emeritus Professor of Urology at the Joan and Sanford I. Weill Medical College of Cornell University and Member Emeritus at Memorial Sloan-Kettering. Dr. Fair serves on the Cancer Advisory Panel for the National Center for Complementary and Alternative Medicine. He is the Editor-in-Chief of Molecular Urology and the Associate Editor of Alternative Therapies in Health and Medicine, and on the editorial boards of other highly respected journals. He has published extensively in the areas of urology and oncology. He chairs the Committee on Complementary and Alternative Medicine of the American Urological Association, and is Chairman of the Clinical Advisory Board of Haelth, LLC. Dr. Fair received his B.S. from the Philadelphia College of Pharmacy and Science and his M.D. from Jefferson Medical College.

Dr. Joseph J. Fins, of New York, NY, is an internist and Director of Medical Ethics at New York Weill Cornell Medical Center of New York - Presbyterian Hospital, Associate Professor of Medicine and Medicine in Psychiatry at the Joan and Sanford I. Weill Medical College of Cornell University, Associate Professor in the Program in Clinical Epidemiology and Health Services Research at Weill Cornell Graduate School of Medical Sciences, and Associate for Medicine at The Hastings Center. He lectures extensively and has written widely in the field of Medical Ethics. Dr. Fins received his B.A. from Wesleyan University and his M.D. from Cornell University Medical College.

Dr. Veronica Gutierrez, of Lake Stevens, Washington, practices with Gutierrez Family Chiropractic. She is a professional member of the World Chiropractic Alliance, serving on the Board of Directors. She serves as Chair of the Council on Women's Health and Director of Programs in Public Policy. Dr. Gutierrez has been very active in the chiropractic community, serving on many boards and commissions. She has received numerous awards in her profession, including awards from the Chiropractic Society of Washington, the Straight Chiropractic Academic Standards Association, and the International Chiropractic Association. Dr. Gutierrez received her Doctor of Chiropractic from Palmer College of Chiropractic and did post-graduate work at Cleveland College of Chiropractic.

Dr. Wayne B. Jonas, of Alexandria, VA, is currently a member of the Department of Family Medicine of the Uniformed Services University of the Health Sciences F. Edward Hebert School of Medicine. Previously, Dr. Jonas served as the Director of the Office of Alternative Medicine for the National Center for Complementary and Alternative Medicine at the National Institutes of Health. Prior to that, he served as the Director of the World Health Organization Collaborating Center for Traditional Medicine. He has authored and co-authored numerous publications on alternative and homeopathic treatment and care. Some of his current research includes projects in environmental toxicology, neurotoxicology, stroke, and biofield healing. Dr. Jonas received a B.A. from Davidson College and a M.D. from Bowman Gray School of Medicine.

Sister Charlotte Rose Kerr, R.S.M., of Baltimore, MD, is a Registered Nurse, a Practitioner of Traditional Acupuncture and, since 1977 a Senior Faculty Member at the Traditional Acupuncture Institute. Previously, she was an Assistant Professor of Nursing at the University of Maryland School of Nursing. Sister Kerr has been a member of the Advisory Council of the National Institutes of Health (NIH) Alternative Medicine Program. She has spent several summers in Europe, studying such subjects as Theology and Healing. In her work, Sister Kerr emphasizes the integration of Western traditional medicine and complementary healing methods. Sister Kerr received her B.S.N. from the University of Maryland School of Nursing. She received her Master's Degree in Public Health from the University of North Carolina and another Master's Degree in acupuncture from the College of Traditional Chinese Medicine, U.K.

Ms. Linnea Larson, of Oak Park, Illinois, is Associate Director of West Suburban Health Care (WSHC), Center for Integrative Medicine in Oak Park. Previously, she was the Behavioral Science Coordinator at WSHC Family Practice Residency Program. She was a clinical social worker at St. John's Hospital in Springfield, Illinois, where she provided inpatient and home hospice services and was also associated with the St. John's Center for Mind-Body Medicine. She also has worked as a family therapist and as a lecturer at the University of Illinois at Springfield. Ms. Larson received a B.A. from Knox College and a M.S.W. from the University of Illinois at Urbana-Champaign.

Dr. Tieraona Low Dog, of Corrales, New Mexico, currently serves as the Medical Director for the Tree House Center of Integrative Medicine in Albuquerque. With more than twenty years in the field of botanical medicine, she was recently elected to serve as Chairperson for the Dietary Supplements and Botanicals Expert Panel for the United States Pharmacopoeia. Dr. Low Dog received her medical degree from the University of New Mexico School of Medicine. She is part of the core faculty for Columbia University's Botanical Medicine Course for Physicians. Dr. Low Dog is currently working with Beth Israel on the development of a continuing medical education program on herbal medicine for physicians. She frequently lectures on the subject of herbal medicine. In 1998, she received the International Martina de la Cruz award for her work with indigenous remedies.

Dr. Dean Ornish, of Sausalito, CA, is one of the founders, and the president and director of the non-profit Preventive Medicine Research Institute. He is Clinical Professor of Medicine at the University of California, San Francisco, and a founder of the Osher Center for Integrative Medicine there. He was the first to prove that heart disease is reversible by changing diet and lifestyle. He has published many books and academic papers and has received numerous awards in recognition of his work. Dr. Ornish received a B.A. from the University of Texas and completed his medical training at the Baylor College of Medicine in Houston, Harvard Medical School, and the Massachusetts General hospital. He was a clinical fellow in medicine at the Harvard Medical School. Dr. Ornish was recognized by Life magazine as "one of the 50 most influential members of his generation."

Dr. Conchita M. Paz, of Las Cruces, NM, has maintained a private practice, in which she specializes in family medicine, for ten years. Currently, she serves as a part-time faculty member at the University of New Mexico School of Medicine and at the Southern New Mexico Family Practice Residency Program. She was Chairperson of the Family Practice Department and serves on a number of committees at Memorial Medical Center. Dr. Paz received her B.S. and M.D. degrees from the University of New Mexico.

Joseph E. Pizzorno, Jr., N.D., of Seattle is one of the world's leading authorities on science-based natural medicine. A physician, educator, researcher, and expert spokesperson, Dr. Pizzorno is co-founder and founding president of Bastyr University, the first fully accreditated, multidisciplinary university of natural medicine in the United States. Dr. Pizzorno is the author of Total Wellness and co-author of the Textbook of Natural Medicine and the Encyclopedia of Natural Medicine. In 1996, he was appointed to the Seattle/King County Board of Health, the first natural medicine practitioner in the country to receive such appointment. In 1999, Dr. Pizzorno was elected Chair of the American Public Health Association Special Primary Interest Group on Complementary and Alternative Medicine. He has been licensed as a naturopathic physician in Washington State since 1975. Dr. Pizzorno is now President Emeritus and Senior Advisor to the President of Bastyr University. In September 2000, the Cancer Treatment Centers of America recognized Dr. Pizzorno as Humanitarian of the Year. He currently travels worldwide, lecturing and promoting science-based natural medicine and integrative healthcare. He also co-founded a company to bring natural medicine concepts to corporate health promotion programs.

Mr. Buford L. Rolin, of Atmore, AL, has been the Health Administrator for the Poarch Band of Creek Indians since 1984. He is a member of the State of Alabama Public Health Advisory Board and a member of the Board of Directors of the Creek Indian Heritage Memorial Association. Mr. Rolin is currently the Chairman of the Creek Indian Arts Council. He is the former Chairman of the National Indian Health Board, and he still serves as a member of the Executive Committee and as a Member-At-Large. He has received several awards from the National Indian Health Board, and he has also received a Lifetime Achievement Award from the Poarch Band of Creek Indians. Mr. Rolin attended the Health Services Administrators Development Program at the School of Community and Allied Health of the University of Alabama and Pensacola Junior College.

Ms. Julia Scott, of Washington, DC, is Past President of the National Black Women's Health Project (NBWHP), a national membership organization that focuses on wellness, self-help, and health advocacy. Previously, she was Director of the Public Policy and Education Office of NBWHP. Ms. Scott was Special Assistant to the President and Coordinator of the Adolescent Pregnancy Child Watch at the Children's Defense Fund. She has directed and administered to several foundations and community health agencies and has written numerous articles on African American Women's health. Ms. Scott was educated in nursing at the Waterbury Hospital School of Nursing.

Dr. Xiao Ming Tian, of Bethesda, Maryland, is Director of the Academy of Acupuncture and Chinese Medicine and Wildwood Acupuncture Center. Dr. Tian is currently conducting a National Institute of Health (NIH) supported clinical trial with Georgetown University Medical School to treat fibromyalgia patients using acupuncture. He has completed many research projects on the use of Chinese herbal medicine and dietary supplements to treat and prevent arthritis, sports injuries, and fibromyalgia, in collaboration with NIH and the U.S. Department of Agriculture Nutrition Center. In 1991, Dr. Tian was the first person to be appointed a Clinical Consultant of Acupuncture to the NIH medical staff. He is an Adjunct Assistant Professor of Preventive Medicine at the United States Uniformed Health Service. Dr. Tian is the President of the American Association of Chinese Medicine. He is also the Honorary Director of the China Association of Traditional Chinese Medicine and Vice President of The International Academy of Medical Qigong, both in Beijing, China. He currently serves as an advisor to World Health Organization and Pan-American Health Organization on traditional medicine. Dr. Tian received his Medical Degree from Beijing Medical University and was a Ph.D. Research Fellow at NIH.

Dr. Donald W. Warren, of Clinton, Arkansas, currently practices general dentistry, which includes dental cranial osteopathy, an alternative and complementary approach to health; temporomandibular joint dysfunction treatment, an alternative treatment for head, neck and facial pain and orthodontics/orthopedics. Since 1989, Dr. Warren has presented seminars on dental cranial osteopathy, temporomandibular joint dysfunction treatment, contact reflex analysis and designed clinical nutrition, and correct dental occlusion. Since 1999, these seminars have been accredited by the Academy of General Dentistry. He also instructed a hands-on clinic at the Texas College of Osteopathic Medicine, hosted by the Sutherland Cranial Teaching Foundation. Dr. Warren has taught in the United States, the United Kingdom, and Australia. Dr. Warren received a B.A. from Hendrix College and a D.D.S. from the University of Tennessee College of Dentistry. Since then, he has continued to study in his fields of expertise and is a diplomat of the American Board of Head, Neck and Facial Pain.

To Contact WHCCAMP:

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White House Commission on Complementary and Alternative Medicine Policy

COMMISSION ROSTER

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(2/16/01)

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agenda

Agenda

White House Commission on Complementary and Alternative Medicine Policy

Meeting on Training, Education, Credentialing and Licensing of Complementary and Alternative Medicine Practice

February 22-23, 2001

Hubert H. Humphrey Building, Room 800, Washington, DC

AGENDA

DAY ONE: THURSDAY, FEBRUARY 22, 2001

7:30 a.m. **Registration Opens**

8:15 a.m. **Opening Remarks**

Welcome

- *Dr. Stephen C. Groft, Executive Director*
  White House Commission on Complementary and Alternative Medicine Policy

Charge for Day One

- *Dr. James Gordon, Chair*

8:30 a.m. **Plenary Session I: CAM Education and Training: Establishing Educational Programs**

- *Louis H. Orzack, Ph.D.*
  Rutgers University
- *Jennifer Engstrom*
  Case Western Reserve University
- *Deborah Danoff, M.D.*
  Association of American Medical Colleges
- *Peter V. Scoles, M.D.*
  National Board of Medical Examiners
- Discussion

9:35 a.m.

- *Alfred P. Fishman, M.D.*
  University of Pennsylvania School of Medicine
- *Geraldine Bednash, Ph.D., R.N., F.A.A.N.*
  American Association of Colleges of Nursing
- *Neil Sampson, M.P.H., M.G.A.*
  Bureau of Health Professions, HRSA
- *Sara Collina*
  National Breast Cancer Coalition
- Discussion

10:35 - 10:50 a.m. **15-MINUTE BREAK**

10:50 a.m. **Plenary Session II: Continuing CAM Education and Training: Building Knowledge and Skills**

- *Joseph M. Helms, M.D.*
  American Academy of Medical Acupuncture
- *Lixing Lao, Ph.D.*
  University of Maryland Baltimore
- *Mark Blumenthal*
  American Botanical Council
- Discussion

11:40 a.m.

- *Denise Murray Edwards, A.R.N.P.*
  Oncology Nursing Society/The Center for Health and Well-Being
- *Susan South, M.A.*
  Program in Integrative Medicine, University of Arizona
- *Murray Kopelow, M.D.*
  Accreditation Council for Continuing Medical Education
- Discussion

12:30 - 2:00 p.m. **LUNCH BREAK: MEDIA TRAINING**

2:00 p.m. **Plenary Session III: CAM Credentialing and Licensure: Assuring Quality and Accountability in CAM Practice**

- *Michael H. Cohen, Esq.*
  Center for Alternative Medicine Research and Education
- *Boyd J. Landry, M.P.A.*
  The Coalition for Natural Health, Inc.
- *Sharon Hall, M.P.H.*
  Washington Casualty Company
- Discussion

2:50 p.m.

- *Steven C. Olson, B.A.*
  American Massage Therapy Association
- *Clement Bezold, Ph.D.*
  Institute for Alternative Futures
- *James R. Winn, M.D.*
  Federation of State Medical Boards
- Discussion

3:55 - 4:05 p.m. **15-MINUTE BREAK**

4:05 p.m. **Charge for Breakouts and Day Two**

4:15 p.m. **Breakout Session I**

5:45 p.m. **Progress Report**

6:00 p.m. **ADJOURN**

DAY TWO: FRIDAY, FEBRUARY 23, 2001

7:30 a.m. **Registration Opens**

8:15 a.m. **Breakout Session II**

9:45 - 10:00 a.m. **15-MINUTE BREAK**

10:00 a.m. **Breakout Session III**

11:30 a.m. - 12:30 p.m. **LUNCH BREAK**

12:30 p.m. **Full Group Discussion**

4:00 - 4:15 p.m. **15-MINUTE BREAK**

4:15 p.m. **Public Comment Session** (Open Session-as pre-registered)

1. Susan Silver, George Washington Center for Integrative Medicine
2. Margaret Huddleston, Center for Psychology and Social Change, Harvard Divinity School
3. Robert Scholten, Beth Israel Deaconess Medical Center
4. Rustum Roy, Pennsylvania State University
5. Diane Miller, National Health Freedom Coalition
6. Susan Herschkowitz, Self Representation
7. Colleen Smethers, Progress in Medicine Foundation
8. Michele Forzley, Attorney at Law
9. Victoria Mary Goldsten, Washington Institute of Natural Health
10. Brenda Jasper, Association of Physician Assistant Programs
11. Emily WhiteHorse, Association of Physician Assistant Programs
12. Ingrida Lusis, American Chiropractic Association
13. Brian McAulay, Sherman College of Straight Chiropractic
14. David Molony, American Association of Oriental Medicine
15. Kathleen Quain, Foundation for Health and The Environment
16. Shula Edelkind, Progress in Medicine Foundation
17. Karen Scott, Progress in Medicine
18. Christina Walker, The Schenk Human Energetic Institute
19. Chi Chow, New York Institute of Chinese Medicine
20. George Krutz, Feldenkrais Guild of North America

5:45 p.m. **MEETING ADJOURN**

White House Commission on Complementary and Alternative Medicine Policy

Meeting on Training, Education, Credentialing and Licensing of Complementary and Alternative Medicine Practice

February 22-23, 2001

Hubert H. Humphrey Building, Room 800, Washington, DC

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Plenary Session I
CAM Education & Training: Establishing Educational Programs

Plenary Session I

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White House Commission on Complementary and Alternative Medicine

Good Morning. I am Geraldine Polly Bednash, executive director of the American Association of Colleges of Nursing. Our organization represents over 550 senior colleges and universities that offer baccalaureate and graduate degrees in nursing. I am pleased to be here today to provide you with some comments related to nursing education, the nature of the education for professional nursing practice and the types of issues that nursing educators face when they are addressing the subject of Complementary and Alternative Medicine.

As part of my remarks this morning, I was asked to provide you with a brief overview of professional nursing education. As many of you may know, there are a variety of ways that an individual can be prepared for entry level practice as a professional nurse. This morning, however, I will address the baccalaureate and master's level nursing program characteristics. Over 550 senior level colleges and universities in the U.S. have baccalaureate nursing programs that prepare for entry level practice. In addition, a master's degree in nursing is offered in almost 400 institutions.

The typical baccalaureate nursing education consists of four years of study with the first two years focused on the general studies, a core of physical and social sciences course work, and the liberal arts. Nursing course work begins typically in the second year of the baccalaureate program while a small percentage of the programs begin their nursing course work in the first year. Nurses prepared for entry-level practice in baccalaureate programs are typically awarded a Bachelor of Science in nursing. These graduates are prepared for practice in complex environments that demand systems competencies, critical thinking and analysis skills, and the ability to function in teams and in ambiguous environments.

The master's degree educated nurse is prepared for advanced practice with the greatest portion of these receiving preparation to serve as a nurse practitioner. Over 2/3 of all masters' graduates are prepared in the role. Other roles at the advanced level include preparation as nurse midwives, nurse anesthetists, and clinical nurse specialists. The curriculum is typically 1 /1/2 to two years in length and after graduation these nurses typically sit for certification in their area of specialization.

Nurses prepared at the baccalaureate entry level and at the advanced practice level each must have both an awareness of the potential for complementary or alternative therapies to be part of a patient's armamentarium of self-care interventions and must have an ability to assess how these therapies are either complementary or potentially harmful to that patient. Our organization has developed standards for both baccalaureate and master's level education in nursing. In each of our standards documents, we explicitly note the requirement that thorough assessment of cultural, life style, and multiple therapies be a basis for any interventions by the nurse clinician. In addition, we have an explicit

standard that the student must "develop an awareness of complementary modalities and their usefulness in promoting health."

Unfortunately, however, there are great gaps in the available science for nurses and other health professionals who attempt to assess the utility of these therapies or provide advice and counsel to the patients for whom they care. Nurses, like other health care professionals, are acutely aware of the growing practice of consumers to self-select a range of complementary therapies or to seek consultation from nontraditional health care providers.

In a recent issue of *Nursing Spectrum*, a Gannett corporation publication that has a circulation of over one million registered nurses, focused on the issue of complementary therapies and provided for the practicing nurse a range of resources to use in assessing these therapies.

The American Holistic Nurses Association has published guidelines related to curricula for CAM. In addition, a number of nurse educators have designed tools for education of nursing students to assist them in making evidence-based decisions about interventions related to CAM therapies. At a minimum, nurses must be prepared to advise patients and their families who use self-selected CAM therapies and practices, must have a core of evidence-based content for their practice, and must be able to evaluate critically the best evidence available on any new therapies.

At the University of Virginia, Dr. Ann Taylor, a professor in the School of Nursing, directs the C enter for the Study of Complementary and Alternative Medicine. She notes that a major deficit faced by nursing and other health professional educators is the lack of a significant base of data on these therapies and comments that even existing resources are quickly outpaced by the emergence of new alternative practices of therapies. In addition, much of the content given to nurses, and other health professionals, is limited in its focus and often, exposure to this content depends upon the availability of an interested or concerned faculty member.

Our organization would not support the establishment of a requirement that a specific and separate course in CAM therapies be required for all nursing students. However, we would support the need to have clear and consistent information provided to nursing students about these therapies in the full range of course work that the student experiences. This Commission could make a significant contribution to the education of all health professionals through a recommendation that an easily accessible, and evidence-based resource of data on these therapies be made available to educators and clinicians.

The use of the Internet can assist not only the consumer of CAM therapies, but also can assist the provider who is attempting to intervene or consult successfully. The major barrier to successful education on this important topic is more likely to

be overcome through a widespread education program for faculty and clinicians and through the development of sophisticated resources for effective interventions. The work of the National Center for Complementary and Alternative Medicine at NIH is central to this. Several websites – including those sponsored by the NIH Cancer Institute, the National Center for Complementary and Alternative Medicine, and Quackwatch – also offer beginning resources for both providers and consumers. These types of resource must be expanded and public awareness of these must also increase.

Using state board exams as a carrot or stick to force attention to specific issues is often seen as an attractive option. This discussion is also often accompanied by a call to require the accrediting bodies to assess whether this content is given to the student. However, it is unlikely that more that a cursory assessment of the knowledge base of the test taker is possible on any given specialized topic when a lengthy and comprehensive test is administered. Moreover, accreditation is less likely in today's world to focus on specific prescriptive practices than it is to focus on outcomes of the educational program.

One last thought should be part of any conversations about the use of complementary and alternative therapies. The growing interest in these by consumers of health care is symptomatic of a concern that also should be addressed. Consumers turn to these therapies primarily because they do not believe or trust in the ability of traditional forms of health care to resolve their health care needs. And, these consumers, already distrustful of the health care system, are highly unlikely to readily volunteer information about their use. Consequently, it is vitally important that health care providers have the ability to develop strong therapeutic relationships and have an ability to elicit truthful histories in their assessment of the consumer's health care practices and beliefs. This requires both good interpersonal relationship skills and a sensitivity to cultural diversity and beliefs. Without these, the provider is unable to elicit the information that will assist both individuals in the therapeutic relationship to reach their health care goals.

In closing, we would therefore like to offer the following recommendations:

1. Establishment of expanded data bases on the range of complementary and alternative therapies and providers that are in use, the evidence that has emerged on these therapies and their efficacy, and a resource base for information and consultation...
2. The development of a generic curriculum on complementary and alternative therapies and the skills necessary to assess their use by patients and their families with a strong emphasis on the therapeutic relationship and interpersonal skill development.
3. Continued federal support for research to assess CAM therapies.
4. A communication vehicle for health professionals to provide a consistent stream of information on these therapies.

5. A train-the-trainer initiative to provide faculty in nursing or other health professions education programs with the skill to teach the future clinician about these therapies.
6. A widespread continuing education intervention for the practicing nurse or other health professional.
7. A communication tool for the consumer of health care to provide accurate and timely information about the evidence available on complementary and alternative therapies.

Thank you for the opportunity to be here and part of this important work.

The Decreasing Supply of Registered Nurses
Inevitable Future or Call to Action?

Geraldine Bednash, PhD, RN

THE FUTURE OF HEALTH CARE IN THE UNITED STATES increasingly pivots on a sufficient supply of appropriately educated and skilled professional registered nurses (RNs). The study by Buerhaus and colleagues[1] in this issue of THE JOURNAL should create concern among physicians and RNs as well as others charged with providing, managing, or financing health care services. Buerhaus et al forecast that the future sufficient availability of RNs is not ensured given the continued aging of the RN workforce and the decreased propensity for potential students to choose nursing careers. The most important factors contributing to the aging of the nursing workforce are a long-term trend of declining interest in nursing by women, who today enjoy a wide choice of career opportunities, and the decrease in the number of individuals born after 1955 who have pursued nursing as a career.[1]

The analysis by Buerhaus et al comes on the heels of a recent report by the American Association of Colleges of Nursing, which found that enrollments in entry-level baccalaureate nursing programs decreased by 4.6% in fall 1999—the fifth consecutive decline in as many years.[2] In addition, recent data from the National League for Nursing (NLN) indicate declines in enrollments in all types of entry-level nursing programs (Theresa M. Valiga, RN, EdD, NLN, May 30, 2000, unpublished data for 1998).

Attracting a cadre of young, college-bound students will require reform in nursing education and in the licensure and certification mechanisms used to grant practice to RNs with different educational preparation. Currently, entry-level nursing education is offered in 3-year hospital diploma programs, 2-year associate-degree programs (ADs) in community colleges, and 4-year university-based baccalaureate programs (BSN). Graduates of the 3 types of programs receive the same license to practice and most often are employed in the same entry-level positions.

Hospital-owned diploma programs were based on an apprenticeship model of training but have evolved to include some college course work in the social and physical sciences. Although more than 1100 diploma programs existed in the first decade of the 1900s,[3] the number of diploma programs (currently 89[4]) and the percentage of entry-level graduates from these programs (currently, 4% [NLN data for 1998]) have declined rapidly as educators, employers, and others recognize the need for educational changes in nursing.

Associate-degree nurse education programs were established in the late 1950s in response to a nursing workforce shortage and as "an experiment in technical education" for nurses.[5] These AD programs provide students with limited general studies and physical sciences course work and include nursing courses directed at the care of patients with common, well-defined diagnoses. The preponderance of AD programs, which totaled 876 nationwide in 1997[6] and now account for 59% of new entry-level graduates (NLN data for 1998), may have contributed to the aging of the RN workforce. In 1996, graduates of AD programs were, on average, aged 33.5 years vs 28.0 years for graduates of basic baccalaureate programs.[7]

Baccalaureate nursing programs are offered in 661 four-year colleges and universities and include a base of liberal arts education and core physical and social sciences course work as well as the nursing science curriculum.[3] Baccalaureate graduates represent 37% of all new entry-level RNs (NLN data for 1998).

The current RN workforce includes 27% with diplomas, 32% with ADs, 31% with BSNs, and 10% with master's or PhD degrees.[7] Although about one third of all students enrolled in BSN programs are AD- or diploma-prepared RNs acquiring the BSN,[3] these students represent less than 3% of all RNs without the BSN.[7] Only 16% of RNs prepared initially at the AD level acquire a BSN or higher degree in nursing.[7]

The continuation of a system of nursing education that provides graduates of 3 different levels of nursing programs with the same license and role expectations creates a major disincentive to attracting an adequate supply of BSN-educated RNs for the future. For instance, in focus groups conducted to gather information and perceptions from nurse educators regarding factors associated with declining BSN enrollments, nurse educators consistently reported that potential BSN students were discouraged from pursuing a nursing career by the confusing array of entry-level options avail-

See also p 2948.

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able in the profession and noted that such confusion had led many secondary school students and guidance counselors to not view nursing as an intellectual endeavor.[8]

At the same time that BSN enrollments are declining, an increasing amount of evidence has demonstrated an association between health care quality and the educational level of nursing staff, the number of RNs in the clinical setting, and the perceived value placed on nursing by the practice setting.[9-16] These findings have been documented in institutions designated as "magnet" hospitals by the American Nurses Credentialing Center. This center, a major national certification organization, established the magnet hospital program as a mechanism for recognizing excellence in nursing care. Hospitals seeking this designation must meet 14 standards through a process that entails both written documentation of the institution's ability to meet the standards and an on-site evaluation review.

The original series of magnet hospitals were selected in the 1980s and recognized for their ability to attract and retain RNs in a time of shortage.[9] Magnet hospitals have a higher proportion of nursing staff prepared at the BSN level (average, 59% vs 34% for all hospitals).[9,12,17] Despite the common perception that RNs with a BSN or more advanced degree leave the direct patient care setting, 64% of all BSN-prepared RNs are employed in hospitals in direct patient care (64% of RNs with ADs and 47% of RNs with master's degrees are employed in hospitals).[7]

Aiken et al[12,14-16,18] found higher levels of BSN-educated nursing staff, nurse-to-patient ratios, and nurse satisfaction in magnet hospitals. In a 1994 study, Aiken et al[15] investigated whether 1988 mortality rates for Medicare patients differed significantly between 39 institutions designated as magnet hospitals and 195 matched control facilities that did not hold that designation. After controlling for a number of factors known to influence mortality, such as number of beds, average daily census, organizational structure, facilities and services, medical staff characteristics, Medicare discharges, annual budget, and RN-staff mix, the researchers found that Medicare patients in magnet hospitals had significantly lower mortality rates (approximately 5% less excess mortality) than matched control hospitals. Aiken et al suggested that "the mortality effect derives from the greater status, autonomy, and control afforded nurses in the magnet hospitals, and the resulting impact on nurses' behaviors on behalf of patients."[15]

Using similar statistical matching and comparison techniques, Aiken et al[14] reported that patients with acquired immunodeficiency syndrome in magnet hospitals had significantly higher satisfaction levels and a nonsignificant trend toward lower mortality rates.[15] Moreover, RNs in magnet hospitals had significantly lower burnout rates and a nonsignificant trend toward lower needlestick injury rates.[16]

In 1998, the US Congress charged the Division of Nursing, US Department of Health and Human Services, with implementing strategies to enhance the production of BSN-educated RNs.[19] In the same year, citing the complex needs of veterans, the Department of Veterans Affairs announced its intention to require the agency's RNs to have a BSN by 2005 to achieve a position above the first entry-level paygrade positions. The Department of Veterans Affairs has initiated an extensive program of educational support to assist its nursing staff to acquire additional education in an effort to facilitate improvement of the staff's competencies and knowledge base.[20]

Studies documenting hiring preferences and salary differentials provided for RNs with different levels of nursing education are limited. In a 1987 American Hospital Association survey, nurse executives in community hospitals reported that they would prefer to have, at minimum, an average of 55% of their nursing staff prepared with a BSN.[21] In a 1999 survey of University Healthsystem Consortium chief nurse officers, respondents reported their preference for an average of 70% of their staff RNs to be prepared at the BSN level.[22] Although 72% of these nurse executives indicated that they perceived that BSN-prepared nurses are better equipped than RNs with AD or diploma education to apply critical thinking and analysis, use evidence-based practice, provide leadership, and focus on prevention and patient education, only 44% of their institutions provided differentiated salaries, and only 33% applied differentiated role descriptions based on education.[22]

Decisions regarding skill mix, differentiated roles or salaries, and the appropriate regulatory mechanisms to validate knowledge and competencies should be based on a clear analysis of the health care system's requirements for nursing care. The development of a rationalized model for credentialing RNs also should be based on the different educational preparation and competencies achieved in AD or BSN programs. This could be implemented through the development of different licensure examinations for graduates of different levels of educational preparation. An alternative would be to follow the model used by physicians to develop a certification process that validates the different competencies acquired by specialty training.

This discussion is reminiscent of the concerns that confronted the medical community in the early part of the 20th century when medical specialty training was available through a wide array of both commercial and university-based training programs. As noted by Ludmerer,[23] a consensus developed in the medical community regarding the need to develop uniform expectations for the scholarly and clinical training activities necessary to ensure the quality of medical specialists. This consensus was accompanied by a framework of credentialing mechanisms (ie, specialty board examinations) to validate the different training experiences of specialty clinicians and the practice authorities that should be given to them. A similar consensus must be developed for nursing and accompanied by a more thorough and scholarly assessment of the skill mix requirements of the types of RNs needed to deliver the best care to patients amid the ever-increasing complexities of the current health care system.

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Similar to medical specialty certification, master's degree–educated advanced-practice RNs, who include nurse practitioners, nurse midwives, clinical nurse specialists and nurse anesthetists also hold certification in various specialties, often as a mechanism for acquiring practice authority. In addition, entry-level RNs with extensive experience in specialty areas such as critical care or oncology are eligible to take specialty certification examinations that validate this experience.

In its 1996 report on nurse staffing in hospitals and nursing homes, the Institute of Medicine recommended a comprehensive study of the relationship between skill mix and quality of care.[24] Data from this type of analysis will provide the framework and rationale for differentiated credentialing mechanisms, whether by licensure or professional certification processes.

Several groups have begun to address these concerns. In a recent joint report, the American Association of Colleges of Nursing, National Organization for Associate Degree Nursing, and American Organization of Nurse Executives determined that real differences exist between AD and BSN educational experiences and the competencies achieved in these programs.[25] The American Nurses Credentialing Center intends to implement a certification process for nurses with the BSN degree to validate the role competencies achieved in BSN programs.[26] Work to date on this Certified Professional Nurse examination has included a national role delineation study to identify competencies held by BSN-prepared nurses only.[27] This examination may provide an appropriate means of validating BSN competencies.

These efforts to validate educational competencies also should be accompanied by restructuring practice environments that employ nursing staff according to differing RN educational and patient care capabilities. In particular, these environments should allow for the full utilization of the professional-level competencies of BSN graduates. Studies of magnet hospitals have found that a well-regarded nursing staff headed by a chief nurse executive with authority to lead and manage that staff is associated with positive outcomes such as ensuring patient satisfaction, decreasing mortality rates, and retention of a stable workforce.[9,12] The higher RN staffing level in these hospitals is evidence of their ability to recruit and retain high-quality RNs to remain in patient care. Similarly, a recent study of community and academic acute-care hospitals indicated that the most successful approaches for recruiting and retaining RNs over the long term included models that allow RNs more predictable and flexible work schedules, autonomy over their own practice, and shared governance programs in which RNs actively participate in decision making about patient care issues.[28]

The stability of the complex systems of health care in the United States depends on an available supply of well-educated nursing personnel with clearly defined roles that are sanctioned through a system of licensure and certification. Reforming the education and credentialing mechanisms for nursing, restructuring work environments, and developing systems of care that empower RNs to use their professional skills are essential. Recognizing the contributions of RNs to the delivery of high-quality health care and to the well-being of those health systems will provide potential nursing students with a career option that is attractive and rewarding. Without dramatic reform, the shortage of skilled professional RNs predicted by Buerhaus and colleagues is inevitable.

Disclaimer: This editorial was written by the author in her private capacity. No official support or endorsement by the American Association of Colleges of Nursing is intended or should be inferred.

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REFERENCES

1. Buerhaus PI, Staiger DO, Auerbach DI. Implications of an aging registered nurse workforce. *JAMA*. 2000;283:2948-2954.
2. *1999-2000 Enrollments and Graduations in Baccalaureate and Graduate Programs in Nursing*. Washington, DC: American Association of Colleges of Nursing; 2000.
3. Burgess MA. *Nurses, Patients, and Pocketbooks*. New York, NY: Committee on the Grading of Schools of Nursing; 1928:36.
4. *Profiles for Member Boards, 1998*. Chicago, Ill: National Council of State Boards of Nursing; 1999.
5. Montag ML. *Community College Education for Nursing*. New York, NY: McGraw Hill; 1959.
6. *Nursing Data Source*. New York, NY: National League for Nursing; 1997.
7. Moses E. *The Registered Nurse Population*. Rockville, Md: US Dept of Health and Human Services; 1996.
8. *Recommendations for Expanding Baccalaureate Nursing Enrollments*. Washington, DC: American Association of Colleges of Nursing; 1999. Order No 99-0185(P).
9. Kramer M, Schmalenberg C. Magnet hospitals, I: institutions of excellence. *J Nurs Adm*. 1988;18:13-24.
10. Kovner C, Gergen PJ. Nurse staffing levels and adverse events following surgery in U.S. hospitals. *Image J Nurs Sch*. 1998;30:315-321.
11. Havens DS, Aiken LH. Shaping systems to promote desired outcomes: the magnet hospital. *J Nurs Adm*. 1999;29:14-20.
12. Aiken LH, Havens DS, Sloane DM. The Magnet Nursing Services Recognition Program. *Am J Nurs*. 2000;100:26-35.
13. Hartz A, Krakauer H, Kuhn E, et al. Hospital characteristics and mortality rates. *N Engl J Med*. 1989;321:1720-1725.
14. Aiken LH, Sloane DM, Lake ET. Satisfaction with inpatient acquired immunodeficiency syndrome care. *Med Care*. 1997;35:948-962.
15. Aiken LH, Sloane DM, Lake ET, Sochalski J, Weber AL. Organization and outcomes of inpatient AIDS Care. *Med Care*. 1999;37:760-772.
16. Aiken LH, Sloane DM, Klocinski JL. Hospital nurses' occupational exposure to blood. *Am J Public Health*. 1997;87:103-107.
17. Kramer M. The magnet hospitals. *J Nurs Adm*. 1990;20:35-44.
18. Aiken LH, Smith HL, Lake ET. Lower Medicare mortality among a set of hospitals known for good nursing care. *Med Care*. 1994;32:771-787.
19. US Congress. Amendments to Public Health Service Act: Title VIII—nursing workforce development. *Congressional Record*. October 13, 1998:144: H10760.
20. Department of Veterans Affairs. VA commits $50 million to new national nursing initiative [news release]. December 18, 1998. Available at: http://www.va.gov/pressrel/98nni.htm. Accesibility verified May 24, 2000.
21. *Report of the Hospital Nursing Personnel Survey*. Chicago, Ill: American Hospital Association; 1987.
22. *Survey on Educational Preparation of Nurses*. Oak Brook, Ill: University Healthsystem Consortium; 1999.
23. Ludmerer KM. *Time to Heal*. New York, NY: Oxford University Press; 1999.
24. Institute of Medicine. *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?* Washington, DC: National Academy Press; 1996.
25. *A Model for Differentiated Nursing Practice*. Washington, DC: American Association of Colleges of Nursing; 1995.
26. American Nurses Credentialing Center. ANCC to make certification available to all registered nurses through Open Door 2000 program [news release]. February 25, 2000. Available at: http://www.nursingworld.org/pressrel/2000/pr0225a.htm. Accessibility verified May 24, 2000.
27. *Executive Summary: Certified Professional Nurse Role Delineation Study*. Princeton, NJ: Chauncey Group International; April 5, 2000.
28. American Organization of Nurse Executives. *Nurse Recruitment and Retention Study*. Chicago: Ill: AONE Institute for Patient Care Research and Education; 2000.

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Career Narrative: January 2001

As Professor at Rutgers University, I helped create the University Committee on Professions and Public Accountability and later chaired the Committee. I serve as member of the Executive Committee of the Research Committee on Professions, RC52, of the International Sociological
Association.

The distinctive honor of my appointment as Visiting Jean Monnet Professor at the European University Institute in Fiesole, Italy in Spring 1992 further broadened the focus of my scholarly studies.

During many field visits in the USA and abroad, I have interviewed, lectured, and consulted with public officials and private sector leaders representing a wide variety of professions. I have developed an extensive private collection of documentation from professional associations,
educational institutions, national and international public bodies. I am Consultant for the Center on Educational Documentation.

My continuing interest in professions and public policy began with research and publications about work careers, changes in professional responsibilities, rivalries among and within health professions, and shifts in public expectations that affect professional services.

How public authority affects mutual recognition of qualifications of professionals is of central importance in my research. This leads to the intriguing question my work seeks to answer: How do diverse national requirements for higher education, training, and service responsibilities
which serve as pre-conditions for entry into professions become reconciled as globalization continues?

Focussed at first on studies of professional services in the USA and the European Union, my current work concerns how services provided by professions are affected by regional or global trade agreements: WTO, EU, NAFTA, GATS, MERCOSUR, ASEAN, ANZCERTA, and APEC.

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Members of the Commission:

Thank you for your invitation.

The time allotted is brief, the challenge enormous.

At the outset, I wish to make several points concerning elements of professions, what they are.

I then plan to summarize how change in and of professions and their services occurs --- and does not occur.

Next, I will assess how complementary and alternative medicine can influence medical practice and medical education.

This relies on examples of significant change in two non-CAM fields.

One was once far outside the mainstream of health care; the second has recently seen a dramatic change in educational standards for entry to practice.

Finally, I offer some suggestions for the process of educational change for CAMs

The list of elements presented below is not provided as an academic exercise. (It is adapted from a chapter in a book I co-edited listed below.)

It is a roster of elements of what all of us refer to when we use the term "profession".

At this time, I will neither define nor elaborate on these items but I must point out some truisms at the beginning.

The first is that professions are complex.

The second is that change in any one or more of the elements is likely to touch off changes elsewhere in the system.

Whether we choose to discuss established professions or emerging professions, all of these elements ultimately must be affected.

Elements of Professions

All professions, emerging now or previously emerging, comprise a complex of elements derived ultimately from the societies where they exist.

The infusions of resources that sustain, allow expansion, or curtail existence of professions come from exchanges with the larger societies.

Professions flourish or disappear depending on the stability, the increases, or the decreases of those infusions. Compare health care in the modernized world with that in regions where Doctors Without Frontiers choose to work.

I use the schema in research about professions and professional services in the United States, in other nations, and in current studies of how inter-governmental bodies (EU, NAFTA, APEC and WTO} affect professions and their services. (Orzack, 1993, 2000, 2001.)

NATIONAL DOMAINS OF PROFESSIONS

1. Cultural and ideological mandates
2. Services and responsibilities: scopes
3. Public expectations and consumer issues
4. Practice standards: responsibilities and restrictions
5. Educational systems
6. Legitimacy and legal standing
7. Regulatory systems including licensing
8. Qualification mechanisms
9. Associations and peer interactions
   (group benefits and controls)
10. Association and government exchanges
11. Ethics, discipline, sanctions
12. Scientific research and technological applications
13. Boundary interactions among specialties
14. Practice patterns: independence/organizational
15. Income sources: fees, salaries, third party
16. Socialization and recruitment
17. Career trajectories

(Adapted from Orzack, 1998)

Scholars, public officials, practitioners, educators, patients/consumers, and advocates for or critics of existing or proposed health services, supporters of "traditional medicine" or of "complementary and alternative medicine" -- all of us must continue to be aware of the complexities of professions. emerging now or previously emerged,

The scheme of elements provides a basis for understanding each profession.

The scheme serves as a reference guide for comparative analyses of diverse professions in different sectors of the world economy: health, legal, financial, aesthetic, and others.

The scheme serves as a reference guide to the complexities that make up when any one refers to or discusses "profession", "professional services," and of course "professional education."

None of the entire series of elements exists by itself. They are inter-related. Professions comprise all of these and these elements are intertwined and interconnected.

Many of us use the term "profession" loosely when we talk about, support, and criticize "professions". For the most part, discussions focus on a portion of this extended list of elements. That strikes me as unfortunate.

Transformation of Professions

Professions evolve dramatically from era to era, as public support and societies' expectations evolve.

Change in any one of the elements has consequences for the other elements. The complex of elements is not static and has never been static. It never will be static.

External sources of change of professions often arise.

If public confidence in health services or in the services of particular kinds of practitioners deteriorates, a profound crisis may occur.

Internal sources of change may induce dramatic shifts in the stability of elements of professions.

Changes in public perceptions of the provision of health care provided by medical practitioners may over time take several forms.

Medical education's adaptation to those changes may be hastened through several avenues, among which the following can be identified:

(1) When entering medical students introduce messages calling for change;

(2) Patients' and consumers' orientations to CAM practitioners and reliance on CAM-initiated or CAM-informed sources of information (via Internet) mount.

(3) Insurance carriers, state workmen's compensation systems, Medicare and Medicaid programs, and regulatory/licensing boards develop more accepting approaches to CAM services.

Changes in compensation levels, restrictions upon practitioners' choices induced by HMO's, pushing of medications upon physicians by pharmaceutical representatives, are illustrations of counter-trends.

Ethical shortfalls in provision of services sought by patients, in research, in practitioner-patient relations (abuse, mistakes, exploitation, boundary crossing, neglect) modify access and trust as well as the quality of services available to consumers.

Practitioners, educators, associations of professionals, and regulatory/licensing boards can lose sight of shifts in public expectations concerning CAM-oriented services. That is unfortunate in the short run, risky in the medium term, and finally hazardous to their stability.

Specifying and evaluating outcomes of services of medical doctors, of practitioners of allied health services, of practitioners of complementary and alternative medicine, are essential.

Determination of the validity of CAM contributions and interventions is an essential key to their acceptance by medicine, their incorporation within medical practice, and their inclusion within education both in medical schools and in continuing education programs for those already in practice.

Practitioners in complementary and alternative medicine can increasingly become primary providers within the overall spectrum of health care services, provided that medical practitioners gain improved knowledge of competencies of CAM-providers and reciprocally refer patients.

CAM influence on medical practice and medical education

I wish to focus first on examples of several health specialties once outside the central framework of medicine and health care..

These can demonstrate how drastic change occurred while those fields mentioned took steps to acquire a more firm place in health services.

They exemplify change in elements of professions. They are examples. They are not prototypes.

The professional fields listed might not immediately come to mind. Their moves forward from beyond the fringe of acceptability may suggest parallels for adaptation by CAMs.

The fields I chose are two in number. Both faced and still face opposition.

They are: optometry and audiology

Optometry boasted around 1900 that it was a drugless profession.

In all states, optometrists are now legally able to use topical anesthetics and therapeutic agents, employ complex instrumentation in examining eyes, and provide a significant range of vision care services.

The formal educational base of schools and colleges provides the O.D. degree.

Accreditation of the schools and colleges requires adherence to developed standards; a national examination tests graduates while licensing boards in every state rely on its use. Further, clinical residency slots in health care settings have been established for optometrists.

Reciprocal referral exchanges with public health practitioners, internists, pediatricians, and other primary care providers are increasingly common; this is still not common with ophthalmologists.

As a leader in that field puts it, the scope of practice responsibility advanced when leaders in education and in associations in the field chose to move ahead.

The result claimed is that "...the practicing O.D. has become part of the mainstream of health care activities...." (Haffner, 2000)

Audiology is on the verge of major change. Last year, an out-of-court settlement of a law suit in a U. S. federal court provided opportunity for a landmark shift in educational practice.

The American Speech/Language and Hearing Association and the Audiology Foundation of America settled the bitterly fought litigation. (U.S. Federal Court, 2000; Orzack and Blount, 2001))

The agreement sanctions the Doctor of Audiology degree, to be awarded by accredited universities.

Audiological testing has hitherto been largely carried out by Masters level holders of a state license, the newly sanctioned AuD degree will bring on line a stream of practitioners likely to seek complete autonomy from control or linkage with otolaryngolists.

The examples of optometry and of audiology represent different strategies of change that occurred through focussed and concerted effort by groups initially considered to be non-legitimate participants in health care services.

An essential conclusion derived from these examples is that change in professions occurs differentially and along diverse time scales.

Another conclusion is that change CAN occur . and it must be pursued as a vital objective.

The Process of Educational Change for CAMs

Based on the development of other professions, I suggest the following:

CAMS should place greater emphasis on educational standards involving programs located in diverse regions and states.

CAMS should strive to advance common educational standards in CAM specialties through support for accreditation mechanisms.

Concerning medical practice and medical education, the following come to mind:

CAMS should strengthen efforts to encourage consumers of its services to seek opportunities to support CAM inclusion in health services programs supported by state and local government.

CAMS should move toward still greater public support by encouraging generating greater public attention to CAM interventions in media and in community events.

CAMS should seek greater participation in health service programs and facilities jointly with medical practitioners.

CAMs should participate in and support validation projects in collaboration with health care researchers included on multi-professional bases.

These are initial suggestions for change. Other avenues for change in CAM's involvements with medical education and health care provision.

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References and Sources:

A. N. Haffner. "What We Think We Know and the Years Ahead," Hall of Fame Address, East West Eye Conference, 2000.

Louis H. Orzack and Marie-Louise Blount, "Credential Disparity and Practice Doctorates in Health Professions: Audiology Testing and Hearing Wars in the United States and in Europe." in press, 2001: Jesi, Italy, Conference on Professions.

Louis H. Orzack, "Professions and World Trade Diplomacy: National Systems and International Authority," in: V. Olgiati, Louis H. Orzack and M. Saks, editors: PROFESSIONS, IDENTITY AND ORDER IN COMPARATIVE PERSPECTIVE. Onati, Spain: International Institute for Sociology of Law, 1998. ISBN: 84-89933-00-8.

Louis H. Orzack, "Accountability, Credentialing, Codes of Ethics, Enforcement/Discipline, and Accreditation in Professions". AAAS/NATO Advanced Research Workshop...: the Role of Scientific and Technical Societies. Visegrad, Hungary: 28-31 October 1994.

Louis H. Orzack, "Social Scientific Myopia? ...Current Professions Studies and recommendations for Change." Lisbon, Portugal: ISA Conference on State Political Power and Professional Structures:...," 2000. In press, 2001.

Louis H. Orzack, "Further Problems Confronting Professionals' Credentials...." Paris, France: OECD Workshop on Professional services, February 1997

U. Sharma, "Medical Practice and the Future of CAM," in:M. Kellner & B. Wellman, editors, CAM: Challenge and Change. 2000

House of Lords, Committee on Science and Technology. Sixth Report. Complementary and Alternative Medicine. London: 2000

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Divider Title: Engstrom

Jennifer E. Engstrom

Ms. Engstrom is a clinical exercise specialist and currently a third year medical student at Case Western Reserve University School of Medicine (CWRU SOM). She graduated *summa cum laude* with a BSE in Biomedical Engineering from Case Western Reserve University in 1996. She has been actively involved in several initiatives to support and expand Complementary Alternative Medicine (CAM) education for medical students. During her first year of medical school, Ms. Engstrom founded the Integrative Medicine Interest Group at CWRU SOM. Activities of this group include a monthly journal club on CAM and related topics and quarterly events that are designed to expose medical students to CAM modalities through didactics and experiential workshops. Popular topics include Traditional Chinese Medicine, Massage Therapy, Herbal Therapies, and Tai Chi. Ms. Engstrom also serves on the University Hospitals/CWRU CAM Steering Committee and has helped expand the medical education curriculum to include all seven of the major CAM categories defined by the NIH NCCAM. CWRU now offers 12 CAM elective courses including, but not limited to, Acupuncture, Mind-Body Medicine, Manual Therapies, Medicinal Herbs and Supplements and Energy-Based Healing. As a student intern for the American Medical Student Association (AMSA), Ms. Engstrom recently completed a grant proposal to the NIH NCCAM to support CAM educational programs for US medical students. In addition to her medical studies, she has also acquired over 50 hours of CAM related CME at national conferences including Harvard's annual *Alternative Medicine: Implications for Clinical Practice.* Her other activities most notably include the Ohio Academy of Family Physicians Foundation Board of Trustees and volunteer services for New Hope Alternative Therapy of Cleveland, a clinic that provides free alternative medical therapies to the underserved population. In association with New Hope, Ms. Engstrom recently gave a presentation on *Exercise Therapy for HIV Patients* to a group of Cleveland physicians. She has also given community presentations at the Cleveland Parkinson's Association on *Functional Conditioning and Balance.* Currently, Ms. Engstrom is working with the Infectious Disease Department of University Hospitals of Cleveland in a clinical research study looking at the effects of exercise therapy in the prevention and treatment of osteoporosis associated with HIV antiretroviral therapy.

Medical Student Perspective on Complementary and Alternative Medicine Education

Jennifer E. Engstrom, BSE, MS III

Medicine today is experiencing a paradigm shift in what is perceived as fundamental to the nature and delivery of health care. Specifically, this involves the blending of two philosophies; biomedicine and holistic medicine. An increasing knowledgeable patient population is now seeking alternatives to conventional medical therapies. Patients choose to use CAM because they find that it provides relief from symptoms, promotes healing and empowers them to take an active role in their own healthcare (Astin, 1998). Recent trends indicate over 42% of the general population uses some form of complementary and alternative medicine (Eisenberg et al, 1998). Consequently, there is an overwhelming trend toward reforming health care education, research, and delivery to better serve the needs of society. Although alternative therapies would have been readily dismissed by many physicians as fringe medicine only five to ten years ago, alternative medicine is now beginning to earn mainstream approval and academic stature (Levy, 1999). Furthermore, the AMA regards competency in complementary and alternative medicine as relevant to and representative of cultural competence in health care delivery (AMA Cultural Competency Compendium).

Medical students have expressed tremendous support for the inclusion of CAM within traditional core curricula. According to the 1999 AAMC Medical School Graduation Questionnaire results, 63% of medical students rated their education in alternative medicine to be "inadequate." Interestingly, this number has only improved by 3% since 1998 (66%) despite the doubling of CAM elective courses offered at medical schools over the past two years, from 34 medical schools in 1996 to 75 schools in 1998 (Eisenberg, 1998). Evidently, CAM elective courses alone are not adequately preparing future physicians to advise their patients about CAM.

A recent report by the AAMC on the Medical School Objectives Project calls for physicians to be sufficiently knowledgeable about both conventional and non-conventional modes of care. In order to accomplish this goal, medical education must begin to reflect a more integrative type of medical practice. Presenting information about CAM within core curricula does not constitute blind advocacy, but instead prepares future physicians to critically evaluate the research literature and advise their patients accordingly. Currently, less than 30% of patients who use CAM disclose this information to their physicians. It is important to note that patients properly counseled by a physician knowledgeable about CAM are more likely to reject modalities found to be unsafe or ineffective than patients who do not receive such counsel due to lack of physician education (Straus, 2000).

Education about CAM serves four major purposes:

(1) To increase cultural competency with respect to patient belief systems and cultural values
(2) To prevent contraindicated and deleterious care
(3) To potentially improve the results of medical care beyond what might be achieved using either conventional or alternative medicine alone
(4) To explore potential cost-effective alternatives to expensive medical technology, particularly when 70% of the current healthcare budget is spent on chronic, debilitating illnesses such as cardiovascular disease and chronic pain which are particularly amenable to complementary therapies

Incorporation of CAM within traditional medical education should involve cohesive integration of CAM across all subject areas. Limitations in time and resources are a reality at all medical

institutions and necessitate that integration be without tremendous increase in the volume of factual information. Instead, medical students should be introduced to CAM as representing a wealth of potentially valuable healthcare models needing further investigation.

The following list outlines the main objectives which would be considered representative of a comprehensive CAM curriculum. These general guidelines represent the interests of US medical students and recommendations of the NIH First National Conference on Medical and Nursing Education in Complementary Therapies, the Society for Teachers of Family Medicine, the American Association of Medical Colleges and the Uniformed Services University of Health Sciences.

1. To define CAM and the modalities encompassed by this definition.
2. To facilitate and encourage medical students to reflect upon the issues raised by the growth and practice of CAM in scientific, clinical and social contexts.
3. To introduce medical students to the historical development, philosophy and cultural origins of CAM modalities.
4. To provide students the opportunity to observe CAM practice in both alternative and allopathic settings so that they may formulate their own opinions of CAM.
5. To give students the opportunity to look at specific CAM therapies in more depth with optional didactic and clinical electives. Would include hands-on training in basic techniques.
6. To consider the evidence base for CAM regarding safety, efficacy and cost effectiveness.
7. To discuss the relevance of CAM in specific clinical situations. Would include information on indications, contraindications, frequency and duration of treatment required for clinical response and costs.
8. To provide students with guidelines for appropriate referral to CAM providers including proper follow-up and methods to facilitate communication between providers.
9. To prepare medical students for practicing medicine within the context of a multidisciplinary, integrative health care team.
10. To give students training regarding the medico-legal and ethical aspects of CAM including licensing, referral, and liability issues.
11. To provide students with opportunities to learn how to talk to patients regarding their health care belief systems, which may include use of CAM. Emphasis should be placed on how patient's cultures and belief systems affect their health seeking behaviors, outcomes, quality of care and satisfaction.
12. To allow students to personally experience the underlying concepts of mind-body medicine from which many CAM modalities derive, including techniques for stress reduction.

Medical students not only want access to CAM; they want to see CAM cohesively integrated into the classroom and clinical training. It is important to note that this does not imply that an exhaustive CAM curriculum be implemented overnight. Ideally, CAM education would be best integrated into traditional medical education in two major ways. During the first year of medical school, it would be most appropriate to offer a general survey course in CAM to introduce students to the various modalities and provide an overview of the seven major CAM categories defined by the NIH NCCAM. Second, relevant CAM topics should be integrated into traditional medical courses. Pharmacology should include evidence-based information on herbals and nutritional supplements including potential benefits, side effects and contraindications. Ideas on energy-based medicine including acupuncture and qi gong could be discussed within the context of neurology.

Case Western Reserve University School of Medicine represents a potential model for comprehensive CAM education. Over 15 CAM electives are offered to first and second year medical students covering topics such as Mind-Body Medicine, Manual Healing Techniques and Spirituality in Healing. Lectures on acupuncture and psychoneuroimmunology are directly integrated into the core Neurology curriculum. During their fourth year, students can also complete a clinical CAM elective in which they spend a month with various CAM providers. CWRU provides Area of Concentration credit in CAM for students who complete a minimum of the aforementioned electives. Furthermore, 10 hours of CAM education is included in the Family Medicine Residency Program at University Hospitals of Cleveland.

Future physicians need to become conversant in complementary and alternative medicine so that they are more adequately prepared to meet the needs of their patients. Comprehensive CAM education will not only serve to prevent deleterious care, but more importantly it will facilitate the advancement of a new integrated paradigm for health care delivery; one which represents the best that both conventional and alternative medicine has to offer. After all, science is interested in increasing the accuracy of knowledge, not in the finality of opinion.

References

American Medical Association (AMA) Cultural Competence Compendium, Section V. Complementary and Spiritual Practices and their Impact on Effective Care. URL: http://www.ama-assn.org.

American Association of Medical Colleges (AAMC). (1999). Medical School Graduation Questionnaire. All Schools Report.

AAMC Medical School Objectives Project. (1998). Report I: Learning Objectives for Medical Student Education: Guidelines for Medical Schools. Washington, DC.

Astin, JA. (1998). Why Patients Use Alternative Medicine. JAMA, 279 (19), 1548-1553.

Eisenberg, DM. (1998). Unconventional Medicine in the US: Prevalence, Costs, and Patterns of Use. JAMA.

Kaczmarczyk, JM. (2000). Uniformed Services University of Health Sciences (USUHS). CAM Learning Objectives.

Klinger, B. (1996). Challenges for the Future: Report on the First NIH National Conference on Medical and Nursing Education in Complementary Therapies. Journal of Alternative and Complementary Medicine, 2 (4), 539-546.

Klinger, B, Gordan, A, Stuart, M, Sierpina, V. (1999). Suggested Curriculum Guidelines on Complementary and Alternative Medicine: Recommendations of the Society of Teachers of Family Medicine Group on Alternative Medicine. Family Medicine, 31 (10), 30-33.

Levy, E. (1999). Integrative Medicine Gains Acceptance. Medical Tribune, 40(17), 1&7.

Straus, SE. (2000). NCCAM Director's Senate Testimony. URL: http://nccam.nih.gov/nccam/ne/senate.html.

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Danoff

Divider Title: _____

Debra Danoff
AAMC

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Jordan J. Cohen, M.D., President

February 21, 2001

Stephen C. Groft, Pharm.D.
Executive Director
White House Commission on Complementary and
Alternative Medicine Policy
6701 Rockledge Drive,
Suite 1010
MS 7707
Bethesda, Maryland 20817

Dear Dr. Groft,

The AAMC appreciates the opportunity to contribute to the deliberations of the White House Commission on Complementary and Alternative Medicine Policy. The Association of American Medical Colleges is a non-profit association founded in 1876 to work for reform in medical education. Originally representing only medical schools, the Association now comprises the 125 accredited U.S. medical schools, the 16 accredited Canadian medical schools, 400 major teaching hospitals and health systems, 90 academic and professional societies representing nearly 100,000 faculty members, and the nation's medical students and residents. Additionally, the administrative leadership of medical schools and teaching hospitals are served by a variety of professional development groups housed within the AAMC.

The AAMC has as its purpose the improvement of the nation's health through the advancement of medical schools and teaching hospitals. As an association of medical schools, teaching hospitals, and academic societies, the AAMC works with its members to set a national agenda for medical education, biomedical research, and health care, and assists its members by providing services at the national level that facilitate the accomplishment of their missions. In pursuing its purpose, the Association works to strengthen the quality of medical education and training, to enhance the search for biomedical knowledge, to advance research in health sciences, and to integrate education into the provision of effective health care. Today the Association carries out a broad range of programs and studies to represent its constituents.

The AAMC recognizes the importance of an evolving curriculum in medical education to meet the needs of our patient population. The AAMC strategic plan "Taking Charge of the Future" stated "The AAMC should stimulate change in medical education to create a better alignment of educational content and goals with evolving societal needs, practice patterns and scientific developments. We know that complementary and alternative

medicine (CAM) has a significant presence in the United States. Statistics show that in 1997 over 40% of Americans used CAM and that spending on CAM was more than $ 42 billion.

The AAMC has undertaken a number of major initiatives to assist our institutions in their review and revision of curriculum for medical students and residents. The Medical School Objectives Project (MSOP) was established in 1996 and has issued 3 major reports with an additional three reports due this year. Expert panels following consultation with major stakeholders and focus on the education of medical students developed these reports. In 1999 we also established a committee to develop a Graduate Medical Education Core Curriculum. This committee which included representatives from the Group on Educational Affairs (GEA)/Section on Graduate Medical Education, the Group on Resident Affairs and the Organization of Resident Representatives issued their report in January 2001. We have also focused specifically on CAM with the establishment in 1998 of a Special Interest Group on CAM. The following provides some of the highlights of these reports.

Medical Schools Objectives Project (MSOP)
MSOP addresses directly the expectations of graduating medical students and makes concrete recommendations for educational objectives to assure that our graduates will be able to meet the needs and expectations of the 21st century.

MSOP 1 entitled Learning Objectives for Medical Student Education, Guidelines for Medical Schools report set forth 30 program level learning objectives that represented a consensus within the medical education community on the knowledge, skills, and attitudes that students should possess prior to graduation from medical school. It focuses on the attributes of physicians who must be altruistic, knowledgeable, skillful and dutiful. Particularly relevant to your commission are the following specific recommendations that medical schools must ensure that before graduating a student will have demonstrated the following:

- Knowledge of the important non-biological determinants of poor health and of the economic, psychological, social and cultural factors that contribute to the development and/or continuation of maladies.
- Knowledge of the epidemiology of common maladies within a defined population and the systematic approaches useful in reducing the incidence and prevalence of those maladies.
- An understanding of the power of the scientific method in establishing the causation of disease and efficacy of traditional and non-traditional therapies.
- Knowledge about relieving pain and ameliorating the suffering of patients.
- The ability to communicate effectively, both orally and in writing, with patients, patients' families, colleagues, and others with whom physicians must exchange information in carrying out their responsibilities.

MSOP 2 Contemporary Issues in Medicine: Medical Informatics and Population Health identifies specific educational elements for educating medical students to have a

population health perspective. This perspective "encompasses the ability to assess the health needs of a specific population; implement and evaluate interventions to improve the health of that population and provide care for individual patients in the context of the culture, health status and health needs of the populations of which the patient is a member."

MSOP 3 Communication in Medicine focuses on the critically important issue of patient-physician communication. The report reviews general recommendations for teaching and evaluating communication skills. In addition, because cross cultural sensitivity/awareness is so critical to developing an effective doctor-patient relationship this report specifically addresses this area as well as that of spirituality in medicine and end-of life care.

Graduate Medical Education Core Curriculum

The Core Curriculum working group included representatives from the Group on Educational Affairs/ Section for Graduate Medical Education, the Group on Resident Affairs, and Organization of Resident Representatives. Their Report published in December 2000 identifies five domains of knowledge and provides examples of measurable educational objectives. This work closely parallels and complements the work of the Accreditation Council for Graduate Medical Education. The five domains are: biomedical ethics, scholarly medical practice, communication in medicine, medical professionalism, and the healthcare system. Objectives identified for these domains include a number that speak directly to issues relevant to the Commission. These include:

- Knowledge of differing ethno-cultural viewpoints and religious beliefs.
- The ability to provide their patients clear information about treatment programs and options, health maintenance and illness prevention.
- The ability to serve as the patient's advocate.
- Knowledge of the healthcare needs of the community.
- Knowledge of community healthcare organizations and resources.
- Knowledge of the principles of population-based medicine and the ability to organize and implement population based care in the context of their own practice.
- The ability to work with social service and public health agencies, religious institutions, police and other community organizations as appropriate in assisting their patients.

With the publication of these reports the AAMC and its member institutions will be developing educational and evaluation programs to support these objectives.

I hope that this brief overview of some of the educational initiatives of the AAMC will be helpful to you. We would be pleased to provide additional details on your request.

I am pleased to respond below to the thoughtful questions raised by your Commission.

1. *What is the status of CAM in undergraduate and/or graduate medical education? To what extent is CAM included in medical school curricula and/or graduate medical education? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in medical school curricula and graduate medical education?*

The increased attention paid to CAM in our medical schools mirrors the trend among American health care consumers. All of our medical schools provide education about mind-body interaction through our focus on the biopsychosocial model of disease. We also provide specific instruction on the pathophysiology of disease as well as attention to disease prevention and health promotion. In addition to these general educational experiences a significant number of schools provide teaching about CAM. Data from the 1998-99 LCME school report indicates that more than 75 of the 125 schools provide this education. A sampling of offerings in 2001 include: Overview of CAM, Human Values in Medicine, Prevention of Injury from Herbal Medications, A Scientific Look at Alternative Medicine, Foundations of Medical Practice, Patient Centered Learning. Schools are developing both required and elective programs that focus on a wide range of topics.

Information on teaching in the more than 7000 Graduate Medical Education programs is not as well defined. We know that particularly those programs in primary care are incorporating this teaching into their residency education programs. It should be noted that the ACGME recently established core curriculum requirements that emphasis the need to deal with diverse patient populations.

The AAMC recognizes the importance of exposing medical students to CAM. Physicians must be aware of the potential value as well as the complications of CAM therapies and of the potential drug interactions that can occur between herbal preparations and standard pharmaceuticals. The AAMC believes that the focus should be on "evidence based medicine" regardless of origin, conventionality or approach.

2. What are the barriers to inclusion of CAM in medical school curricula and/or graduate medical education, for example, resources, expertise, interest? Conversely, what are the incentives for inclusion of CAM in medical school curricula and/or graduate medical education?

This is a time of considerable change in the expectations of the medical profession. At all levels in the continuum of medical education, educators are working to incorporate new areas into the curriculum. These include but are not limited to domestic violence, genetics, end of life care, professionalism, cross cultural care etc. Thus, CAM is part of this group of evolving topics and it requires time and financial resources to assist the schools and graduate programs to develop effective educational strategies. Attention must be focused on both program development and evaluation.

3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in medical school curricula and/or graduate medical education?

The Medical School Objectives project and the ACGME core curriculum requirements have already established general principles for the education of physicians trained to practice in the 21st century. These guidelines will provide the framework for the inclusion of an appropriate CAM content in the curricula of medical schools and graduate programs.

In March 2001, the journal *Academic Medicine* will publish a special section of articles under the title "Alternative Medicine– the importance of Evidence in Medicine and Medical Education." Articles in this section will provide additional assistance in the development of curricular objectives. The AAMC does not recommend any policy change at the present time. The AAMC and its member institutions share with the rest of the medical community a long-standing opposition to externally mandated curriculum requirements.

4. What should every medical student know about CAM? How should that level of knowledge be determined?

Physicians need to be well informed about the conceptual basis, efficacy and safety of alternative therapies. They need to be able to obtain accurate information from patients about their use of these therapies. In addition, physicians must be able to assist their patients to make informed choices in health care and thus be able to discuss CAM in this context. The foundations of this education should occur in medical school with further development, as appropriate, in residency training. At each stage, evaluation should reflect the specific objectives of teaching and techniques for evaluation should be reflective of those objectives.

5. What should every resident-irrespective of specialty-know about CAM? How should that level of knowledge be determined?

The AAMC does not recommend the dictation of specific curricular content in specialty residency training. The curricular content should reflect the core curriculum as defined by the ACGME as well as unique specialty needs. Definition of specific knowledge, skills, attitudes and values should be the purview of the residency review committee in consultation with the specialty boards Evaluation should reflect the specific objectives of teaching and techniques for evaluation should be reflective of those objectives.

6. What should every fellow-irrespective of specialty-know about CAM? How should that level of knowledge be determined?

The AAMC does not recommend the dictation of specific curricular content in fellowship training programs. The curricular content should reflect the core curriculum as defined by the ACGME as well as unique specialty needs. Definition of specific knowledge, skills, attitudes and values should be the purview of the residency review committee in consultation with the specialty boards. Evaluation should reflect the specific objectives of teaching and techniques for evaluation should be reflective of those objectives.

7. Should integrative residency programs be developed? If not, why? If so, what would the most important elements be, and how could such programs be most effective?

The AAMC does not recommend the establishment of a separate residency program. Proponents of CAM have provided strong support for the inclusion of teaching about CAM into established residency programs. The creation of a separate residency program would send a message that this is focused area of expertise and might well discourage its inclusion in curricular content of all appropriate residency programs.

8. How and by whom should the inclusion or expansion of CAM in medical education be funded?

Seed grants from appropriate agencies would provide assistance to medical educators at all levels of training to review current CAM content and refine and enhance these educational experiences.

I hope that the information I have provided is of assistance in your deliberations. Please do not hesitate to contact me or my staff if we can be of additional assistance.

Yours sincerely,

Jordan J. Cohen, M.D.

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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Jordan J. Cohen, M.D., President

On

Complementary and Alternative Medicine Policy

Presented before the

White House Commission on

Complementary and Alternative Medicine Policy

By:

Deborah Danoff, M.D.

Assistant Vice President

Division of Medical Education

February 22, 2001

Mr. Chairman and Commission members, the AAMC appreciates the opportunity to contribute to your deliberations. The Association of American Medical Colleges is a non-profit association founded in 1876 to work for reform in medical education. Originally representing only medical schools, the Association now comprises the 125 accredited U.S. medical schools, the 16 accredited Canadian medical schools, over 400 major teaching hospitals and health systems, 90 academic and professional societies representing nearly 100,000 faculty members, and the nation's medical students and residents. Additionally, the administrative leadership of medical schools and teaching hospitals are served by a variety of professional development groups housed within the AAMC.

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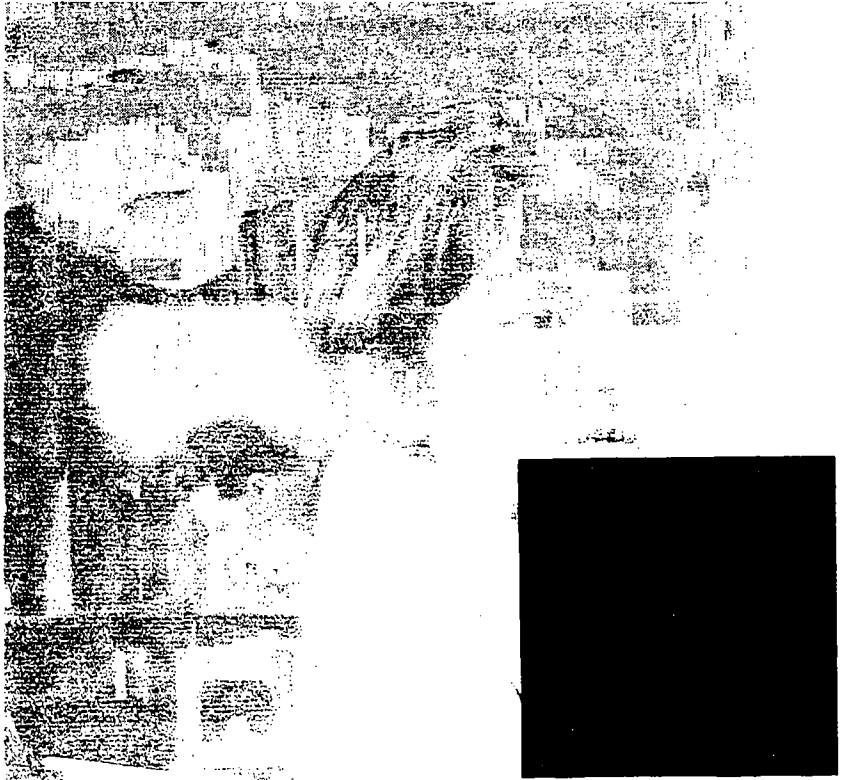
The AAMC and its member institutions are committed to improving the health of the public. We believe that the focus should be on "evidence based medicine" regardless of origin, conventionality or approach.

I hope that the information I have provided today will be of assistance in your deliberations and look forward to responding to your questions.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES



Report III

Contemporary Issues in Medicine: Communication in Medicine

Medical School Objectives Project

October 1999

In January 1998, the Association of American Medical Colleges (AAMC) issued Report I of the Medical School Objectives Project (MSOP). The purposes of the MSOP were to set forth program level learning objectives that medical school deans and faculties could use as a guide in reviewing their medical student education programs (initial phase), and to suggest strategies that they might employ in implementing agreed upon changes in those programs (implementation phase). MSOP Report I concluded the initial phase of the project. That report set forth 30 program level learning objectives that represented a consensus within the medical education community on the knowledge, skills, and attitudes that students should possess prior to graduation from medical school.

Report I set forth a number of learning objectives that reflected a growing awareness that, in the future, physicians will be expected to be more effective than now appears to be the case in communicating with patients and their families, and with other members of the health care team. These objectives are restated below:

For its part, the medical school must ensure that, before graduation, a student will have demonstrated, to the satisfaction of the faculty:

- The ability to obtain an accurate medical history that covers all essential aspects of the history, including issues related to age, gender, and socio-economic status
- The ability to communicate effectively, both orally and in writing, with patients, patients' families, colleagues, and others with whom physicians must exchange information in carrying out their responsibilities
- Knowledge about relieving pain and ameliorating the suffering of patients
- Knowledge of the important non-biological determinants of poor health and of the economic, psychological, social, and cultural factors that contribute to the development and/or continuation of maladies
- Compassionate treatment of patients, and respect for their privacy and dignity

Task Force Report

Spirituality, Cultural Issues, and End of Life Care

Introduction

The Task Force on Spirituality, Cultural Issues, and End of Life Care was sponsored by the National Institute for Healthcare Research (NIHR), with a grant from the John Templeton Foundation. NIHR is a private, non-profit organization dedicated to advancing the study of under- recognized factors that promote or negatively impact on physical or mental health. The Task Force was composed primarily of individuals involved in curriculum management or reform at several medical schools, with staff support provided by the AAMC's Division of Medical Education (the Task Force members are identified at the end of the Report). The Task Force was charged with developing detailed learning objectives relevant to the topics of concern, and suggesting learning strategies that deans and faculties might employ in their educational programs to enable students to achieve the stated objectives.

In preparing MSOP Report III, the AAMC staff reviewed the Task Force's work, and decided to include sections of the Task Force's Report in this report (MSOP III). In order to provide a context for the content set forth below, it is important to recognize that there are more than 50 medical schools that now offer courses or course content on topics such as spirituality in medicine, cross cultural sensitivity/awareness, and end-of-life care. Because communication about these sensitive topics is so critical to developing an effective doctor-patient relationship in some circumstances, it seems appropriate to place special emphasis on them in this report.

Definitions

The following definitions were agreed upon by the Task Force members and were used to guide them in the course of pursuing the Task Force charge:

Health is not just absence of disease, but a state of well-being that includes a sense that life has purpose and meaning. The Pew – Fetzer definition of health is:

We are coming to understand health not as the absence of disease, but rather as the process by which individuals maintain their sense of coherence (i.e. sense that life is comprehensible, manageable and meaningful) and ability to function in the face of changes in themselves and their relationship with the environment (Antonovsky, 1987).

Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another.

Culture is defined by each person in relationship to the group or groups with whom he or she identifies. An individual's cultural identity may be based on heritage as well as individual circumstances and personal choices. Cultural identity may be affected by such factors as race, ethnicity, age, language, country of origin, acculturation, sexual orientation, gender, socioeconomic status, religious/spiritual beliefs, physical abilities, and occupation, among others. These factors may impact behaviors such as communication styles, diet preferences, health beliefs, family roles, lifestyle, rituals, and decision-making processes. All of these beliefs and practices, in turn, can influence how patients and health care professionals perceive health and illness and how they interact with one another.

End-of-Life refers to the part of the life cycle when the possibility of death becomes a major concern for the patient and his or her family, and for the physician. End-of-life issues are those that the individual person faces when he or she is confronted with a condition in which dying is a distinct possibility. There is no clear demarcation between active treatment of an illness and the end of life. Rather, end–of-life refers to the entire time, even during treatment of an illness when dying becomes an important consideration. Both a person's spirituality and culture may affect significantly his or her beliefs, attitudes, and behaviors toward end-of-life health care interventions.

Outcome Goals

Students will be aware that spirituality, and cultural beliefs and practices, are important elements of the health and well being of many patients. They will be aware of the need to incorporate awareness of spirituality, and culture beliefs and practices, into the care of patients in a variety of clinical contexts. They will recognize that their own spirituality, and cultural beliefs and practices, might affect the ways they relate to, and provide care to, patients.

Students will be aware of the range of end-of-life care issues and when such issues have or should become a focus for the patient, the patient's family, and members of the health care team involved in the care of the patient. They will be aware

of the need to respond not only to the physical needs that occur at the end of life, but also the emotional, socio-cultural, and spiritual needs that occur.

Learning Objectives

With regard to *spirituality* and *cultural issues*, before graduation students will have demonstrated to the satisfaction of the faculty:

- The ability to elicit a spiritual history
- The ability to obtain a cultural history that elicits the patient's cultural identity, experiences and explanations of illness, self-selected health practices, culturally relevant interpretations of social stress factors, and availability of culturally relevant support systems
- An understanding that the spiritual dimension of people's lives is an avenue for compassionate care giving
- The ability to apply the understanding of a patient's spirituality and cultural beliefs and behaviors to appropriate clinical contexts (e.g., in prevention, case formulation, treatment planning, challenging clinical situations)
- Knowledge of research data on the impact of spirituality on health and on health care outcomes, and on the impact of patients' cultural identity, beliefs, and practices on their health, access to and interactions with health care providers, and health outcomes
- An understanding of, and respect for, the role of clergy and other spiritual leaders, and culturally-based healers and care providers, and how to communicate and/or collaborate with them on behalf of patients' physical and/or spiritual needs
- An understanding of their own spirituality and how it can be nurtured as part of their professional growth, promotion of their well-being, and the basis of their calling as a physician

With regard to *end-of-life care issues*, before graduation, students will have demonstrated to the satisfaction of the faculty:

- An understanding that death is a natural part of life, that suffering and loss are an integral part of the human life cycle, and that the physician's role encompasses the comprehensive care of the patient and their family during the entire transition between life and death

- The ability to deliver difficult news about end-of-life issues to patients and their families in a caring and compassionate manner; to elicit patients' values, beliefs, and preferences for treatment at the end of life; to obtain advance directives and knowledge of surrogate issues
- Recognize that when death becomes a likely possibility, treatment options may change depending on the risks and benefits of a particular treatment, the consequences of that treatment for the patient and patient preference for type of care.
- An understanding that the concept of palliative care refers to all of the dimensions of care (physical, emotional, social and spiritual) that should be provided at the end of life
- The ability to recognize the spectrum of the physical, emotional, sociocultural, and spiritual symptoms of distress patients may exhibit at the end of life, and the appropriate ways to respond to them
- The ability to work with, and value, a multi-disciplinary team delivering end-of-life care, and to communicate effectively both orally and in writing with colleagues and other health care providers in order to deliver appropriate care to patients at the end of life
- The ability to access data on end-of-life issues and utilize these data in the case formulations and management plans of patients at the end of life

Educational Strategies

Listed below are suggestions for strategies that might be employed by deans and faculties to ensure that their students have learning experiences that will allow them to achieve the objectives set forth above.

- Develop specific learning objectives relating to each of the three topics (spirituality, cultural issues, and end-of-life care)
- Develop educational resources designed to accomplish learning objectives
- Establish a curriculum management process that insures that relevant issues are included in all four years of the curriculum, incorporating content into existing courses wherever possible.
- Design educational experiences so that students learn how to elicit a spiritual and cultural history, and talk to dying patients

- Design experiential activities that integrate spiritual, cultural, and end-of-life issues (e.g., videotapes, case studies, standardized patients, problem-based cases) to promote learning
- Provide students with regular opportunities to discuss and explore their feelings about clinical experiences (conflicts created by spiritual and cultural differences, care of dying patients)
- Encourage student self-reflection (e.g., journal writing, small group discussions, role-playing, simulated exercises, using literature, patient narratives, parallel chart)
- Utilize students as peer educators. For example, different cultural and spiritual backgrounds can be explored; skills in obtaining spiritual and cultural histories can be taught and reinforced; strategies for effectively dealing with dying patients discussed.
- Encourage and provide time for students to volunteer in community based activities, and provide a forum for these students to share their experiences with other members of their institution
- Organize both elective and required community and culturally based service learning experiences (medical Spanish course, sign language course, international health course, rotations in clinics with speakers of other languages)
- Establish longitudinal patient care experiences to enhance student understanding of the relationship between spirituality, culture, and end-of-life issues and their patients' health
- Have students participate in interdisciplinary formats in which the patient's spiritual and cultural needs can be a major focus (e.g. hospices, collaborating with chaplains, home visits with nurses, community-based clinics for homeless people, rehabilitation centers, prisons, churches).
- Ensure that students have opportunities to care for dying patients, in hospice, home care, or in-patient settings, thereby allowing students to become familiar and comfortable with the physical, emotional, sociocultural, and spiritual issues faced by the patient, family, and physicians at the end of life

Task Force Members

Christina M. Puchalski, MD (Chair)
George Washington University School of Medicine

Lynn C. Epstein, MD
Brown University School of Medicine

Ellen Fox, MD
Veterans Administration

Mary Anne C. Johnston, PhD
University of Colorado School of Medicine

Gene A. Kallenberg, MD
George Washington University School of Medicine

Lloyd W. Kitchens, Jr. MD
Regent (Texas)
American College of Physicians

David B. Larson, MD, MSPH
National Institute for Healthcare Research

Francis G. Lu, MD
University of California at San Francisco School of Medicine

Margaret A. McLaughlin, MD
Rush Medical College

Joseph F. O'Donnell, MD
Dartmouth Medical School

Kemia Sarraf, MD
University of Utah School of Medicine

James P. Swyers, MA
National Institutes for Healthcare Research

James Woolliscroft, MD
University of Michigan School of Medicine

M. Brownell Anderson
Association of American Medical Colleges

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Divider Title: _____

PETER V. SCOLES, MD

Dr. Scoles is Vice President for Assessment Programs at the National Board of Medical Examiners (NBME). He is a graduate of the Jefferson Medical College-Pennsylvania State University Program in Medicine, received a Master of Science degree from Ohio State University, and a Master of Arts degree in Humanities from John Carroll University.

Dr. Scoles is responsible for all test design and development issues for examination programs developed by the National Board of Medical Examiners including the USMLE Steps 1, 2, and 3, SPEX, and Subject Test Programs. He supervises the Assessment Center project team, the Standardized Patient program, and the Computer-based Case Simulation program. He is responsible for National Board activities related to complementary and alternative medicine.

Dr. Scoles completed his internship at St. Vincent's Hospital and Medical Center of New York, and his residency in Orthopedic Surgery at the Ohio State University. He is a Diplomate of the NBME and the American Board of Orthopaedic Surgery. Prior to his appointment at the NBME, Dr. Scoles was Professor in the Departments of Orthopaedics, Anatomy, and Pediatrics at Case Western Reserve University School of Medicine. At CWRU, Dr. Scoles served as Assistant Dean for Evaluation and Standards, Interim Dean for Information Technologies, and as Chairman of the Committee on Medical Education. He received the Kaiser Foundation award for teaching excellence at Case Western Reserve University in 1994. He is a member of Alpha Omega Alpha Medical Honor Society, the American Orthopedic Association, and the American Academy of Orthopedic Surgery. Dr. Scoles holds a current clinical appointment as adjunct Professor of Orthopedics at Temple University School of Medicine, and is an attending Orthopedic Surgeon at the Philadelphia Shriners Hospital for Children.

Complementary & Alternative Medicine and the United States Medical Licensing Examination

Report to the White House Commission on Complementary & Alternative Medicine Policy

Peter V. Scoles, MD
Vice President
Assessment Programs
13 February 2001

Background

The United States Medical Licensing Examination (USMLE) is the single pathway to licensure for allopathic physicians who are graduates of LCME accredited schools in the United States and Canada, and for all international medical graduates seeking licensure in the United States. The purpose of the USMLE is to assess a physician's ability to integrate basic science and clinical medicine to provide safe and effective patient care. The USMLE is jointly owned by the National Board of Medical Examiners (NBME) and the Federation of State Medical Boards (FSMB), and is governed by a Composite Committee consisting of representatives from the NBME, the FSMB, the Educational Commission for Foreign Medical Graduates (ECFMG) and public representatives. The Composite Committee delegates authority for standard setting and matters of content to three Step Committees. Standards are reviewed every three years, and the content of the three Steps is reviewed annually.

The USMLE consists of three complementary steps. Step 1 and Step 2 are constructed from integrated content outlines organizing basic science and clinical science material respectively. The Step 3 examination is constructed around a databased model of generalist medical practice in the United States. Step 1 and Step 2 are usually taken during undergraduate medical school. Step 3 is usually taken during post-graduate training. The Step 1 and Step 2 examinations are each one-day long, and consist of 350 and 400 multiple-choice questions. The Step 3 examination is two days long, and consists of approximately 500 multiple choice questions and 9 computer based case simulation exercises. The examinations are delivered by computer year-round at test centers operated by Prometric, a subsidiary of Thomson Learning. Students must pass Steps 1 and 2 and have completed medical school to be eligible to take the Step 3 examination.

Although the USMLE is primarily intended to assess competency to practice medicine, it has a powerful effect on undergraduate and graduate medical curriculum design. For this reason, it is essential that the NBME avoid the perception of endorsing unproven, ineffective, or unethical methods of treatment. If items regarding alternative therapies are included on the USMLE, they must be held to the same standard of evidence as traditional therapies.

Complementary and Alternative Medicine in the USMLE

There is extensive evidence that the use of complementary and alternative medical treatments (CAM) is increasing in all segments of the population. More than half of adults in the United States use one or more alternative medical therapies; most do not inform their primary physician. Although many individuals self-prescribe, the use of alternative providers ranging from nurse practitioners through naturopathic physicians is growing rapidly. Third party coverage for CAM is increasing. Unfortunately, there is little available data regarding the efficacy of many alternative therapies. Some alternative therapies are clearly dangerous, and a number of others have potentially severe interactions with conventional drugs.

There is growing pressure on practitioners and teachers of traditional medicine to consider the positive and negative consequences of alternative therapies in the practice of medicine. The AAMC Report on Medical School Objectives emphasizes that physicians should be sufficiently knowledgeable about traditional and nontraditional modes of care to provide intelligent guidance to their patients. Wetzel's 1997 survey of 125 US medical schools (excluding osteopathic schools) indicated that 64% offered instruction in complementary or alternative medicine, most often as elective courses. Despite AAMC recommendations, there are currently no standards for curriculum content in CAM.

The Step committees reviewed USMLE content in CAM at the Step Committee Retreat in August 2000. Dr. Wayne Jonas, a member of this panel, was invited to address the issue of CAM on USMLE. Dr. Jonas pointed out that current courses on CAM are inconsistent in content and quality; some schools, such as Jefferson Medical College provide survey courses concerning the nature of alternative medical practices. Others, such as the University of Pennsylvania provide elective courses in particular alternative modalities. Dr. Jonas also noted the financial incentives associated with CAM; there is a danger that economic pressures may drive some health care institutions and providers to offer alternative therapies to patients. This may, in turn, increase pressure on medical schools to provide instruction in complementary therapies.

The governing committees of the three Steps of the USMLE have had the opportunity to study the recommendations made by Dr. Jonas and have made initial recommendations for further development. Although there is legitimate debate about the nature of CAM course materials that may be appropriate for inclusion in the curriculum of traditional allopathic and osteopathic schools, there is little disagreement that physicians must be able to discuss these modalities with patients under their care. Pathophysiologic processes, principles of pharmacology, evaluation of the effects of therapy, and patient communication skills all fall within the current content and task outlines of the USMLE. Areas in which CAM could be included in the USMLE include

(1) evaluation of communication skills with patients utilizing CAM, and with CAM practitioners;
(2) the side effects and adverse drug interactions associated with herbal or alternative medications;
(3) critical evaluation of medical literature related to CAM.

A more detailed summary of the discussions of individual Step Committees follows.

Step 1 Summary
The Step 1 examination is concerned with the basic sciences fundamental to the practice of medicine. The Step 1 Committee felt that it was appropriate to develop test materials for which mechanisms of action have been established, or for therapies in which adverse drug interactions have been demonstrated. Areas in which evidence for efficacy was based on less than rigorous research should be avoided until further studies are complete. The Step 1 group identified a series of operational guidelines to govern incorporation of CAM items ranging from content coding to qualifications of item authors.

Step 2 Summary
The Step 2 examination is concerned with the fundamental aspects of clinical diagnosis and management. The Step 2 Committee believes that there are a limited number of CAM-related items in the exam and that additional high quality items are needed. The Step 2 Committee believes that current content outlines and item development processes can incorporate CAM items. Since the Step 2 exam is designed to measure the ability to enter supervised medical practice in post graduate training, areas such as side effects from self-prescription, drug interactions, and the reaction of physicians to patients who use CAM are all relevant.

Step 3 Summary
The Step 3 examination assures competency to provide unsupervised general medical care. The Step Committee believes that it is essential to emphasize the scientific basis of practice, and to avoid the perception of endorsement of unproven methods. The Step 3 Committee recognized the need to respond to new content areas and to patient-driven concerns. They recommended five areas where additional consideration could be given: (1) history taking, (2) communication skills, (3) medical effectiveness of alternative therapies, (4) side effects, and (5) drug/drug interactions.

Conclusion

Given the frequency of use of CAM, and the potential for severe drug interactions, it appears reasonable to include items related to CAM on USMLE. Two approaches are possible. The NBME can employ current protocols to appoint basic scientists and academic physicians, and clinical practitioners with interest and expertise in CAM to test material development groups as vacancies open over the course of the next 4 years. This is the usual method for incorporating new content. There would be a lag of approximately 4 years before questions appeared as "live" items on the USMLE. As an alternative, the NBME could assemble a "task force" to develop CAM items for all three steps of the examination. Such task forces have been employed in the past to target such areas as end-of-life care and sports medicine. A CAM task force that met for 3 years could be expected to add 300-600 items to the examination pools, with the first live items becoming available in 1½ to 2 years. The three-year cost estimate including travel expenses and honoraria for such a task force is approximately $200,000. NBME governance is not likely to authorize this expenditure unless outside support can be obtained.

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Fishman

Divider Title: _____

ALFRED P. FISHMAN, M.D.

Alfred P. Fishman, M.D. is the William Maul Measey Professor Emeritus of Medicine and Senior Associate Dean for Program Development at the University of Pennsylvania School of Medicine. He received his A.B. and M.S. degrees from the University of Michigan, and his M.D. from the University of Louisville. He has had extensive research training in physiology, pathology and medicine largely under the sponsorship of the National Institutes of Health and the American Heart Association. In 1966, he became Professor of Medicine at the University of Chicago and Director of the Cardiovascular Institute at Michael Reese Hospital and Medical Center. In 1969, he joined the faculty of the University of Pennsylvania as Professor of Medicine and Associate Dean of Research. His background in physiology, pathology and medicine has been primarily directed at research in cardiovascular and pulmonary medicine. Between 1990-1996, he served as Chair of the Department of Rehabilitation Medicine. He is Chair of the Health Promotion and Disease Prevention Council and Chair of the Steering Committee of Complementary Medicine at the University of Pennsylvania.

Dr. Fishman has been a consultant to the executive office of the President of the United States; a member of the National Heart, Lung, and Blood Institute and Chairman of the Health Sciences Policy Board, Institute of Medicine, NAS. He has served on numerous editorial boards, as editor of the Journal of Applied Physiology, and as Chairman of the Publications Committee of the American Physiological Society and as a member of the Board of Directors of the American Heart Association. He has served as special consultant to the Health Commissioner, New York State, Dr. David Axelrod and as Chair of the New York State Cardiology Planning Committee. He is currently a member of the Board of Directors of the National Space Biomedical Research Institute.

Dr. Fishman was President of the American Physiological Society, and is or has been a member of several national societies, including the American Society for Clinical Investigation, the Association of American Physicians, the Institute of Medicine of the National Academy of Sciences, the Interurban Clinical Club, and Royal Society of Medicine (London) and the American Academy of Arts and Sciences. He was Chairman of the United States National Committee of the International Union of Physiological Sciences. He has served on a succession of committees and the Cardiopulmonary Council of the National Institutes of Health and is currently Chair of the Steering Committee of the National Emphysema Treatment Trial which involves 18 medical centers in the United States. Dr. Fishman serves on a number of Boards of Directors, and is on the Board of Visitors of several medical institutions. He is the Immediate Past President of the College of Physicians of Philadelphia. He has edited nine books and published over 250 scientific articles.

During the last 3 years, Dr. Fishman has served as Chair of a Working Group charged by the CEO/Dean to define the role of complementary/alternative therapies in the academic medical center. The Group drew up recommendations and supporting documents that have been adopted by the faculty and administration of the University of Pennsylvania Medical Center. These recommendations deal not only with the research, educational, and clinical aspects of complementary-alternative therapies but also with the ethical, cultural, legal, and credentialling aspects. The research component was presented previously to the White House Commission, the Royal Society of Medicine, and the Wellcome Trust (London) among others.

See Tab 30 under Discussion Group II for DRAFT Executive Summary to be discussed by Dr. Fishman

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Divider Title: Sampson

Title VII-VIII PH-3 Act
Legislative/Oversight Purpose
1741- Nurse-combination Grant (
Physicians, Nurses, allied Hlth P,
dentists
- they should be considered in emergency preparedness

Neil Sampson ⇒

Excerpt

HRSA

1. How and by whom should the inclusion or expansion of CAM in medical education be funded?

HRSA's Bureau of Health Professions will invest $353 million in fiscal year 2001 in assuring that an adequate and competent health workforce is available to meet the health care needs of all Americans. We do this through collecting data to analyze the existing workforce and charting future needs, working to build a diverse workforce that better reflects the population as a whole, and assuring that health care providers are available where they're needed most.

All of the Bureau's 40 different competitive, peer-reviewed, categorical grant programs are established through specific legislation in the Public Health Service Act under Titles VII and VIII. These programs are directed toward specific health disciplines, such as physicians, nurses, dentists, public health, etc. In fiscal year 2000, the Bureau awarded 1,741 new and continuation grants. There is no provision in the legislation for non-allopathic, non-osteopathic physicians or other health providers practicing complementary and alternative medicine.

We recognize that there appears to be a widespread and growing opinion in medical education that students and residents should be exposed to issues related to CAM, because a significant proportion of the patient population is using or considering the use of these therapies, and because there are both potential value and potential complications in their use. We understand that at least one-half of medical schools currently have coursework or other educational activities involving teaching about CAM.

We believe that CAM should be included in other health professions education programs and not limited to physician education. For example, the Bureau's Division of Nursing currently funds three graduate programs, which include content on complementary and alternative therapies. In addition, BHPr's Chiropractic Demonstration Project Grants Program supports research demonstration projects in which chiropractors and physicians collaborate to identify and provide effective treatment for spinal and lower-back conditions. Currently, research is the only activity legislatively authorized under this program. Additional legislative authority would be required to support chiropractic training, educational activities and other complementary and alternative medicine therapies.

2. Should there be a required minimum level of postgraduate training for non-allopathic and non-osteopathic physicians and other unconventional physicians? If so, why or why not? How should this postgraduate training be created, structured, funded?

As awareness of the effectiveness of these therapies becomes known, educational content about these therapies is being integrated into the curriculum and clinical practice of providers. Graduates of these programs are increasingly using these therapies to promote the health and well being of their patients.

While this knowledge in the field of CAM is still developing and evolving, there are some known benefits and risks to the public, the latter including incorrect use of certain alternative medications and misapplication of such medications if the practitioner does not recognize some diseases.

The Bureau believes that there should be a minimum level of postgraduate education requirement for non-allopathic or non-osteopathic physicians and other non-conventional physicians, which will lead to a state certification or license. This would allow for some level of standardization across the professions.

Because the field and body of knowledge are still new, such postgraduate training should be created in an evolutionary manner until consensus is reached among health professions educators. However, postgraduate training is not applicable for all of the disciplines identified as complementary and alternative. All educational and training programs should address a set of core requirements. These core requirements should be aligned with the requirements necessary for program accreditation, other methods of recognition, and licensing bodies, if applicable.

And while it should not be structured or fully funded prematurely, the Federal government can play a leadership role by convening medical education leadership conferences and encouraging the development of standards of education for providing CAM services. One other option is to position Titles VII and VIII as a vehicle for initiatives such as encouragement of training in and standards for CAM.

3. Are there scholarship and/or loan repayment programs available for students of CAM or emerging professions, particularly for those who wish to provide services to underserved populations? If not, why not?

The Congress must authorize scholarship and loan repayment programs. Titles VII and VIII of the Public Health Service Act, the vehicles by which BHPr provides its health professions leadership and by which considerable emphasis and priority are given to health professions training for care to underserved populations, currently do not include specific authorization or appropriations for work in this area.

The only exception is for Chiropractic students, who are eligible for "scholarships for disadvantaged students," a program directed by the Bureau's Division of Student Assistance. Chiropractic students may also qualify for scholarships from their individual schools and some state associations provide a limited loan repayment program for students that agree to serve in rural areas.

4. Should the future health care workforce be structured differently in view of the effects of CAM and emerging professions on medical education and training, and health care delivery? If so, how should the future health care workforce be structured and why?

The structure of the workforce, in the sense of scopes of practice, credentialing, roles, numbers and mix, has been and continues to be a matter of debate. Emerging therapies and professions are part of this debate. Such changes can be influenced, but probably not imposed, from the federal level. It is important and relevant to periodically monitor the workforce to determine shifts and trends which could impact access to practitioners, health care, cost and quality. Such efforts help identify problems and allow for health policy makers, state and national leaders, health professionals, service providers and payers and consumers to determine issues, discuss strategies and consider appropriate actions. The HRSA National Center for Workforce Information and Analysis in December, 2000 held a national meeting on health workforce issues which served a forum for the recently completed studies on pharmacy, nursing and public health workforces. Through such research meetings we can better assess the impact of workforce on health care delivery.

III.

ABSTRACT

Project Title: Integrative Therapies in Primary Care Subspecialty Program
Organization Name: Columbia University School of Nursing
Address:
630 West 168th Street
New York, NY 10032
Project Director: Joyce K. Anastasi, PhD, RN, FAAN, L.Ac
Project Period: 2000-2003

Phone: 212-305-1296
Fax: 212-305-6937
Email: jka8@columbia.edu

The Columbia University School of Nursing (CUSN) will offer a subspecialty that will incorporate Integrative Therapies in Primary Care within the Master of Science (MS) Nurse Practitioner programs at CUSN. A 9-credit sequence of three courses will be offered as a subspecialty in any of the ongoing MS Nurse Practitioner specialties (Adult, Geriatric, Family, Pediatric, Women's Health, Midwifery, Oncology, Psychiatric/Mental Health). The first two courses will be didactic and will provide an overview of, and theoretical grounding in, the different integrative modalities. Lecture topics will focus on various traditional systems of health care such as: Ayurveda, Homeopathic Medicine, Naturopathic Medicine, Native American, Latin American, Kampo and Traditional Oriental Medicine. Specific classes will also be devoted to the discussion of safety and regulation of integrative therapies from a primary care perspective. The third course will be clinical in focus, with each student being assigned to observe a practitioner of integrative medicine in a chosen modality. Additional clinical focus will be provided in weekly case studies where students will be challenged to appropriately incorporate integrative therapies into the treatment plan of patients with traditional Western illnesses (diagnoses) such as hypertension, cancer, etc. This course will be co-led by an integrative practitioner and a nurse practitioner. The essence of this course will be to reinforce, in practical ways, the interrelationship of two points of view. To this end, the Western allopathic approach of differential diagnosis and treatment will be held as the standard of care. However, students will be instructed on how to appropriately and safely infuse integrative therapies into their clinical practice with the ultimate goal of improving the quality of the care given to clients.

CUSN is committed to educating and training primary care nurse practitioners who specialize in health promotion and disease prevention initiatives in underserved areas. In order to advance this commitment, a subspecialty program has been designed to teach cultural traditions related to health care and the use of alternative medicine practices. This approach is an important component in preparing primary care nurse practitioners to work in ethnically diverse underserved urban communities. Culturally relevant knowledge can positively impact communication in the healthcare relationship (patient/provider), and is crucial to the provider's ability to prevent/improve health outcomes related to disease.

Through advanced knowledge of the cultural and philosophical origins of various integrative therapies, as well as safety and regulatory factors, graduates of the program will be prepared to engage this expanding area of health care in all domains of nurse practitioner practice. Additionally, graduates will be eligible to sit for the American Holistic Nurses' Association credentialing examination in Holistic Nursing.

ABSTRACT

Project Title: Advanced Practice in Gerontologic/Complementary Care
Organization Name: Medical University of South Carolina, College of Nursing
Address: 99 Jonathan Lucas Street
P.O. Box 250160
Charleston, SC 29425
Project Director: Barbara K. Haight
Project Period: 7/1/00-6/30/03

Phone: (843) 792-3108
Fax: (843) 792-1741
E-mail: HaightB@MUSC.EDU

Abstract Narrative:

The purpose of this project is to enhance nursing education and practice by significantly expanding the existing graduate program in gerontological nursing to create a new model for advanced practice and primary care in gerontologic/complementary care nursing. This advanced practice nurse will be educated in a blended role and will be prepared to sit for the geriatric nurse practitioner certification, and the gerontological clinical nurse specialist certification. The education of this specialist is congruent with the draft goals of Healthy People 2010 (**increase years of healthy life and eliminate health disparities**) and with the National Workforce Goals I (**increase access through appropriate preparation of health professionals**) and II (**Improve access to a culturally competent health profession workforce**). The need for this health professional is evident when looking at the cohort of aging baby boomers who will number 65.6 million this millennium. These aging health care consumers make approximately 629 million visits per year to practitioners of alternative medicine, which exceeds the total number of visits per year to primary health care providers. In view of these facts, our objectives which reflect the national goals will be to: **1) Improve access to quality health care by designing, implementing, and evaluating a comprehensive curriculum to prepare advanced practice nurses for the gerontologic and complementary care of aging adults; 2) Improve access to a diverse and culturally competent work force by recruiting and educating at least 18 qualified students and graduating 12 qualified students, with a focus on African-American students (20%), for the gerontologic/complementary care specialty; 3) Improve the cultural competence and sensitivity of the nursing work force by developing and educating students in culturally diverse and underserved work sites with qualified preceptors.** Linkages have been established and are ongoing in an interdisciplinary clinic where nursing, pharmacy, occupational therapy, dental, and medical students are all educated and practice together. The clinic in subsidized housing and a rural practice will provide ongoing interdisciplinary experiences with a culturally diverse, poor and medically underserved population. A second linkage for the Kids into Health Careers initiative has been established with Burke High School and with the children of families living in subsidized housing. These linkages contribute to a statutory funding preference that will substantially benefit underserved populations.

000003

D23 NU 01251

Title: Expansion of the Gerontology/Chronic Care APN Program
Amount of Award: $206,380

Dr. Betty Chang, DNSc
School of Nursing
University of California, Los Angeles
700 Tiverton Avenue
P.O. Box 951703-1702
Los Angeles, California 90095-1702
310/206-3834
bchang@sonnet.ucla.edu

Start - 7-01-99
End - 6-30-00

Summary

The purpose of the proposed project is to significantly expand the enrollment of Gerontology/Chronic Care (gero/cc) specialists in a Master of Science in Nursing Program in the preparation of Advanced Practice Nurses (Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP) in a blended role in our current curriculum).

Objectives

1. Increase the enrollment of gero/cc students by a minimum of 25% in the first year;
2. develop and implement two new courses with increased emphasis on theoretical foundations, of common complementary health care;
3. evaluate the effectiveness of the new courses and the gero/cc specialty;
4. develop and implement instructional material for use on the School of Nursing Internet website; and
5. evaluate the website.

Grant Number	Project Coordinator Institution	Telephone Number Fax E:Mail
1 D24 NU 00842-01	Dr. Susan Janson School of Nursing University of California at San Francisco 521 Parnassus Avenue, N505 San Francisco, CA 94143-0608	415/476-5282 415/476-6042 susan_janson_at_nursing@ccmail.ucsf.edu

Start Date: 7/01/99 End Date: 6/30/02

ANP: Integrated Complementary Healing Tract

ANP: Integrated Complementary Healing Tract This application, as authorized in Section 822 of the Public Health Service Act, proposes Development and significant expansion of a master's level program preparing Adult Nurse Practitioners with a special focus on the integration of complementary approaches to health and healing in primary care practice.

Graduates from UCSF's Adult Nurse Practitioner (ANP) program are in a prime position to introduce complementary healing approaches deemed to be within the scope of nursing practice and coordinate and safely integrate the use of appropriate complementary therapies into the health plan.

Since 1983, the Adult Nurse Practitioner (ANP) graduate program has trained and educated nurses to care for the primary care needs of healthy and ill adults. Over the past two years, we identified many more patients in our training sites with interest and questions in alternative and complementary therapies. Many of these patients were seeing practitioners of non-traditional therapies, and most had not informed their primary providers. It became obvious these needs could be better handled in the context of the primary care practice, where care could be integrated and the use of alternative and complementary approaches could be supervised appropriately. It is now necessary to train ANP students in the complementary modalities that are within the scope of the California Nurse Practice Act and to increase awareness of the alternative complementary therapies that require specific training and licensure and are best supervised by the primary provider of ongoing care. With this information for our basis, our overall goal is to increase the number of Adult Nurse Practitioners (ANP) who can safely and effectively integrate complementary approaches to health and healing with the comprehensive primary care of adults, including medically underserved and vulnerable populations.

Chiropractic Demonstration Projects

Purpose

Section 755 (b)(3) of the Public Health Service Act authorizes the Secretary of the U.S. Department of Health and Human Services to carry out demonstration projects in which chiropractors and physicians collaborate to identify and provide effective treatment for spinal and lower-back conditions

Program Description

Each project must include the following:

1. The project must address the identification and treatment of spinal and/or lower-back conditions.

2. The project must represent collaborative efforts between chiropractors and allopathic or osteopathic physicians.

3. Each project must include a strong research protocol which will result in a significant expansion of documented research in the area addressed and which is suitable for publication in refereed health professions journals, including research-oriented publications.

4. The project must include an explicit strategy for case-finding and a strategy for making direct comparisons to other forms of treatment. The results must be generalizable to patients cared for in clinical practices addressing spinal and/or lower-back conditions.

5. Whenever feasible, minorities and women should be included in study populations so that research findings can be of benefit to all person at risk of the disease, disorder, or condition under study.

Previous Funding Experience

Although Public Law 102-408 authorized $1 million for the program in each of the fiscal year 1993 through 1995, no funds were appropriated in FY 1993. With the first appropriation of $742,000 in FY 1994, three applications were approved and funded. These three grant demonstration projects continued funding in FY 1995 ($792,000) and FY 1996 ($905,000). With $748,000 appropriated in FY 1997, a second competitive cycle of applications were reviewed and 5 applications were approved; three projects were funded. In FY 1998 ($739,511) the three projects continued to be funded. In late 1998 within Public Law 105-392 of the Health Education Partnerships Act, the chiropractic demonstration program was reauthorized. In FY 1999 ($739,511) the three projects originally funded in FY 1997 continued with funding. In FY 2000 ($664,898), four (4) applications were approved; three projects were funded. In FY 2000, additional funding (379,983) was awarded from the National Center for Complementary and Alternative Medicine (NCCAM)/NIH.

Eligibility

To be eligible for a Chiropractic Demonstration Project grant, the applicant shall be: a health professions school, an academic health center, a State or local government, other appropriate public or private nonprofit entity, a private nonprofit school, or a college or university of Chiropractic.

Application Procedures

No competitive cycle is planned for FY 2001.

Applicants should address inquiries regarding grants management to:

Grants Management Officer (R18)
BHPr, HRSA
Parklawn Building, Room 8C-26
5600 Fishers Lane
Rockville, Maryland 20857
Telephone Number: (301) 443-6960

Programmatic inquires should be addressed to:

Jennifer Hannah
Program Officer
Division of Interdisciplinary and Community-Based Programs (DICBP)
HRSA/BHPr
Parklawn Building
5600 Fishers Lane, Room 8C-09
Telephone Number: (301) 443-0908
Fax (301) 443-0650
E-mail: jhannah@hrsa.gov

Chiropractic Program Web Page

http://www.hrsa.gov/bhpr/dadphp/chiro.htm

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Collina

Divider Title: _____

Sara Collina
National Breast Cancer Coalition
1707 L Street NW 10th Floor
WDC 20036
202-296-7477
fax 202-265-6854
shcollina@natlbcc.org

Sara Collina is a Senior Policy Analyst and the Director of the Quality Care Initiative at the National Breast Cancer Coalition. Prior to this, she designed and then directed Project LEAD, the Coalition's science course for breast cancer activists. Ms. Collina has worked in the field of women's health care for more than a decade, and earned her B.A. from Cornell University and her J.D. from Boalt Hall School of Law. She has a family history of breast cancer.

NATIONAL BREAST CANCER COALITION

NBCC

F U N D

« a grassroots advocacy effort »

TESTIMONY OF SARA COLLINA, J.D.
SENIOR POLICY ANALYST
NATIONAL BREAST CANCER COALITION
BEFORE THE WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY
February 22, 2001

Background and Introduction

I am Sara Collina, Senior Policy Analyst at the National Breast Cancer Coalition (NBCC). On behalf of NBCC I would like to thank you for the opportunity to testify before the White House Commission on Complementary and Alternative Medicine Policy. We strongly support the goals of the commission and appreciate the opportunity to contribute.

NBCC is a grassroots organization dedicated to ending breast cancer through the power of action and advocacy. It's main goals are to increase federal funding for breast cancer research and collaborate with the scientific community to implement new models of research; improve access to high quality health care and breast cancer clinical trials for all women; and expand the influence of breast cancer advocates in all aspects of the breast cancer decision making process.

I will be addressing the issue of the education and training of Complimentary and Alternative Medicine (CAM) Practitioners in the context of quality health care. Ultimately, this is what CAM and all other health care policy is about—finding ways to describe, measure and provide quality health care for everyone.

NBCC's Vision of Quality Care

What is quality care? Some focus exclusively on reducing morbidity and mortality. Others describe it by what it isn't-- too much, too little or the wrong care. These approaches lack a patient perspective. We need the right care at the right time. But the right care can be a very personal choice. Two reasonable patients with the same diagnosis may choose very different treatments.

On the other hand, quality care is not simply personal taste, or a popularity contest. Of course we want to avoid rude doctors and long waits. But we can get free parking, sparkling water in the waiting room, a long relaxed visit with the doctor, and leave with the wrong diagnosis.

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NBCC has a different approach. We think quality breast cancer care is made up of six core values: **Access, Information, Choice, Respect, Accountability and Improvement**. Together, we believe these values capture the essence of quality breast cancer care.

We are publishing a Guide to Quality Care based on these core values and would be pleased to share it with you. Briefly, the goal of our guide is to give breast cancer patients a different and better way of thinking about quality care. We want to move away from the "doctor knows best" mentality and the equally damaging "more care is better care" approach. Instead, we ask patients to take some time to learn about breast cancer care and become their own advocate.

The guide is our best advice—it's what we tell our family and friends about breast cancer care. We explain the value of medical evidence, how doctors do—and do not—use it, and how it should be used. We describe what clinical guidelines are, and how to find them. We explain the difference between absolute and relative risk. We discuss why a second opinion should be from a doctor outside the institution of the first doctor. We describe the laws regarding medical confidentiality and those requiring coverage of certain procedures. We advise bringing a tape recorder to doctor appointments. We describe what "coordinated" care is, and what should be covered in a comprehensive treatment plan.

These are just few examples to provide a general sense of our values and how we approach the issue of education and training of CAM practitioners.

Not Conventional verses CAM but Evidence-Based Medicine

NBCC believes that both the medical community and patients should approach CAM with an open but critical mind—exactly as they should approach conventional care. The same questions apply—what are the risks, what are the benefits, and how strong is the evidence that answers these questions?

The two categories of CAM verses conventional medicine are really not helpful to patients. The categories themselves encourage the misperceptions that conventional medicine is all based on medical evidence (it is not), and that CAM therapies are natural and therefore harmless (this is frighteningly untrue).

Many conventional providers are justifiably angry and worried that patients are being tricked into wasting precious resources on dangerous and ineffective CAM treatments. But many neglect to learn about effective CAM therapies. For example, an oncologist may have no idea acupuncture may alleviate nausea associated with certain cancer treatments.

This us/them mentality about CAM has serious consequences. Because many conventional health care providers know so little about CAM therapies, they fail to discuss the issue with their patients. Patients respond by lying or withholding

information about their interest in or use of CAM. They then end up weighing the potential risks and benefits of CAM therapies on their own.

The medical community needs to stop thinking in two categories of conventional and CAM, and instead focus on developing better systems for creating and weighing evidence that can tell what us we really need to know—what does and does not work?

Allow me to use the Quality Care core values to describe in more detail our recommendations for CAM education and training.

Information: Patients need accurate and complete information in order to make good decisions. They need a clear and complete presentation of all conventional medical options, along with what is and is not known about how well they work and what harm they can do. *Patients need the exact same evidence-based information for CAM, and they need it at the same time and place that they receive information about conventional treatment options.*

Choice: Guided by accurate information, patients should be able to choose among therapies that offer some benefit. Patients should also be told about all clinical trials that are relevant to them. *CAM that has some evidence of efficacy must be part of the range of choices presented to patients. Relevant CAM clinical trials need to presented to all patients as a health care option.*

Respect: Providers need to treat the patient as a whole person rather than as a disease or a body part. For example, discomfort and anxiety need to be taken seriously—they are a real and powerful part of the breast cancer experience and can often be alleviated. *All care providers should have a basic knowledge of CAM and provide an overview to patients, and respectfully encourage patients to be honest about their interest in or use of CAM.*

Accountability: Patients need competent providers with credentials that mean something to patients. The system should be easy to understand and transparent, so everyone can easily learn what a credential or license means. But credentials by themselves do not create accountability. It is a clear and accessible appeals process that protects patients. *Any licensing or credentialing process must include a convenient and effective way for patients to appeal or complain, and there must be meaningful consequences. This is true for both CAM and conventional practitioners.*

Access: Breast cancer patients should have access to interventions that have been shown to help. *All providers should either provide or refer patients to CAM therapies that have been shown to have some efficacy. Health insurers and plans should have an evidence-based approach to coverage and educate patients about CAM.*

Improvement: We want a health care system that is continually learning from patient care. We need more and better evidence about both conventional breast cancer care and CAM.

NBCC believes that CAM research has been extremely under-funded. A large investment in this kind of research could not only bring great health benefits to patients, but in the long run may provide savings in health care costs. Right now breast cancer trials consist mostly of drug companies exploring slightly different ways of using their patented drug, or slightly different combinations of existing drugs. We need a different focus, and CAM research is fertile ground for innovative questions about breast cancer.

We also need to expand our notion of health services research. We need to be measuring what matters—not just morbidity and mortality, and not just a handful of quality of life measures. CAM research can require innovative design, which may help expand what we measure and how.

The federal government needs to fund not only CAM research, but also CAM education for all players—patients, health care providers, third party payers, etc. There is so much misinformation and mistrust around this issue. A major educational effort by the federal government could go a long way in dispelling myths and getting effective treatments to patients.

NBCC strongly supports increased funding for more and better research to find out which CAM therapies are effective. We also strongly support a federal educational initiative on CAM and evidence-based medicine.

National Guidelines

CAM practitioners certainly need consistent educational standards and accountability within the licensing or credentialing process. But this by itself will do little to help women get the care they need. We believe that patients will be better able to choose the right provider (CAM or other) when there are national standards for health care--standards that are comprehensive, evidence-based, updated regularly and accessible to everyone. These guidelines should not be broken into conventional verses CAM, but rather include the entire range of care options.

Guidelines can't tell anyone what their treatment should be, but they can provide an invaluable overview of what we've learned from medical research so far. Patients will—and should—continue to make very different choices about their health care. But one national trustworthy source for evidence-based health care information would be a powerful tool for patients and their loved ones who are trying to get quality health care. It would also highlight what research questions remain.

Conclusion

CAM is not a fad. It is—and will continue to be—an important component of healing for many patients. The truth is, conventional medicine has over-promised. For many breast cancer patients, it has failed them. Patients who are painfully aware of the limitations of conventional medicine will continue to look for health care that works, wherever it may be. From a patient perspective, it is not either conventional or CAM,

but what actually helps that matters. Health care policy needs to reflect this view. CAM must be completely incorporated into all aspects of health care policy.

Thank you so much for this opportunity to share NBCC's views. We believe that breast cancer advocates have an important role to play in the development of CAM policy. We look forward to working with you more closely in the future.