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Plenary Session II - Continuing CAM Education & Training: Building Knowledge & skills

Plenary Session II

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Divider Title: Helms

Biographical Sketch for Joseph M. Helms, M.D.

Joseph M Helms, M.D. is at the forefront of physician acupuncture education in the United States. He has been teaching physicians since 1977, and chairs a continuing education program sponsored by the Office of Continuing Medical Education at the UCLA School of Medicine. Dr. Helms attended the Johns Hopkins University for his undergraduate education and UCLA for his medical training. He studied acupuncture in France through l'Association Francaise d'Acupuncture and l'Ecole Superieure d'Acupuncture France. He is a diplomate of the American Board of Family Practice and the American Board of Pain Management, and has a private practice of acupuncture and family medicine in Berkeley, California.

Dr. Helms is the author of the professional textbook on medical acupuncture, Acupuncture Energetics: A Clinical Approach for Physicians. He undertook and published the first rigorously designed controlled prospective clinical research study in medical acupuncture in the United States ("Acupuncture for the Management of Primary Dysmenorrhea," Obstetrics and Gynecology, 69, 51-56, 1987), and has written chapters on medical acupuncture for two pain textbooks, one physiatry textbook, and a CAM textbook.

Dr. Helms is founding president of the American Academy of Medical Acupuncture, and served as president of this organization from 1987 to 1993. He has served as consultant on the World Health Organization's acupuncture scientific advisory committees that have established international training and practice standards. He has been vice president of the WHO-sponsored World Federation of Acupuncture-Moxibustion Societies, and a participant on the ad hoc advisory panel of the Office of Alternative Medicine, National Institutes of Health. He is vice chairman of the medical advisory panel of OneBody.com, an Internet CAM resource.

White House Commission on CAM Policy, 22 February 2001

Training, Education, Credentialing, and Licensing
of Physician Acupuncturists

Joseph M. Helms, M.D., Founding President
American Academy of Medical Acupuncture

I have been involved in physician acupuncture education since 1977. During this quarter-century the discipline of medical acupuncture has emerged and defined itself, created its training guidelines, established its practice standards, and regulated its credentialing requirements. I am pleased to review its history and current status for the commissioners and the public.

It is necessary to clarify that I address only the discipline of medical acupuncture, that is, acupuncture as taught to and practiced by physicians who are licensed in conventional allopathic and osteopathic medicine. I do not address other disciplines of acupuncture that are taught or practiced by credentialed nonphysicians in this country. M.D. and D.O. physicians come to acupuncture already fully qualified in western biomedical science and practice, having spent over 4,000 hours in their formal training programs. They are experienced as health care providers, and are embracing acupuncture as an additional discipline to integrate into their practices. Most physicians limit their acupuncture practice to 25% or less of their professional activity.

In 1980 the first comprehensive medical acupuncture training program in the United States was sponsored by the American Holistic Medical Association (AHMA) as one of its core training modules. It was accredited for 200 hours of continuing medical education and was the forerunner of the "Medical Acupuncture for Physicians" program, which has been sponsored since 1983 by the Office of Continuing Medical Education of the UCLA School of Medicine. In 1987, graduates of the AHMA and UCLA programs created the American Academy of Medical Acupuncture to represent the professional interests of well-trained physician acupuncturists. Entry membership requirements were established as 200 hours (120 didactic, 80 clinical) of formal training. Full membership requires an additional 20 hours of training.

The formal training of 220 hours was adopted in 1987 by the World Federation of Acupuncture-Moxibustion Societies (WFAS), a World Health Organization-sponsored entity (WHO), as the requirement for physician training in its member societies, consistent with the full membership requirements of the AAMA. In this country, as individual states created training guidelines for physicians, 200 hours was the amount of formal training uniformly adopted as necessary to develop safe and effective practice skills. The UCLA program and that of the New York University College of Medicine and Dentistry, which are the two major resources for physician acupuncture education in the United States, maintained their training programs to conform with these standards.

Since 1984 there have been numerous meetings of physicians from western countries to discuss the standards of physician training and practice of acupuncture. These have been sponsored by national medical acupuncture societies in the United States, Canada, Australia, Sweden, Germany, Belgium, and France, and have served as the forum for cross-fertilization and standardization. Several enduring international societies - the Pan Pacific Forum on Medical Acupuncture for Pacific Rim countries, and the International Council of Medical Acupuncture and Related Therapies (ICMART) for European countries - have developed from these meetings, and continue to serve educational needs and international exchange of the member countries. The common denominator in the national and international societies is integrating western biomedical training with the traditional theory and practice of acupuncture.

In 1996 WHO's Division of Traditional Medicine convened an international assembly that voted on training guidelines for different levels of acupuncture practitioners. This document was approved by the World Health Assembly and distributed to member nations. Qualified physician graduates from schools of contemporary biomedicine who wish to include acupuncture as a technique in their clinical work are recommended to have not less than 200 hours of formal training. This training should include the history and cultural context of acupuncture, the basic theory of acupuncture and Chinese medicine, knowledge of the acupuncture points, traditional methods of diagnosis, and the principles and techniques of acupuncture treatment. The document acknowledges that qualified western physicians

already know medical theory, diagnosis, safe practice techniques, and patient management, and that their use of acupuncture will address problems they commonly treat in their medical specialties.

The WHO training guidelines embody that which has been recommended and practiced in western countries for ten to fifteen years. The regulations have been well established in all European and Pacific Rim countries, and are time-tested in the United States. They provide a matrix in which each training program can provide its physician students with an education in acupuncture that results in substantial theoretical understanding of the discipline and a responsible and effective technique for its execution in clinical practice. Public safety is well protected by the current standards of training and regulation.

In the United States, the AAMA recommends that individual state medical boards require the 200 hour minimum formal training for physicians to register as medical acupuncturists. Currently all states except three that require physician registration follow the 200-hour standard. Most state medical boards, however, are disinclined to regulate or certify physicians in medical acupuncture. They argue that the discipline is included in the scope of practice of medicine and does not need additional registration. In the practice of medicine, it is the hospital staff privilege and liability insurance guidelines that document quality of training. AAMA membership eligibility is the gold standard in every state for practice privileges and insurance coverage.

The American Academy of Medical Acupuncture serves the profession and the public by establishing minimum training and practice standards for membership, offering continuing education in medical acupuncture, recommending practice privileges and liability insurance qualifications, encouraging regulation by state medical boards, and by disseminating reliable information about the discipline to the public. The American Board of Medical Acupuncture, a sister society to the AAMA, offers a certification process in medical acupuncture that requires documentation of acupuncture practice and results and passing an examination.

Because the majority of physicians practicing acupuncture in the United States are graduates of the UCLA "Medical Acupuncture for Physicians" program, the majority of the physicians in the AAMA are UCLA graduates. Membership is not limited to UCLA graduates; rather, members come from all schools and disciplines of acupuncture taught in this country. A survey done of graduates of the UCLA program between 1997 and 2000 confirmed that 97% of the course participants felt well prepared to responsibly and safely incorporate acupuncture into their practices.

In conclusion, with respect to the training and education, credentialing and licensing of physicians practicing medical acupuncture, I contend that the discipline has defined and regulated itself in a fashion that is acceptable by national and international standards. Further, the medical acupuncture training and credentialing infrastructure has shown through 25 years to be reliable for these physicians and safe for their patients. I consider medical acupuncture to be a mature and effective discipline with a responsible training, credentialing, and accountability system, and recommend that it be endorsed by the commission in its current form. I further recommend that exposure programs for medical students, residents, fellows, and practicing physicians be encouraged in all specialties of medicine. Such an education exposure will inform them of the value of medical acupuncture, how to refer appropriate patients for treatment, and the recommended format and content of responsible training. Thank you very much for inviting me for this presentation.

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Lao

Divider Title: _____

BIOGRAPHICAL SKETCH

Lixing Lao, Ph.D., MD (China), L.Ac.

Lixing Lao, Ph.D., L.Ac., is an Associate Professor of the Complementary Medicine Program in the Department of Family Medicine, School of Medicine, at the University of Maryland Baltimore; and Vice-President and Clinical Director of the Maryland Institute of Traditional Chinese Medicine in Bethesda, Maryland. He also served as a Board member on the Maryland State Board of Acupuncture, which regulates acupuncture licensing.

Dr. Lao graduated from the Shanghai University of Traditional Chinese Medicine (TCM) in 1983 after 5 years training in acupuncture, Chinese herbal medicine and Western Medicine. He completed his Ph.D. in physiology at the University of Maryland at Baltimore in 1992. As a licensed acupuncturist, Dr. Lao has practiced acupuncture and Chinese medicine for more than 17 years. He joined the Complementary Medicine Program of the University of Maryland School of Medicine in 1992, and has been actively involved in patient care, teaching and research and became the Clinic Director of the Complementary Medicine Program Clinic in 1998.

As a principal investigator or co-investigator, Dr. Lao has been awarded grants from the National Institutes of Health and the U. S. Department of Defense to conduct research on acupuncture and alternative medicine. He has many publications and has been invited to give presentations at many national and international conferences/symposia including NIH Consensus Development Conference on Acupuncture in November, 1997. He currently serves as a member of the Advisory Board on the *Journal of Alternative Therapies*, and was a member of the International Editorial Advisory Board on the *International Journal of Clinical Acupuncture and Oriental Medicine*.

His interests of research areas are mainly focused on Acupuncture and Traditional Chinese Medicine. He has been conducting clinical trials of acupuncture for chemotherapy-induced nausea and vomiting, postoperative dental pain and for chronic osteoarthritis of the knee. He also has a laboratory to conduct basic science study on animal models to explore the mechanism of analgesic effect of acupuncture.

Testimony by Lixing Lao, Ph.D., M.D. (China), L.Ac.
to the
White House Commission on Complementary and
Alternative Medicine

February 22, 2001

Good morning, and thank you for the opportunity to speak here today. My name is Dr. Lixing Lao. I studied Traditional Chinese Medicine (TCM) and Acupuncture at the Shanghai University of Traditional Chinese Medicine, and have practiced acupuncture and TCM for more than 18 years. Many of you know me as a researcher because of my work at the University of Maryland where I conduct clinical trials on the efficacy of acupuncture. I was the principal investigator on acupuncture research for postoperative pain after dental surgery, which was one of the 2 uses of acupuncture that received full endorsement by the NIH at their 1997 consensus conference, and I continue to do studies on chemotherapy-induced nausea and vomiting, postoperative dental pain, chronic osteoarthritis of the knee, and mechanism of action of acupuncture analgesia.

I come to you today, however, to talk about the education, training, licensure, and certification of acupuncturists in this country. Ten years ago, along with some very dedicated and esteemed colleagues, I founded the Maryland Institute of Traditional Chinese Medicine, a school that is accredited by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM), and is representative of acupuncture schools that prepare students to become certified by the National Certification Commission for Acupuncture and Oriental Medicine. I currently teach and serve as a Board member and Clinical Director of the school, and the comments that I am about to make reflect my experience in this capacity, as well as from my experience as a former Board member of the Maryland State Board of Acupuncture, which regulates acupuncture licensing for the State of Maryland.

First, I would like to talk about the training of professional acupuncturists. Accredited schools provide a minimum of three years for acupuncture training program (more than 2000 hours, with at least 500 hours of clinical training and 360 hours of training in Western medicine), or 4 years for acupuncture and Chinese herbal medicine training program. The Western

medicine component focuses mostly on training acupuncturists to recognize signs and symptoms indicating that the patient should be referred to another practitioner, such as a physician, and also trains students on how to effectively communicate and interact with the conventional medical system. This is similar to other health care practitioners such as chiropractors, psychologists, and even physicians, who are trained to work with the medical system and refer patients when necessary to another type of provider. This is emphasized throughout their acupuncture training, even though it is more common for a patient to come to us after they have already pursued treatment by a conventional health care provider.

This typical 3 to 4 year training program is comparable with the number of training hours required by other health professions, and is considered to be a minimum amount of time required for understanding the richness and complexities of a medical system that has been under development for at least 3 thousand years.

Acupuncture and TCM is a medical system, not just a collection of points on the body, and like modern western medicine, it takes years of study and practice to achieve competency, and a lifetime of learning to achieve mastery. Acupuncture schools provide extensive training in meridian theory, diagnostic methods including tongue and pulse diagnosis, differentiation of disease according to TCM theories, accurate acupuncture point locations, various acupuncture needling techniques, principle of treatment, the dynamics of acupuncture formulas for point combinations, and dynamics of Chinese herbal formulas, which is not unlike the combination of different drugs that, when taken together, have an affect far different than the individual components.

Perhaps the most important part of the training however, is the extensive clinical training that the students receive. Like a doctor fresh out of medical school, it is not until one gets some clinical experience that all the information and theory starts to come together in a practical way. In our school, following ACAOM's high standard, students begin by spending 150 hours doing clinical observation, and then 500 hours where they must provide at least 250 treatments to at least 30 patients before they can graduate. Each case is discussed with a clinical supervisor, most of whom have been trained in China and have many years of practical experience. As we all know, rarely does a patient present as described in a textbook case,

and it takes quite a bit of experience to correctly diagnose and properly treat the variety of patients that walk through the door.

Traditional Chinese medicine is a completely different way of looking at health and illness, as compared to Western medicine. While the bodily organs such as the liver, spleen, heart, lung, and kidney are the same, their function in Chinese medicine is very different then their function in western medicine, and the inter-relationships between the organs is completely different than in western physiology. Therefore, someone presenting with asthma may be diagnosed with a kidney yin deficiency, and someone with irregular menstrual cycles may have liver qi stagnation. Obviously, training in western medicine diagnosis has very little overlap with Chinese medicine. Traditional Chinese medicine and acupuncture often provide fundamental health care for the patient rather than just symptom relief.

I make these points to illustrate the sharp contrast between this 2000 hours high standard acupuncture training as compared to the fewer hours of acupuncture training in other health professions. I believe that it is a very positive phenomenon that more and more physicians are learning about acupuncture and choose to use it as part of the treatment options they have in their profession. When they incorporated this modality into their practice, it can significantly benefit and improve patient care, especially for the temporary relief of some symptoms and simple illnesses. However, just like a family medicine practitioner will recognize his/her limitations by referring a patient with cardiovascular disorder to a cardiologist, a health care practitioner with minimal acupuncture/TCM training should recognize their limits when treating a patient with a complicated, chronic condition that requires comprehensive treatment by a professional acupuncturist.

I must take issue that in some states even a fully trained professional acupuncturist is required to practice under the "supervision" of other types of health care providers. It is incomprehensible to me how a physician, for example, who may have little or no training in acupuncture, can be legally authorized to supervise a licensed acupuncturist. This is like requiring an electrician to supervise a plumber – knowledge of one field does not automatically confer knowledge of the other field, and it does nothing to assure the competency of the practitioner. This is a public safety issue. I urge the Commission to consider this issue and be fully aware of the different levels of training and scope of practice among health professions.

People seeking acupuncture are unlikely to understand the differences in training among different types of practitioners. National certification is one of the few ways that the public can determine the level of training of a practitioner. Just like every medical doctor is required to take a Board exam, most states require acupuncture practitioners to pass the national exam offered by National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in order to be eligible for an acupuncture license. The passage of the NCCAOM exam ensures that the practitioner has the basic knowledge of acupuncture and TCM required for an entry level acupuncture practitioner.

Another reason that it is very important for the Commission to look at education, training, licensure, and certification is for reimbursement. More and more insurance companies are beginning to cover acupuncture, although with many limitations and restrictions. I sincerely hope that in the near future, all government health care programs such as Medicare, Medicaid, and the military include acupuncture in their health care programs. Some of these programs do not even offer acupuncture, or only offer it if performed by a physician. To assure high quality practitioners, I hope that the Commission will recommend that licensed acupuncturists be part of the health care team and help to facilitate that to happen.

As acupuncture and TCM become more and more incorporated into the mainstream medical system, it is important that acupuncture practitioners and medical doctors work together, rather than competing with each other, to deliver the best health care for the patients. In the University of Maryland medical system, physicians, medical acupuncturists, and professional acupuncturists work together as a team, referring patients to each other as appropriate. Our patients are very satisfied with the health care we have been delivering in this system. I truly believe that this should be an ideal model for the health care system in this country. For this to work, however, physicians must have the knowledge and understanding necessary to make referrals to professional acupuncturists. This should be part of the graduate training of all health care practitioners, but especially physicians, since they are often the gatekeepers in the health care system.

In summary, I would like to ask this Commission to recognize that acupuncture is a comprehensive medical system that requires extensive training to be fully and correctly practiced. The national standards for accreditation of acupuncture schools assures high quality and comprehensive

training programs, and the national exam, such as NCCAOM exam, for certification of acupuncturists assures that practitioners have a basic level of knowledge necessary for high quality care. These are the gold standards for all health professions, and are important tools to protect the public from untrained and unqualified providers. Other health professionals should have a basic understanding of acupuncture as a different approach to healing that can complement conventional treatment, and be encouraged to include acupuncture as part of the health care options for their patients.

Finally, I would like to mention that the Association of Acupuncture and Oriental Medicine, and the National Acupuncture and Oriental Medicine Alliance, have read these remarks and fully concur with these recommendations.

Thank you very much and I'll be happy to answer any questions.

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Divider Title: Blumenthal

MARK BLUMENTHAL
BIOGRAPHY

Mark Blumenthal is the Founder and Executive Director of the American Botanical Council (ABC), an independent, non-profit group dedicated to disseminating accurate, reliable, and responsible information on herbs and medicinal plants. He is the Editor/Publisher of *HerbalGram*, an international peer-reviewed quarterly journal whose contents reflect the educational goals of ABC. He is also an Adjunct Associate Professor of Medicinal Chemistry at the University of Texas at Austin, College of Pharmacy, teaching a graduate level course on herbal products in today's pharmacy. Mark has served as Vice-President of the Herb Research Foundation and President of the Herb Trade Association, the former association that represented the interest of the herb industry. He was also a founding board member of the American Herbal Products Association.

He is the senior editor of the book of English translations of *The Complete German Commission E Monographs-Therapeutic Guide to Herbal Medicines.* This publication has been ranked second in the top medical books published in 1998. It is a rational system for evaluating the safety and efficacy of herbal medicines.

Mark has over 25 years experience with herbs, medicinal plants and natural products. He has appeared on over 300 radio shows, written over 400 articles for such publications as *Health Food Business, Let's Live, Vegetarian Times, Natural Health, East West Journal,* has written chapters for natural alternative medicine encyclopedias, and has written a monthly column for *Whole Foods Magazine* for the last 9 years. He has been a consultant to the Office of Alternative Medicine at the National Institute of Health and to the World Health Organization (WHO). Mark is a frequent speaker and/or panelist at conferences, universities, pharmaceutical, natural foods, botanical and agricultural associations. In addition, he has founded a number of herbal/natural product manufacturing concerns.

To schedule an interview or presentation for Mark Blumenthal contact Beverley Ferguson at 512-926-4900. For further information on the American Botanical Council and *HerbalGram*, call 512-926-4900 or write to the American Botanical Council, PO Box 144345, Austin, TX 78714-4345 or visit our webpage: www.herbalgram.org

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Education and Continuing Medical Education in Botanical Medicine

Presented to

The White House Commission On Complementary and Alternative Medicine Policy

Washington, D.C.
February 22, 2001

By
Mark Blumenthal
Founder & Executive Director
American Botanical Council
Austin, Texas

Current CME Courses on Botanical Medicine for MDs et al.

1. Columbia University / University of Arizona Course on Botanical Medicine in Clinical Practice

- 5day course in May
- Designed for MDs, but other professions also accredited
- Taught by MDs and others (PhD pharmacognosists, PhD ethnobotanist, herbalists, acupuncturists

2. American Botanical Council's Monographs on Popular Herbs for Health Professionals

- Accredited by Texas Medical Assn., Texas Nursing Assn., University of Texas
  - College of Pharmacy, American Dietetic Assn.
- CME/CE Course and Reference Book, ca. 400pp.
- 30 Herbs, Therapeutic Monographs w/ Clinical Essentials and Patient Info Sheets
- Inclusion of Researched Herb Combinations
- Inclusion of Branded Herb/Phytomedicine Products subject of published clinical studies

Development of CAM Curriculum in Medical Schools

University of Texas Medical Branch-Galveston CAM Grant from NIH
Victor Sierpina MD -- principal investigator

Recommendations

1. Who should be receiving botanical CE?

All certified healthcare providers who interface with the public in which a working knowledge of the potential risks and benefits of herbs and phytomedicines would be useful and/or essential for the proper delivery of the professional's advice. This includes but should not be limited to many types of physicians (medical and osteopathic), all pharmacists, most nurses, most nutritionist/dietitians, and possibly dentists. In some obvious cases, the need for CME in herbal medicines may be irrelevant to the professional's scope of practice, e.g., a neurosurgeon, an orthopedist, etc. However, in the opinion of many in the herbal community, due to the widespread use of herbal supplements by a significant portion of the adult population, some degree of exposure to appropriate herbal/phytomedicinal instruction should be required for virtually all licensed healthcare professionals, regardless of areas of specialty.

2. Who should be teaching botanical CE?

There are a large number of people who have extensive experience with herbal products, many of whom would probably constitute appropriate instructors in this area. However, one potential drawback here is the fact that many of these people are not trained in conventional medicine. They may be licensed healthcare practitioners in non-conventional fields (e.g., naturopathy). Some of the most knowledgeable people I know in the area of phytotherapy are accredited NDs; others are self-taught herbalists who have extensive experience with medicinal plants. Some have strong clinical experience as herbalists, naturopaths and/or acupuncturists. The potential drawback here might arise when conventionally trained MDs etc. fall prey to professional preferences that might suggest that only MDs (and occasionally PhDs) are qualified to train other MDs. Hopefully, such professional jingoism will not characterize the future of medical education in CAM and botanical medicine, although the historical reasons for this attitude is understandable.

3. What should be taught? How and by whom should the content be determined?

History. In my view, CME/CE courses on herbal medicine should begin with the history of herbs in medicine and pharmacy to remind the practitioner that these fields of conventional healthcare owe their origins to the uses of botanicals as some of the first medicines. Although not directly clinically relevant, a brief general history would be interesting and potentially fun to learn. (Along these lines, I have presented a lecture at Columbia University's Botanical Medicine course for the past five years.)

Regulation. It is also necessary to instruct the professional on the nuances of regulation dealing with botanicals in the U.S. There is too much misunderstanding of the regulatory environment, with the all-too-often repeated phrase "unregulated industry" repeated ad nauseum, without any real understanding of what laws and regulations currently exist. Granted, herbs are not regulated in the U.S. like conventional drugs; this difference is the source of much confusion that bears clarification.

GMP and QC/QA. Another area is the issue of quality control and GMP, and methods for assessing safety and efficacy of herbs. Numerous documents exist that are relevant to these subjects and should be mentioned where appropriate in CE materials.

Therapeutics. Obviously, the appropriate and clinically relevant uses of herbs and phytomedicines need to be included in any comprehensive CE course on herbs. This is the kernel of any course, as it provides the clinically relevant information to the professional. This area includes clinical uses as documented by published trials, meta-analyses, etc. It should also include well-documented case reports from other clinicians. Further, there needs to be instruction on recent findings on safety, including herb-drug interactions and how to distinguish among the varying levels of evidence available that either suggest or confirm an interaction, levels of evidence to support concerns on adverse reactions, and appropriate contraindications. Also, information on appropriate dosage and dosage forms, issues of phytoequivalence to specific proprietary phytomedicinal preparations as reported in published studies, etc.

I have provided a brief outline of the elements of a course I teach at the College of Pharmacy at the University of Texas at Austin. It is found as an addendum to these comments.

4. How should it be taught?

In principle, on-site learning is usually preferable, as it allows the best opportunity for the student (undergrad or post-grad) to be able to interact with the instructor. However, there have been remarkable advances in the area of distance learning, both based on conventional paper-based instruction and electronic modules. A report on CBS' *60 Minutes* this past Sunday dealt with the increasing popularity of Internet-based virtual universities, some of whom, in the opinion of a Columbia University administrator, offered excellent learning opportunities and a strong competitive challenge to traditional on-site university campuses. In an age of increasing educational opportunities via CD-ROM and the Internet, distance learning programs offer excellent opportunities, while lowering costs for the prospective students. This month I observed a new Internet or Intranet-based teaching module developed at Columbia University where professors' course-work and lectures had been put into downloadable formats, complete with video clips and the ability of the student to click on all types of related and ancillary topics displayed on the screen in both text and graphic formats. The prospects for this type of educational delivery are enormous for the instruction of both conventional and CA medicine, including botanical medicine topics.

5. How often should it be taught, e.g. annually or bi-annually? How and by whom should this be determined?

The frequency of instruction in herbal medicine and any professional licensing requirements for annual or bi-annual instruction should be determined by the nature of the professional's specialty. For example, pharmacists – both in retail and health system -- should be required to pass CE material in

herbal medicine on an annual basis. This is needed because the role of the pharmacist is increasingly moving in the direction of clinical counseling on drug safety, potential interactions, etc. Pharmacists need to be kept aware of the latest finding from pharmacovigilance on herbals, including new data suggesting potential safety problems, including new confirmed reports of herb-drug interactions. Additionally, new reports from published clinical studies, critical reviews and meta-analyses on the documented benefits of various herbals will continue to be published in the next decade. Pharmacists and physicians (and to some extent nurses, especially NPs etc., and RDs) will need to be kept aware of the potential benefits of these products, as increasingly documented by new research (or, as in the case of some herbs, new research may cast doubt about various previously held beliefs about some of the purported benefits; example: cholesterol-lowering effect of garlic, *Allium sativum*).

6. What recommendations regarding botanical continuing education should the Commission consider?

As is the case with many other fields of continuing education, there are many providers already producing CE modules for healthcare professionals in the area of herbs and phytomedicines. However, despite their accreditation, there is a potential problem that some of this CE material may include erroneous information.

There should be some form of *appropriate peer review* of CE materials on herbal products. Peer review only by members of a particular profession may not necessarily provide adequate insurance of accuracy. For example, a recent issue of the journal *Pharmacotherapy* published a "White Paper" on herbal medicine in the name of the American College of Clinical Pharmacy. The white paper was co-authored by eight PharmDs, one who is a co-author of a book on herbals for professionals. Presumably, such a document with the gravitas of a "white paper" would be extensively peer reviewed. However, this paper made several errors of fact regarding the regulation of herbs (an area that one does not necessarily expect pharmacists to have expertise), as well as the total misinterpretation of a chemical study used to support the paper's concerns about lack of GMPs for imported Chinese herbal products. The paper cited as an example of "adulteration" of herbs the finding of the brain hormone melatonin in samples of feverfew (*Tanacetum parthenium*), St. John's wort (*Hypericum perforatum*), and Chinese skullcap root (*Scutellaria baicalensis*). In fact, the research cited was a paper published in 1997 showing *naturally occurring* levels of melatonin in these three plants – certainly not the result of adulteration (the act of intentionally adding a foreign substance). It seems clear that the authors and any peer reviewers were not sufficiently familiar with the botanical literature to make this important distinction. Unfortunately, there is a high probability that this paper will become cited as a reference to support the erroneous claim that melatonin is an adulterant in these herbs. I am not aware if this paper was ever approved for CE credit; however, I believe it serves as a good example for the need for peer review of journal articles, books and CE programs by persons who are qualified by experience in the field of botanical medicine. Unfortunately, although the number of such persons is growing, there is still a paucity of such experts.

To attempt to address this situation a group called the Botanical Medicine Academy has joined forces with the American Herbalists Guild to provide guidelines in the professional education of herbal medicine. (BMA consists of trained naturopaths and experienced herbalists; AHG is an herbalists professional group that includes some physicians and other conventionally trained professionals with a strong interest in employing herbs in clinical practice.) While I do not speak for or represent this group (I serve only as an advisory board member of BMA), I believe that some of their concerns are valid and worthy of consideration: There needs to be incorporation of the views of knowledgeable herbal experts into the training of conventional healthcare professionals.

Recommended Reference Materials & Texts

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Basic Course Outline of Herb Course for 5th-Year Pharm D candidates at College of Pharmacy, University of Texas at Austin

"Herbs and Phytomedicines in Today's Pharmacy" (Phr 382 U) (Taught by M. Blumenthal)

1. Current Market Situation and Statistics
   Consumer Trends and Patterns per Surveys
2. History of Herbs in Medicine and Pharmacy
3. Basic Overview of Herbs
   Chemical Complexity
   Types of Herbal Products & Dosage Forms
4. Specific Applications of Herbs per Physiological Systems (e.g., digestive, cardiovascular, neurological, skeletal-muscular, dermatological, etc., as outlined in main course text: Robbers and Tyler's *Tyler's Herbs of Choice: The Therapeutic Use of Phytomedicinals*)
5. Recent Clinical Research on Specific Herbs
6. Legal and Regulatory Issues Affecting the Manufacture, Sale, Marketing of Herbs and Phytomedicines: A review of the regulations governing the manufacturing, labeling, marketing and sale of herbs as OTC drugs and dietary supplements
7. Initiatives for Evaluation of Quality, Safety & Efficacy of Herbs
   International:
   - German Commission E Monographs
   - ESCOP Monographs
   - WHO Guidelines & WHO Monographs on Selected Medicinal Plants

   Domestic:
   - ABC's CME Monographs
   - ABC's Expanded Commission E Monographs
   - American Herbal Pharmacopoeia
   - USPDI

Outline of ABC's Professional Monographs on 30 Popular Herbs

Overview

Includes brief background, geographical origin, history, market status, etc.

Description

Provides description of the crude herb material used in commerce and/or parameters for extracts etc. This is not a detailed botanical description.

Indications

Major and minor indications based on results of clinical trials, general usage documented by published literature, officially approved uses by government review (e.g., German Commission E) and/or uses documented by World Health Organization etc.

Duration of Administration

Periods of minimum or maximum use to ensure efficacy and/or reduce potential adverse reactions.

Chemistry

Brief review of primary chemical constituents, especially those related to the herb's known pharmacology.

Pharmacological Actions

Actions as documented in human, animal, and in vitro research (in three respective sections)

Contraindications

Conditions that are contraindicated for use of this herb, as documented by published reviews, monographs, etc.

Adverse Side Effects

Documented adverse effects from the literature. The clinical significance of some adverse reports is noted when appropriate.

Drug Interactions

Interactions are noted based on a rational hierarchy of evidence, with usually only those reported in humans listed. If other interactions are be listed that are based on animal or in vitro data, or merely speculation, the levels of such evidence are noted.

AHPA Safety Rating

The safety rating as assigned by the American Herbal Products Association *Botanical Safety Handbook* is noted, and in some other cases, some European organizations' assessment are also included.

Regulatory Status in US and Other Industrialized Nations

`Status as a dietary supplement, OTC drug, traditional medicine, etc. is noted in other countries.

Clinical Review

A brief paragraph or two giving an overview of various clinical studies that are summarized in the following table. Comments about reviews, meta-analyses and other relevant observations on clinical trials is included.

Table of Selected Clinical Studies

In some cases all published clinical studies on a particular herb will be summarized in a table; with some herbs in which a significant amount of research has been published, the primary and most recent trials are included. Most tables are divided into various subsections dealing with the primary research parameter of the studies in each section (e.g., cardiovascular, chemoprevention, cognitive, diabetes, immunology, psychomotor response, etc.). The columns of the tables include the author and year, subject, design (including number of subject etc.), duration, dose, preparation (including brand name, if given), results/conclusion.

Brands Used in Clinical Studies

The names of brands of herbs and phytomedicinal products are included in the Table of Clinical Studies, with a section showing the manufacturer, city and country, and a brief description of the product or parameters of the herbal extract.

References

Complete references of all citations are included.

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WHCCAM Commissioners' Briefing Book, February 22-23, 2001 [2]

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

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[001a]

White House Commission on Complementary and Alternative Medicine Policy
February 22-23, 2001

DENISE MURRAY EDWARDS, ARNP, CS, MA, M.ED. M.T.S.
(b)(6) Des Moines, IA 50310
Home Phone: (b)(6) Work Phone: (515) 440-6286
Fax :515 440-6293 e-mail: murrayda@ihs.org
Member Oncology Nursing Society

The Oncology Nursing Society (ONS) supports the concept of patient centered care based on the ethical principle of respect for autonomy. ONS states that "within a level consistent with physical, psychological, and spiritual capabilities and their value system, the client and family participate in care and ongoing decision-making." [1] Within the 28,000 membership, there has been an interest in increasing knowledge of complementary interventions as well as skills training in select modalities. Educational sessions are offered at annual meetings because of the desire of oncology nurses to acquire knowledge that was frequently absent in their professional education. Today's health care professional must be familiar with CAM interventions in order to take a meaningful health history and to collaborate with the patient in making treatment decisions. Since Eisenberg's 1993 article, it is difficult for any clinician to remain unaware of the utilization of CAM interventions by the general population of this country. [2] Without understanding the nature and consequences of CAM interventions, the provider cannot provide culturally competent care.

Education (1) of Consumer

Across the United States, undergraduate nursing programs are uneven in depth and breadth in teaching CAM interventions. When nursing students do not receive their CAM information through formal education, they remain as vulnerable as any other consumer does to the abundance of misinformation in this area. There is a tendency for faculty to teach what they know. This results with a continuum ranging from no CAM content to programs such as the University of Minnesota with eleven CAM electives available to students. Interest will drive students to seek esoteric knowledge but they need to be aware of CAM intervention appropriate for specific symptoms to provide basic care to today's patient. An example would be using the low risk and inexpensive option of acupuncture for pain management. It is not logical to put resources into instruction involving pain management without discussing non- pharmacological options. Inherent in knowing that a patient is using complementary supplements with allopathic medicines is the responsibility to give good information about potential areas of harm including drug interactions. Several strategies would need to be initiated to improve the quality of CAM education.

- Develop Core Curriculum for all professionals
AHCPR - Models - Pain Mgt
Guidelines

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(1) Develop a core curriculum at the national level to be supplemental to content areas currently studied by health care practitioners. It would not need to be discipline specific. A model for this is the AHCPR quick reference guide for the Management of Cancer Pain. [3]
(2) Assess regional concerns about CAM practices that need to be addressed at the local level. For example, although I currently live in the Midwest, most of my practice has been in Boston. I was surprised to learn that a number of individuals were unable to participate secondary to religious reasons, in the infertility groups and cardiac rehabilitation groups offered at The Center for Health and Well-Being because we incorporated yoga. Their spiritual concern was of such magnitude that these potential clients could not participate in any programs at the Center. That may well have been an issue when I practiced at the Dana Farber Cancer Institute but I didn't think to ask the question and the Institute wasn't offering that service to patients at the time.
(3) Integration of CAM content has been under discussion for several years by nursing faculty and one area of concern is faculty competency. Funded opportunities need to be available for faculty to develop expertise in this area. An analogous model would be the weeklong seminar at the Kennedy Center for Ethics at Georgetown. The goal of this program is not to create ethicists but to develop informed graduates with a framework for discussion based on specific principles. A comparable program in teaching CAM interventions would eliminate the potential barrier of faculty recruitment prior to implementation of an integrated curriculum.
(4) The usual methods of testing with the inclusion of relevant questions on the RN State Board Examination would hold students accountable for this new information.

Interdisciplinary electives should be available to students in all academic levels who choose to increase the depth of their knowledge regarding CAM interventions. Discussion of CAM would be a natural fit to a course on psychological and physiological responses to stress and would be the focus of a course on medicinal use of herbs. Many colleges are tailoring courses for adult learners and providing courses free of charge or at a minimal fee to seniors. What a wonderful opportunity this could be to educate providers and consumers in the same classroom. For several years, I was faculty for a course, Ethics in Medicine, offered by Harvard Divinity School and Extension. Much of the richness of this course was the interaction of the divinity students, health care practitioners and interested lay adults from the community. Adoption of this model would broaden the experience of students and provide direct information about the acceptance level of CAM interventions among the community.

Nursing education progresses from the generalist to the specialist level. On the graduate level, the students have more flexibility in their schedules and may choose to learn skills appropriate to the individuals' scope of practice. An essential component of skills training must be emphasis on the importance of comprehensive documentation. Nurses frequently tell me that they do not document CAM interventions in the patient record. There are a number of understandable reasons for this practice. Rationales vary from fear of ridicule to concerns that documentation of CAM interventions may jeopardize third party reimbursement. However, we have to be accountable to the patient and the

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institution for ethical and legal reasons. In addition, if we are to offer evidence-based care, we need to systematically record each intervention and record outcome data.

Continuing Education

(1) For practicing clinicians, it is essential to include information in professional continuing educational programs on current complementary practices as well as supplements used by consumers. Again, I recommend an interdisciplinary approach. Financial resources are becoming a problem for nurses and may be a barrier to access. In many institutions, there is no longer any funding or time allotted to continuing education. There is an emerging role for creative Internet usage.
(2) Education should not be limited to health care workers. It would be wonderful to see nursing faculty offering CAM education to the community. The consumer needs to be educated to access services that are currently available only if they say the magic words. If my clients use functional phrases such as relaxation breathing or muscle relaxation, access to care is quickly denied To open the benefit door, they have to learn medicalese and talk the DSM language labels such as anxiety and depression. It is appropriate for me to use those labels after I have assessed the client because it is the common language of medicine and alerts other professionals to the diagnostic implications. It is not appropriate to expect a consumer to describe the problem or what they think would help using medical terminology.
(3) Insurance providers need to and can be educated about efficacy and cost containment. I recently heard a case manager for an insurance company say to a group of oncology nurses that talking to an insurance gatekeeper should not be compared to "sleeping with the enemy". It was clear to her that she was not being cast in the role of Julia Roberts. She went on to say "many of us are reasonable people who care about patients". Research needs to continue and be made available to those insurance providers who currently deny access for clients lacking adequate financial resources for self-pay. It is ironic, as medicine moves toward a more collaborative model of care, that rank strangers often render the final decisions regarding who provides the care and where that care takes place.
(4) It is no longer a reasonable expectation that clinicians will be familiar with all FDA approved medications let alone a panoply of herbs and supplements. We will need to rely on computer programs that will supplement our knowledge. CAM providers must be participants in groups that are preparing electronic updates on drug interactions and vigilant in incorporating new data as it emerges from clinical trials.

Training

An example of a comprehensive training model has been developed by the Colorado Center for Healing Touch (HT). Included in the curriculum are didactic and demonstration modules, extensive documentation in a yearlong mentorship program and comprehensive return demonstrations. A student must complete the entire process to

attain certification. Additional training is required before the certified healing touch practitioner (CHTP) can instruct others. The consumer can identify the nationally recognized practitioner by the use of these initials after the name. Healing Touch leaders encourage HT research, regularly publishing study results in the HT newsletter, refereed journals and presenting research findings at annual meetings. Healing Touch can serve as an exemplar for other modalities. The rigor and specificity of the training allows for the development of a standard of care for a reasonable practitioner in a specific field. National certification provides a starting place for the consumer seeking care from a competent practitioner.

Quality and Accountability

One of the casualties of the current managed care model is the almost overnight disappearance of supervised practice. JCAHO sets the stage for those of us connected to institutions to have an opportunity to be in the same room with our peers on a regular basis. However, productivity has pride of place in the current culture of health care administration. That reality necessitates an emphasis on alternative methods of monitoring including but not limited to mentoring, entry-level criteria, credentialing, licensure and health systems policy.

Mentoring – As mentioned earlier, to become a healing touch practitioner, the learner is required to find a mentor who will act as role model and supervisor for a year. This model, long encouraged in nursing, has gained prominence in the development of oncology nurses. For example, ONS, in partnership with the American Journal of Nursing and Rhone-Poulenc Rorer funded a writer/mentor program, which included publishing articles on complementary therapies.

Entry-level criteria – For many CAM training programs, there exists no mechanism for screening applicants. I would encourage leaders to require demonstration of competence before allowing students to progress to the next level. At this moment, it appears that having the financial resources is the entry criteria in many situations. I was pleased at a recent Reiki training to hear the instructor tell the group that she would tell them if they were not ready to move on.

Credentialing – The approach taken by The Center for Health and Well-Being seems most reasonable. The practitioner is held accountable for having the required education to achieve the certification and to continue the education to maintain competence. The position description contains the scope of practice in that institution.

Licensure – Licensure is a common, established monitor. A problem remains for practitioners who are not members of established professional disciplines. Nonetheless, to create an environment in which an allopathic provider is comfortable making a referral, there must be a recognized standard body of knowledge and a method of indicating that the practitioner has acquired that knowledge. An example is Aromatherapy. According to

my colleagues in that field, there is no standard body of knowledge. Therefore, there is no way to assess the competency of the practitioner and consequently, no protection for the consumer i.e. the practical purposes of licensing.

Health Systems Policy – To integrate a CAM program into an existing institution, staff must be willing to participate in policy development, participate in discipline selection involving both inclusion and exclusion, assist in determining scope of practice and contribute to the development of quality monitoring and evaluation. To do these things, communicates responsible confidence that we truly have effective treatment to offer.

Exemplar

Two Centers of Excellence should be established in diverse geographical locations to provide excellent CAM interventions and to provide week- long internship programs to be available to both practitioners and administrators.

Conclusion

I have made many comparisons between CAM and the discipline of ethics because I see CAM existing in a place similar to that occupied by ethics ten years ago. Including ethics content in education on a variety of levels has brought ethics into the awareness of practitioners, shifting it from a mere disciplinary arm of professional practice to a model for supporting families and helping resolve ambiguity. The one essential piece that has made an enormous impact, is the role of JCAHO in requiring a format for ethics discussion. It seems a logical progression that the Joint Commission will require CAM interventions be a part of the informed consent process. In fact, ethical principles would lead practitioners to incorporate that information without coercion. The model in health care in the past has been to create a supply of practitioners and resources and worry later about the demand for their services. The health care consumer has already spoken. It is time to respond to consumer demand by creating the supply of CAM practitioners so those patients can improve the quality of their lives while remaining safe from harm.

[1]D.M. Fletcher, *Unconventional Cancer Treatments: Professional, Legal and Ethical Issues,* 19 Oncology Nursing R 1351 (1992).

[2]David M. Eisenberg, *Unconventional Medicine in the United States- Prevalence, Costs, and Patterns of Use,* 328 New Eng. J. Med. 246, 249 (1993).

[3]U.S. Department of Health and Human Services, Clinical Practice Guidelines, *Management of Cancer Pain: Adults*, Number 9, AHCPR Publication No. 94-0593, March 1994.

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DENISE MURRAY EDWARDS, ARNP, CS, MA, M.ED. M.T.S.
(b)(6) Des Moines, IA 50310
Home Phone: (b)(6) Work Phone: (515) 440-6286
Fax :515 440-6293 e-mail: murrayda@ihs.org

BIO

EDUCATION:

1996 & 1993	Georgetown University Medical Center - Advanced Bioethics Course V & IV
1981 - 1987	Harvard Divinity School-MTS Ethics
1974 - 1975	The University of Iowa, College of Nursing, Iowa City, IA. MA Psychiatric/Mental Health Nursing
1970 - 1973	Boston State College - M.Ed. - Counseling and Guidance
1962- 1966	Boston College - BS. Major: Nursing / Minor: Philosophy
1976	Certificate of Award Primary Care for Faculty in Baccalaureate Nursing Programs
1979 - Present	Certification for Nursing Practice As a Clinical Specialist in Psychiatric and Mental Health Nursing
1998-Present	Iowa Certification to Practice as an Advance Nurse Practitioner (ARNP)
1997 & 1996	Healing Touch, Level I & IIB with Mildred Freel
1998	Healing Touch, Level IIA with Sharon Scandrett-Hibdon
2000 & 2001	Reiki, First Degree & Second Degree with Paege Culver

PROFESSIONAL WORK EXPERIENCE:

1999-present	**Nurse Practitioner** **The Center for Health and Well-Being** **Iowa Health System** **2929 Westown Parkway, West Des Moines, IA 50265**
1999-1999	Coordinator – Psychiatric Community Outreach Program VA Central Iowa Health Care System, Des Moines, IA 50310-5774 Leader National Nursing Ethics Advisory Group, VA Member National VA Bioethics Committee Ex-Officio Psychoneuroimmunology SIG ONS
1993 - 1999	Coordinator - Psychiatric Consultation Liaison Service Chairperson - Bioethics Committee Leader - Patient Rights and Organizational Ethics Council VA Central Iowa Health Care System, Des Moines, IA 50310-5774
1982 - 1993	Psychiatric Clinical Nurse Specialist, Dana-Farber Cancer Institute
1985 - 1993	Faculty - Medical Ethics, Harvard Divinity School and Extension, Cambridge, MA
1979 - 1982	Independent Private Psychotherapy Practice
1979 - 1982	Assistant Professor, Simmons College, Boston, MA
1981 - 1982	Geriatric Nurse, Don Orione Home, East Boston, MA
1978 - 1979	Assistant Professor, The University of Iowa, College of Nursing
1975 - 1978	Instructor - University of Iowa, College of Nursing, Iowa City, IA
1969 - 1974	Director, Student Health Service, Graham Junior College, Boston, MA
1968 - 1969	Staff Nurse - Medical and GYN, Lawrence Memorial Hospital, New London, CT
1966 - 1968	Charge Nurse - Medical and Labor Delivery Area, U.S. Naval Hospital, Chelsea, MA, and SubMedCenter, New London, CT

SELECT PUBLICATIONS:

Peteet, J.R., Abrams, H.E., Murray Ross, D., Stearns, N. "Presenting a Diagnosis of Cancer: Patient's Views." Journal of Family Practice, Vol. 32 No. 6, 1991.

Peteet, J., Stomper, P., Murray Ross, D., Cotton, V., Truesdell, P., Moczynski, W. "Emotional Support for Cancer Patients Undergoing Computed Tomography: Results of Semi-Structured Interviews of Patients at a Cancer Institute." Radiology, Vol. 182 No. 1, January 1992.

Murray Ross, D., Peteet, J., Medeiros, C., Ricker, P., Walsh-Burke, K., "Difference Between Nurses' and Physicians' Approach to Denial in Oncology." Cancer Nursing, 15 (6), December 1992.

VIDEO: Finding Your Way: Managing the Discomfort of Treatment, Fanlight Productions, 1989; CINE Golden Eagle; Bronze-Columbus International; Cum Laude-Medikinale Parma; Bronze-British Medical Association; Festival International Film Medical Mauriac

PRINCIPAL INVESTIGATOR:

"Behavioral Training Interventions for Acute Procedural Pain in Adolescent and Adult Cancer Patients." Research supported by National Cancer Institute under CCOP Research Base NCI Grant #CA37428, Cancer Control Division.

WORKSHOP PRESENTATIONS:

1977- Present Numerous Presentations on Ethics and Complementary Interventions.

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Sue South, Director, Associate Fellowship, Program in Integrative Medicine, The University of Arizona

Ms. South is the Director of the Associate Fellowship in the Program In Integrative Medicine at The University of Arizona. Sue brings to the program an extensive background in adult education including structural program development and design, curriculum development, and teaching. Ms. South graduated magna cum laude from The University of Arizona with a Bachelors of Science degree in Family Studies emphasizing relational interaction and group dynamics and earned a Master of Arts with honors in Educational Psychology presenting a thesis concentrating on the integration of adult learning theory with instructional design and retention issues. Ms. South is currently a doctoral student in Educational Psychology with a focus on instructional design of distributed learning programs for adults. Sue has extensive experience designing and consulting on professional education programs for a variety of adult audiences and is often invited as a consultant and guest lecturer speaking on instructional design and delivery methods. Prior to joining the Program In Integrative Medicine, Sue was the Coordinator of Employee & Organizational Development at the University of Arizona, where she designed, developed and delivered professional programs for administrators, faculty and staff at The University of Arizona.

Program In Integrative Medicine
Department of Medicine
College of Medicine

THE UNIVERSITY OF
ARIZONA®
HEALTH SCIENCES CENTER

PO Box 245153
Tucson, Arizona 85724-5153
(520) 626-7222
FAX (520) 626-6484
Clinic (520) 694-6555

Program in Integrative Medicine
The University of Arizona

Oral Testimony for the
White House Commission on Complementary & Alternative Medicine Policy

Susan E. South, M.A., Director, Associate Fellowship
Andrew Weil, M.D. Program Director

The Program in Integrative Medicine at the University of Arizona began in 1996 with a vision. Dr. Andrew Weil had long believed that reform and a redesign of medical education was necessary to meet both the needs of physicians and health care professionals, and the demands of an increasingly more educated patient population. Dr. Weil, and a consortium of his colleagues committed to this vision, assembled to design the framework for a curriculum in integrative medicine and develop strategies for offering a comprehensive education to health care providers. This work resulted, initially, in a few continuing medical education offerings for health care professionals and then in the establishment of an outline for a comprehensive curriculum in integrative medicine. In this curriculum, philosophical foundation subjects such as Philosophy of Science, Medicine and Culture, Art of Medicine, Research Education, Lifestyle Practices, Spirituality, Mind Body interaction, Nutrition, and Physical Activity were included as well as several therapeutic systems and modalities such as Botanicals, Manual therapies such as osteopathy and massage, Chinese Medicine, Homeopathy, and Energy Medicine.

The program then evolved to offer a 2 year residential fellowship in which 4 physicians were competitively selected each year to relocate to Tucson to study with Dr. Weil and other integrative and CAM practitioner faculty. This education focused on the acquisition of knowledge, the clinical practice of integrative medicine and development of leadership skills. The residential fellowship, currently in it's fifth year, emphasizes an active and experiential learning process in which skills and knowledge are applied to clinical care and management practices, which in turn, prepares graduates to assume leadership positions in integrative medicine. This model consists of didactic sessions, discussion groups, a consultative clinic experience with patients, and patient care conferences which include practitioners from various modalities assembled in one room to discuss and contribute to treatment plans for patients.

In addition to the residential Fellowship, a Research unit within the program was established. The objective of this unit emphasizes development of relevant evaluation tools, measurement of effectiveness of educational activities, and enhancement of clinical decision-making of integrative providers. The Research staff also provides

education for residential Fellows including individual and group mentoring, instructional sessions, and facilitation of journal club.

Lessons learned from the residential Fellowship allowed us to refine the curriculum and develop new instructional models based in adult learning theory and grounded in a philosophy of self-care and a strong sense of community. We knew that educating just 4 physicians per year for clinical and leadership positions in integrative medicine was not meeting the demand of physicians seeking an education in integrative medicine, meeting public demand for practicing integrative physicians, nor forwarding the field in integrative medicine on a large scale. Additionally, we knew that many physicians were not able, for various personal, professional, and financial reasons to relocate to Tucson for a 2-year fellowship. It was then that the concept of a distributed education in integrative medicine evolved so as to accomplish several goals. First, it would increase the number of physicians being educated. It would allow physicians to immediately integrate the learning into their medical practices. And, it would forward the agenda of the integrative medicine movement on an international scale. But most importantly, it would allow for thousands of patients to experience healing-oriented medicine through relationship-centered care with their physician.

This new educational concept, named the Associate Fellowship, is a 2 year educational experience delivered primarily over the web but also using a variety of other media such as video, audio, printed material and texts. The Associate Fellowship requires the physicians to spend 8-10 hours per week in study totaling approximately 1000 hours of instruction over the course of the 2 year program. The structure also requires the Associate Fellows to attend 3 separate residential weeks in Tucson. These residential weeks allow the Associate Fellows to learn and practice skills together, meet and collaborate with faculty and residential fellows in person, and build a sense of community among colleagues who share similar philosophies. In the Associate Fellowship, physicians learn about the philosophy, practice, and integration of care through an active and interactive delivery model. Associate Fellows read texts, printed materials, and peer reviewed journal articles, engage in interactive exercises on the password-protected internet site, participate in threaded dialogues with faculty, experts, practitioners, and other Associate Fellows, complete case studies and clinical scenarios modeled after the patient care concept introduced in the residential Fellowship, and conduct field trips, interviews, and other practical activities that emphasize integration of the learning into their personal lives as well as into their active practices. One of the most important objectives for Associate Fellows is to experience behavior change. By integrating the learning with practical application, we consistently present opportunities for Associate Fellows to challenge their beliefs and behaviors and make resolutions for change. As a result of this design, Associate Fellows are reporting that after only 6 months in the program they are changing the way they practice medicine. For example, one physician reported that he spends twice as much time now as before in counseling patients on nutritional concepts.

The Associate Fellowship is a unique educational experience in several ways. The learner-centered approach places emphasis on a balance between delivery of a structured education in integrative medicine with a self-directed and self-explorative

process in which the physician is both encouraged and challenged to seek out new knowledge independently and in groups, and address his/her own misconceptions and paradigms about medicine and their role as a healer. For example, Associate Fellows recently completed an assignment in which they selected and examined, in small groups, a therapy which was considered "on the fringe" of conventional medicine. They had to find literature about the therapy, examine its uses, discuss indications and contraindications and share findings with other groups of Associate Fellows on line. What resulted was a collection of informed dialogues about various fringe therapies that now serve as a resource to which Associate Fellows can refer, as well as a sense of pride of ownership that the database was co-created by the entire group. Assignments such as this result in the creation of a bank of knowledge and data virtually impossible to create by any one person, and also in the establishment and maintenance of a sense of community among participants, the cornerstone of the Associate Fellowship. Building this sense of community allows participants to share knowledge, exchange ideas, debate constructively and gain confidence in a safe and supportive "virtual" environment. Although distributed learning programs historically have high attrition rates, we believe that our community-based approach will maintain persistence and add to the richness and retention of the educational experience. And so far, we believe it is working. Seven months into this inaugural class, we remain at 100% enrollment. However, without hard data to challenge our assumptions and inform our decisions about the future of the program, we could not be, nor prove ourselves, successful. Therefore, we created a comprehensive evaluation plan that allows us to examine and analyze participant and patient characteristics and demographic data, acquisition of knowledge, integration of the learning into clinical practice, program structure, curricular design, and satisfaction with the educational experience from various viewpoints. We have developed evaluations for each on line module, constructed survey instruments that evaluate physician attitudes and practices, and designed patient satisfaction measurements. And since most of the activity in the program is completed on line, the data are easily extractable from our database.

This entire instructional design, we believe, is highly effective in delivering this education, and requires a diverse team of professionals to administer. The staff consists of 10 professionals combining their unique talents in producing the program. The team consists of instructional design specialists, content experts, a medical editor, web design technologists, and program coordinators. In addition, the team works with dozens of content providers, reviewers, and faculty from all over the world and depends greatly on the contributions of dedicated volunteers. For example, we have been honored to have been able to work with renowned experts such as Rachel Naomi Remen, Marty Rossman, and Jon Kabat-Zinn. Each curricular area is coordinated by a development team that works with faculty and content providers to produce the curriculum for delivery on the web. This concept requires that content experts and faculty provide an education often very different from previous teaching experiences. Faculty members are expected to be "facilitators of learning" rather than simply teachers. They assist the development team in the design of interactive exercises and group projects, as well as providing textual content. Faculty also participate on line with Associate Fellows by seeding dialogues with philosophical questions and statements about the curriculum creating opportunities for sharing of knowledge and experiences.

Although the Associate Fellowship is still in it's infancy, we believe we are building a solid foundation, backed by positive feedback, thus far, from Associate Fellows, integrative physicians, content experts, and patients, for developing additional educational offerings to other health care providers. We would be honored to share our success and learning with you and therefore, invite you to visit us at the University of Arizona to examine and gain a more personal understanding of our educational philosophy and practices. With experience and learning from the residential Fellowship and evidence & support from the program's research initiatives, we believe the Associate Fellowship is an excellent model of a comprehensive education in integrative medicine delivered in an innovative and community-based environment.

For more information about the Associate Fellowship, visit our web site at:
http://integrativemedicine.arizona.edu/af

Overview of Associate Fellowship

The Associate Fellowship is presented as **Foundations**, **Elements** and the process of **Integration**.

Foundations of Integrative Medicine

Learning the philosophical basis of integrative medicine is the primary focus of Foundations and is the heart of integrative medicine. The 6 Foundations are as follows:

Healing Oriented Medicine
Focuses on the nature of the body's healing system; healing versus curing

Medicine & Culture
Teaches the origins and development of conventional medicine as well as other major systems of healing and anthropological perspectives

Philosophy of Medicine
Addresses the philosophical heritage and current structure of the sciences

Spirituality & Medicine
Discusses the spiritual dimension of human life and its relevance to health, illness and healing

Art of Medicine
Reflects on the doctor as a facilitator of healing

Ethics
Introduces and discusses the ethical issues associated with being a health care professional

Elements of Integrative Medicine

Foundations and Elements coupled together prepare the health care practitioner for a transition into an integrative medicine practice. Elements are broken down into the 3 major following categories:

Clinical Elements:

Nutritional Medicine
Explores the contribution of diet to health and disease

Botanical Medicine
Identifies a basic repertory of botanical remedies with known safety and efficacy

Mind/Body Medicine
Addresses the scientific basis of mind/body interactions; a critical review of existing therapies; the role of the mind in health & illness

Supporting Elements:

Research Education
Helps Associate Fellows master critical thinking & appraisal of research; how to find & assess existing research and evaluate its significance

Integrative Medicine & Law
Helps Associate Fellows understand the legal implications and issues associated with a practice in integrative medicine

Medicine, Leadership & Society
Provides the basis for examining the administrative aspects of practicing integrative medicine

"Dicuss & Refer" Elements:

The Associate Fellowship provides a broad overview of the following modalities in order to prepare the health professional to discuss options with patients and refer to other practitioners:

Homeopathy
Chinese Medicine
Manual Medicine
Energy Medicine

Integration

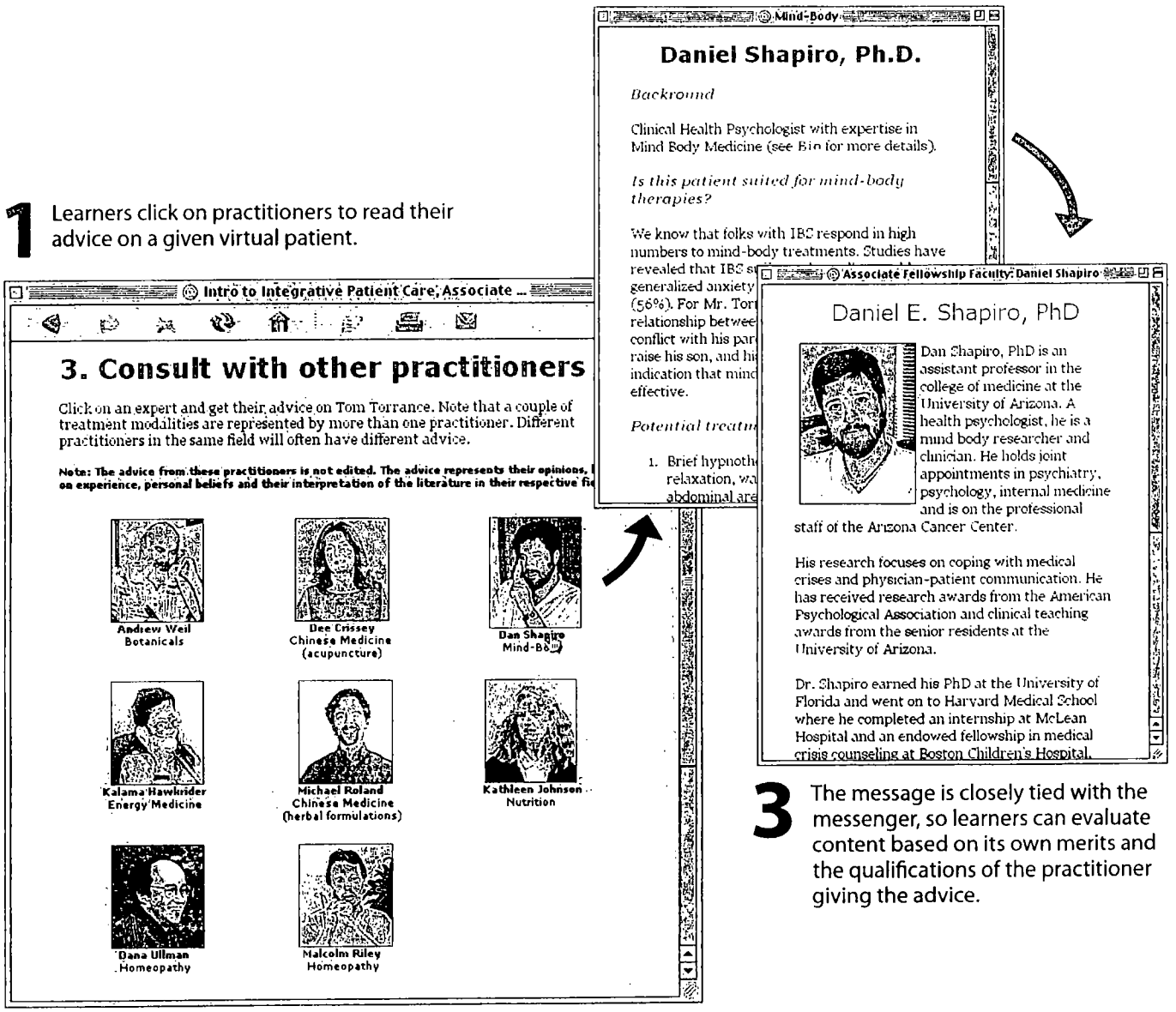
The real challenge for the health care professional is integration of the **Foundations** and **Elements** to form an integrative medical practice. The Asscíate Fellowship goes beyond simply teaching complementary and alternative medicine. It addresses the unification of the philosophy, techniques and practical applications of integrative medicine with the personal values, beliefs and commitment of the health care provider into new ways of approaching their own lifestyle and medical practice.

The next few pages demonstrate major features of the Associate Fellowship's instructional design. 

Advice from recognized experts

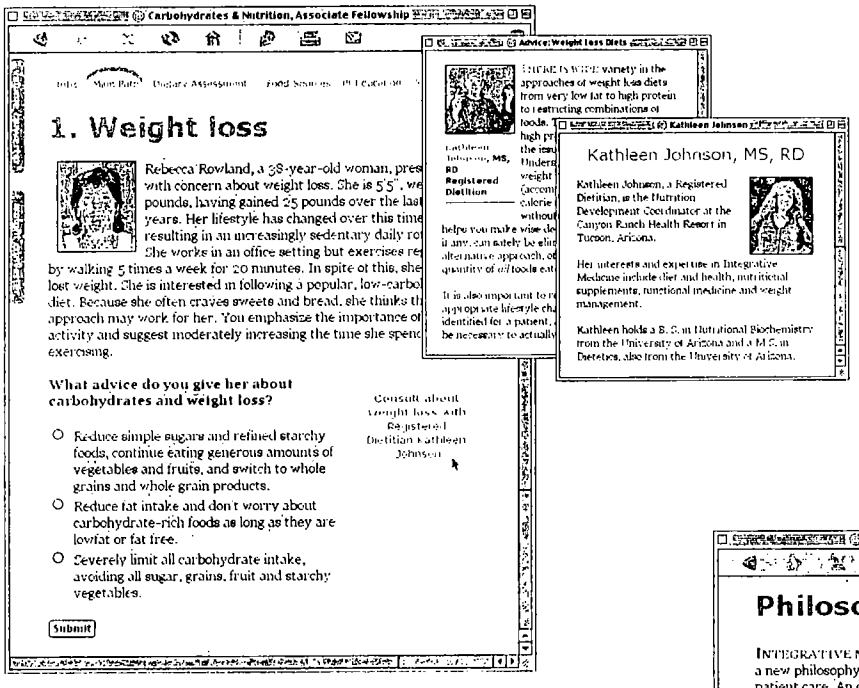
1 Learners click on practitioners to read their advice on a given virtual patient.

2 Practitioner advice is targeted and prioritized, based on the practitioner's professional experience and interpretation of the literature.

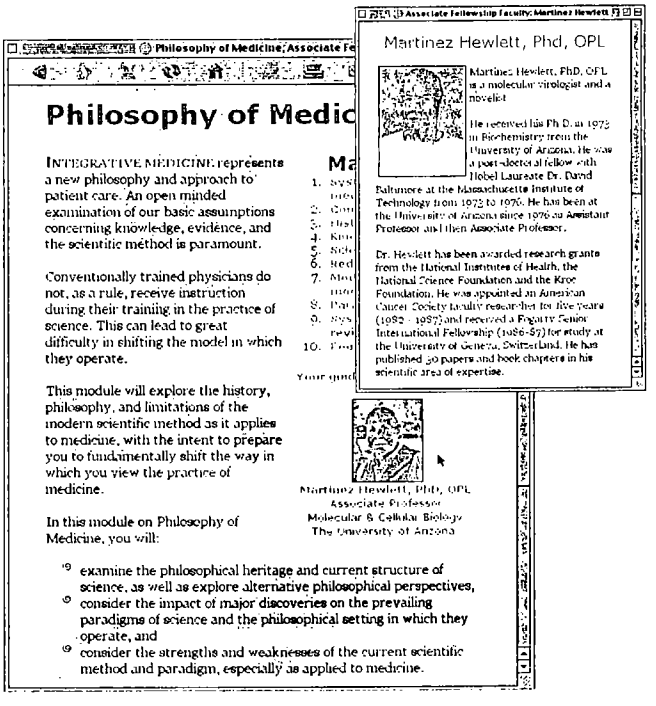


3 The message is closely tied with the messenger, so learners can evaluate content based on its own merits and the qualifications of the practitioner giving the advice.

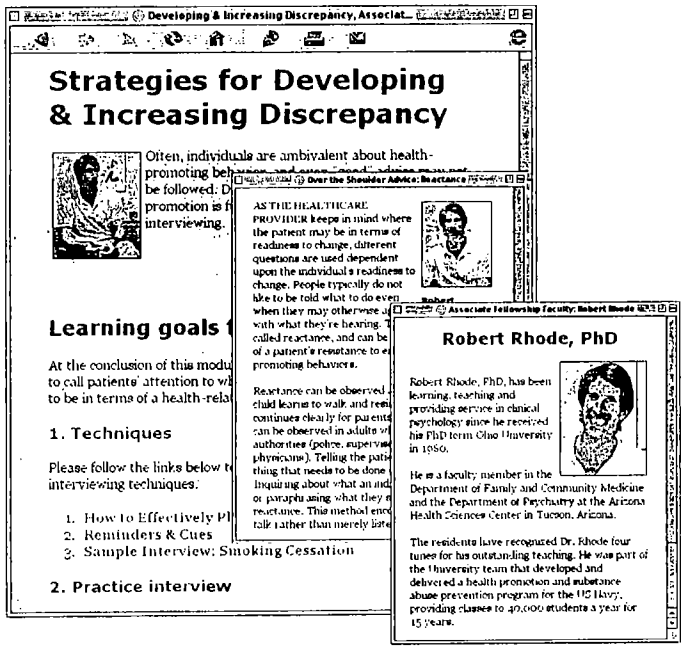
Over-the-shoulder advice from experts accompanies clinical vignettes designed to introduce specific topics.



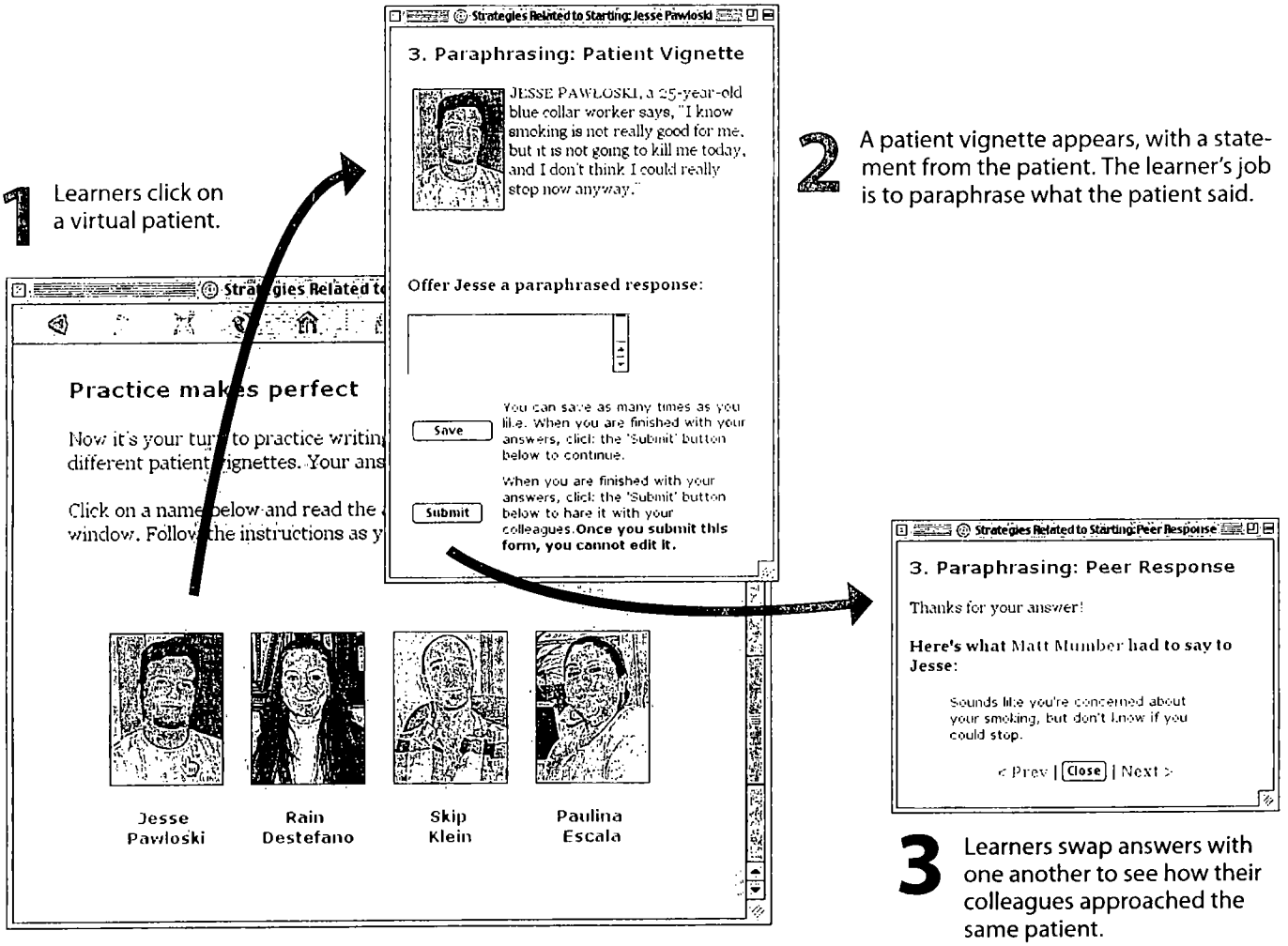
Faculty experts serve as guides to different topic areas, crafting the learning experience for the audience and moderating web-based dialogues.



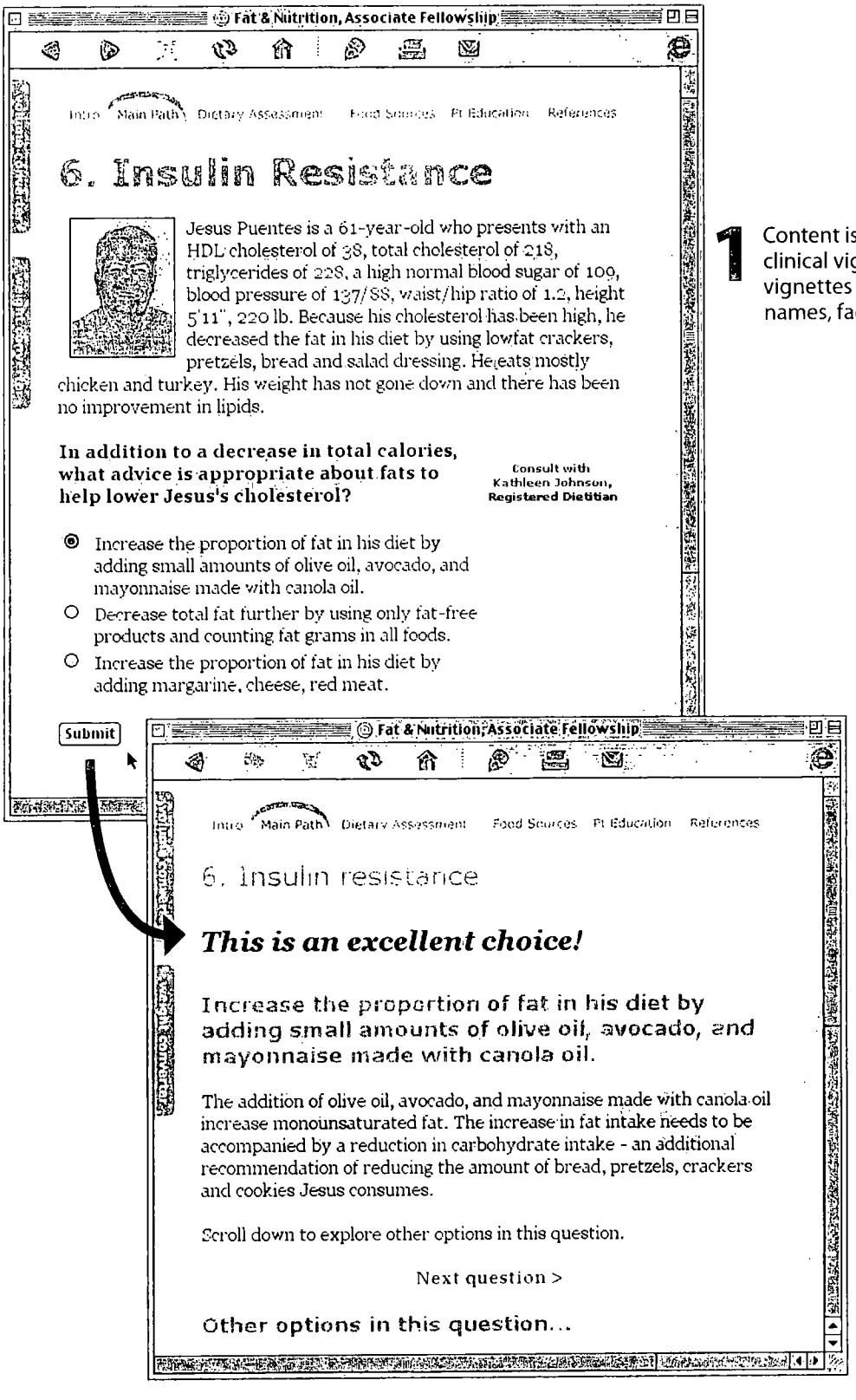
Content is always closely tied to the qualifications of the expert guide.



Clinically-relevant content



3 Learners swap answers with one another to see how their colleagues approached the same patient.

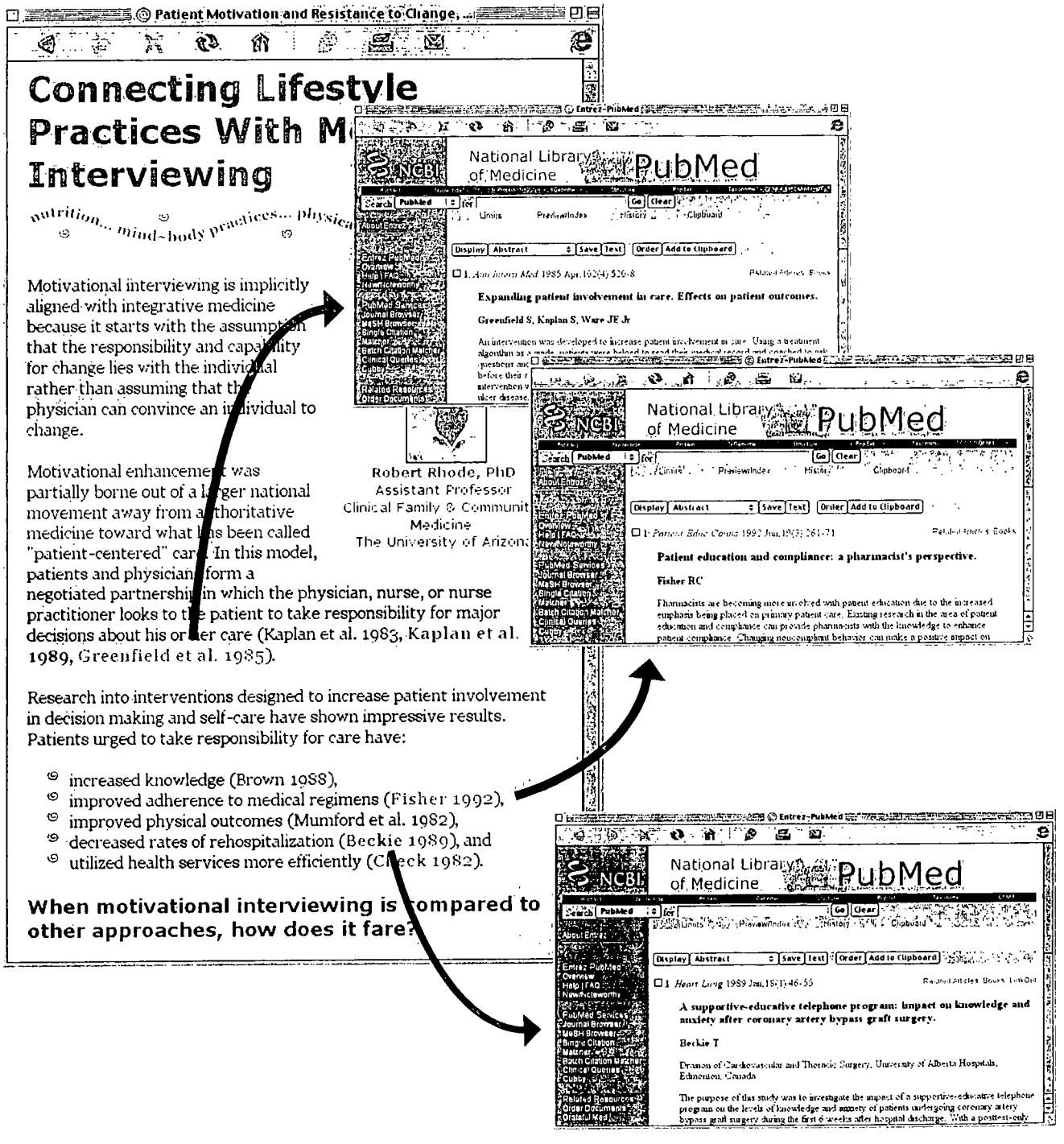


1 Content is introduced in the context of clinical vignettes. Virtual patients in these vignettes are designed to be realistic, given names, faces and personal characteristics.

2 Multiple choice questions are used as learning tools, with immediate, customized feedback. Learners who know the content move more quickly through learning modules than those who need to learn or review.

Emphasis on Evidence

Alll content is closely tied to the medical literature. LIterature citations link to Medline abstracts when available.



Physicians develop information-gathering skills by applying clinical questions to different resources for evidence. The example on this page shows a Bandolier report on peppermint oil and irritable bowel syndrome.

Intro to Integrative Patient Care: Associate ...

4. Information-gathering strategies

Once you have a feel for what questions to ask about a particular therapy, you can start searching for answers. Asking colleagues for advice and consulting references on your bookshelf are obvious places to start.

Denice Warren

Information on the Internet is often more up-to-date than other resources, and, if you're comfortable with searching, it can be a very efficient process.

On this page, you'll work with simple clinical qu
briefly explore three types of Internet resource

1. Medline database of the medical literature
2. evidence-based collections
3. web search engines

1. Medline database of medical al

Question: Do Chinese herbs help IBS symptom

To answer: Go to the PubMed site and search `bowel Chinese` Experiment with the search results differ.

http://www.ncbi.nlm.nih.gov/PubM
PubMed is National Library of Medicine's resource for searching MEDLINE and othe
MEDLINE contains citations in the medical to 1966.

2. An evidence-based approach

Question: How effective is peppermint oil in de symptoms?

To answer: Go to the Bandolier site and sear `oil`

www.jr2.ox.ac.uk/Bandolier/
Bandolier is an online journal resource of evidence-based reviews, searchable by subject or individual journal issue. Much of this data is presented in easy-to-use and interpret charts and tables.

3. Searching the web

Question: Energy medicine practitioner Kalama Hawkrider mentioned a therapy called "Bach's Rescue Remedy." What is that, anyway?

To answer: Go to the Google search engine and search for `Bach's rescue remedy`

Bandolier Home Page

Bandolier — **Evidence-based health care**

new stuff

Bandolier December 2000 (#82)

- thinking time directive (Onslow's law)
- Washing hands reduces hospital-acquired infection
- Genital wart treatments
- Melatonin for jet lag?
- Cancer Test 'Holy Grail'?
- Meeting Announcements
- Bandolier's 10 steps to healthy living
- web essay - medical waste

What's new this month

under the skin

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- Allergy, asthma and respiratory disorders
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- Gastrointestinal
- Genetics
- Healthy living
- Management
- Men's health
- Mental health
- Migraine
- Neurological

search entire site

©Bandolier, 05-Dec-2000
Tel: +44 1865 226132
established 1994

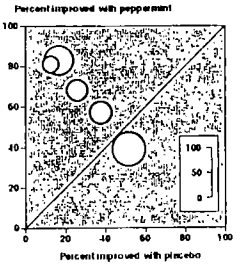
Peppermint oil for irritable bowel syndrome

Findings

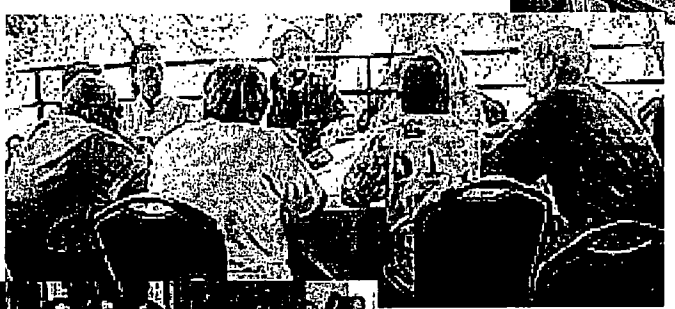
Five trials were included in the meta-analysis. Diagnostic inclusion criteria were not always reported. Doses were 0.2 to 0.4 ml three times daily, and treatment period ranged from two to four weeks. Three of five trials showed significant benefit of peppermint oil for global improvement of symptoms, based on the odds ratio. Combined odds ratio showed significant benefit (figure not reported), with a chi-square of p < 0.001.

For doses of 0.2 to 0.4 ml three times daily, relative benefit suggested significant benefit over placebo for global improvement in symptoms over two to four weeks. Relative benefit 2.1 (1.5 to 2.8), and NNT 3.1 (2.3 to 4.9)

Figure: L'Abbé plot of trials comparing peppermint oil for IBS symptoms with placebo

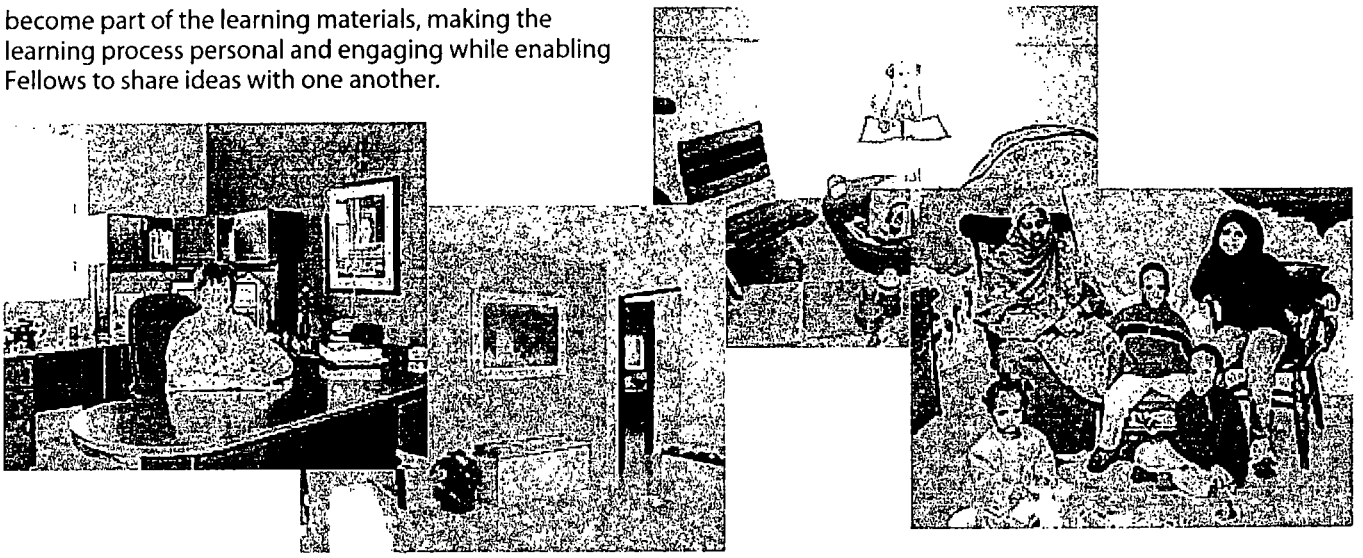


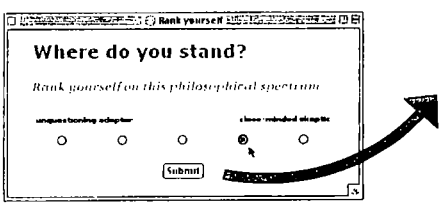
Community of Learners

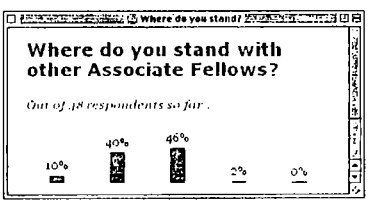


Associate Fellows meet for three one-week residential sessions during the course of the two-year program. The community developed in this real-world environment is then maintained and enhanced through technology-mediated learning experiences when the Fellows return home.

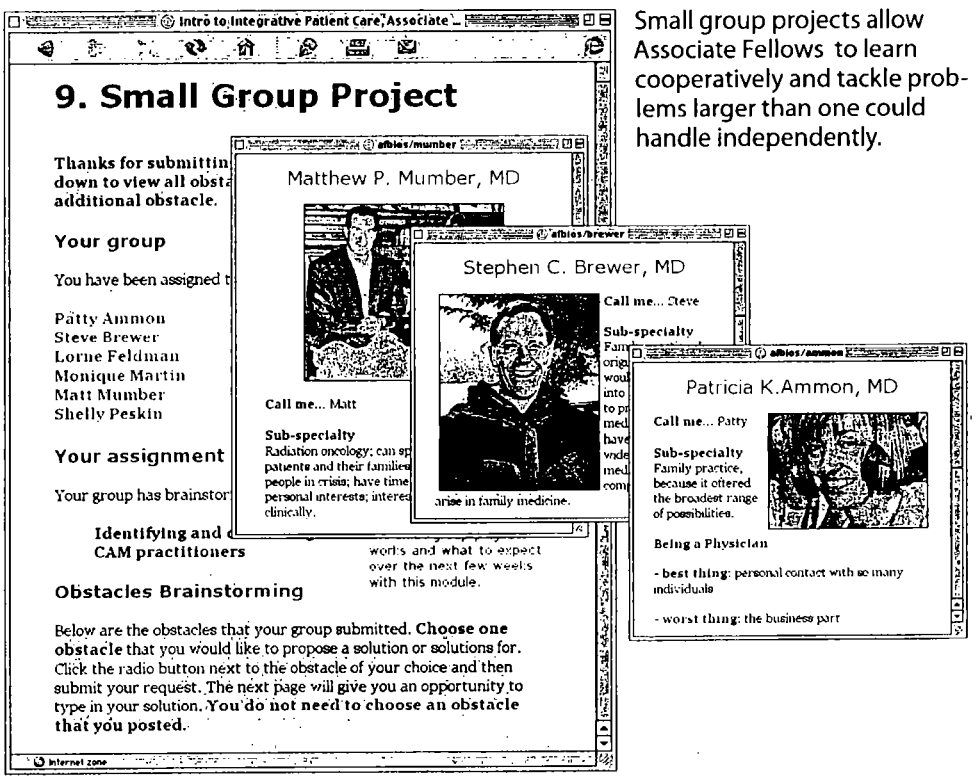
Photos of Associate Fellows' clinic environments become part of the learning materials, making the learning process personal and engaging while enabling Fellows to share ideas with one another.







Opportunities for self-reflection and sharing of viewpoints with colleagues are woven throughout the curriculum.



Small group projects allow Associate Fellows to learn cooperatively and tackle problems larger than one could handle independently.

What the Fellows have to say...

About the Associate Fellowship In General

"I can't tell you how much I am learning from and enjoying the fellowship. My only patient in the office here this morning had the benefit of some integrative suggestions, and I am using it with residents as well. I recently gave a talk at a Physician's teaching day entitled "Putting technology at the service of the physician/patient relationship. Integrative medicine received a prominent part in some solutions to our health care crisis."

"Great news!!! The Rockefeller foundation has recommended that my Wellness Center be funded for a year operating. costs. This means that I get to hire a holistic nurse practitioner, and plan for patient evaluations in the format of integrative medicine evaluations!! Finally a chance to practice what we've been learning. "

"I am definitely enjoying the AF. It is a joy and a privilege to be able to communicate with others of like mind. Either-or, it's a wonderful life of opportunity with integrative medicine. "

"Do you know this is just the most amazing learning experience? I can't believe how wonderful it is to learn all these new ways of thinking. The motivational interviewing lessons are so valuable, the nutrition information is all things we were never taught... I just think you guys are amazing! Thanks! "

"I am really enjoying the material - this fellowship has rekindled such a wonderful spirit for medicine. Thanks again! "

About the Residential Week

"I have attended many workshops and courses in my career. I have to say, yours was about the best organized and run that I have seen. Congratulations."

"I just wanted to tell you what a great experience "first week" provided. I think you guys created a wonderful sense of family, and started the healing process for all of us...which was so badly needed. We are very fortunate to have such great people as our leaders and mentors for the next two years."

"Thank you so much again for a wonderful week! Already looking forward to next year."

About the Staff

"The staff has wonderful energy and a commitment to the program. "

"Unbelievable dedication and responsiveness."

"The staff is 100% consistently wonderful -- and that is hard to do."

About the Web Design & Content

"I enjoyed the feeling of shock when my medical school answer regarding epilepsy was "wrong". It made the point very experiential and succinct. Also, it was fun to read the other explanations in their contexts."

"Good interactive questions with responses as if it were direct dialogue."

"I'm using the material in other [nutrition] modules to try to do nutritional counseling for my patients. I estimate that the total amount of time spent doing nutritional counseling has more than doubled since beginning this program. (A small success for the good guys!)"

"...your web site is awesome. I show it off to friends."

"Needless to say, I think you are all doing a fantastic job! I am slowly learning so many thing! My favorite so far is the MI module, because that is so new for me, and I'm still trying to figure out how to do it in pediatrics, with families. I hope to take a workshop and maybe get more practice that way."

About Technical Support

"Thanks for the quick response. You all are fantastic! The web site is phenomenal!"

"Your web site diffuses anxiety about the technological aspect of the Associate Fellowship."

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Kopelow

Divider Title: _____

Murray Kapelow
ACCME

We will need to work on procedure for
ED and ICARE.
Invitation to next

Memorandum

To: President's Commission on Complementary and Alternative Medicine

From: Murray Kopelow MD MSC FRCPC

Chief Executive, Accreditation Council for Continuing Medical Education

Date: February 8, 2001

Re: Complementary and Alternative Medicine

Thank you for you January 31, 2001 **e**-mail in which you requested material about continuing medical education with which to inform the Commission's meetings of March 22-23, 2001.

The ACCME was created in 1981 by the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, Association of American Medical Colleges, Association for Hospital Medical Education, the Federation of State Medical Boards and the Council of Medical Specialty Societies. The *ACCME Constitution and Bylaws (1981)* state,

> *"The purposes of the ACCME shall be to promote, develop, and encourage the development of principles, policies, and standards for continuing medical education; to relate continuing medical education to medical care and the continuum of medical education; to apply these principles, policies, and standards in the accreditation of institutions and organizations offering continuing medical education, and to deal with such other matters relating to continuing medical education as are appropriate."*

The mission of the ACCME is,

> *"The identification, development, and promotion of standards for quality continuing medical education (CME) utilized by physicians in their maintenance of competence and incorporation of new knowledge to improve quality medical care for patients and their communities.*
>
> *The ACCME fulfills its mission through a voluntary self-regulated system for accrediting CME providers and a peer-review process responsive to changes in medical education and the health care delivery system."*

The ACCME manages its national system for accreditation of CME providers through the direct accreditation of over six hundred and fifty institutions and organizations. In

addition, the ACCME reviews and recognizes fifty state or territorial medical societies as accrediters state based institutions and organizations with programs of CME activities. There are over two thousand providers accredited within the national ACCME system.

Eligibility for accreditation by ACCME is established in ACCME policy which in part reads,

> *"An organization, group or society desiring accreditation must document its capacity to carry on the education of physicians in a medical or medically related field and must document in its adopted policies a commitment to continuing medical education. Continuing medical education activities shall be distinguished from activities which are promotional or appear to be intended for purposes of creating familiarity with a specific commercial product.*
>
> *To be eligible for accreditation, a sponsor must offer a program of continuing professional education for physicians. An organization is not eligible to apply for accreditation if its program is devoted solely to advocacy of a modality of diagnosis or treatment which is not a subject for instruction in most medical schools.*
>
> *An organization is not eligible to apply for accreditation if, in the judgment of the ACCME, its program is devoted to the advocacy of unscientific modalities of diagnosis or therapy."*

	<u>ACCME Response</u>
The Commission asked: What is the status of CAM in continuing medical education (CME)? To what extent is CAM included in CME curricula? 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 CME curricula?	*The ACCME does not maintain a database of the content of CME activities produced by providers with ACCME accreditation.* *ACCME directly evaluates activities at the time of accreditation only in order to determine compliance with ACCME requirements. (see Appendix 1)*
The Commission asked: What are the barriers (resources, expertise, interest) to inclusion of CAM in CME curricula? Conversely, what are the incentives for inclusion of CAM in CME curricula?	<u>Barriers</u>*: As for all "regulatory" requirements ACCME eligibility and accreditation requirements can act as a barrier-to-entry as well as to retention for any CME provider, irrespective of the content delivered by the CME program of that provider.*

ACCME does not have the information inquired about by the Commission in Questions 3, 4, 5 and 6.

In its 2000 strategic planning process the ACCME decided to " *innovate and develop a new, continuously improving and evolving ACCME accreditation system - addressing the content of CME activities, the educational methodology used, as well as learner competency-based criteria...*" To this end ACCME has established a Task Force to evaluate and make recommendations on the ACCME's approach to eligibility and accreditation with respect

to the content of the continuing medical education activities presented by providers with ACCME accreditation. The Task Force is expected to complete its work during 2002.

I have attached a document describing the ACCME requirements, descriptive data concerning the CME enterprise in the United States as well as the ACCME eligibility requirements.

Thank you for requesting ACCME's input into your Commission's deliberations.

A SYSTEM FOR ACCREDITATION OF PROVIDERS OF CONTINUING MEDICAL EDUCATION

GENERAL

PURPOSES OF ACCREDITATION

The major purposes of accreditation are to ensure quality and integrity of accredited providers by

- Establishing criteria for evaluation of educational programs and their activities,
- Assessing whether accredited organizations meet and maintain standards,
- Promoting organizational self-assessment and improvement, and
- Recognizing excellence.

THE ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION (ACCME) MISSION STATEMENT

The **ACCME's Mission** is the identification, development, and promotion of standards for quality continuing medical education (CME) utilized by physicians in their maintenance of competence and incorporation of new knowledge to improve quality medical care for patients and their communities.

The **ACCME** fulfills its mission through a voluntary self-regulated system for accrediting CME providers and a peer-review process responsive to changes in medical education and the health care delivery system.

RESPONSIBILITIES

The primary responsibilities of the ACCME are to

- Set and administer standards and criteria for providers of quality CME for physicians and related professionals,
- Certify that accredited providers are capable of meeting the requirements of the Essential Areas,
- Relate CME to medical care and the continuum of medical education,
- Evaluate the effectiveness of its policies,
- Assist providers in continually improving their programs, and thereby
- Assure physicians, the public, and the CME community that CME programs meet the ACCME's criteria for compliance with the Essential Areas.

ACCREDITATION STATUS AVAILABLE WITHIN THE ACCME SYSTEM

Status	Term
Accreditation with Commendation	Six years
Accreditation	Four Years
Provisional Accreditation (For Initial Only)	Two years
Probation	Two years maximum with full accreditation status resumed when progress report on correction of deficiencies received, validated, and accepted by the ACCME
Nonaccreditation	Accreditation withheld/withdrawn for noncompliance

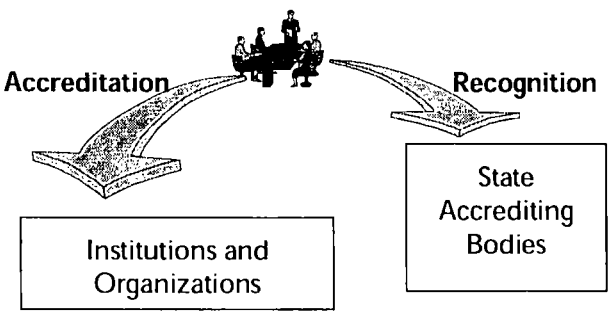
THE ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION

GENERAL

The ACCME conducts a voluntary accreditation program for institutions and organizations providing continuing medical education (CME). By evaluating and granting accreditation to an institution or organization whose CME program complies with the ACCME's Essential Areas and policies, the ACCME seeks to improve the quality of CME and to assist physicians in identifying CME programs that meet these standards.

The ACCME establishes its direction from the organizations or constituencies that are its members who have a professional interest in the **competence of physicians** or the **competence of the CME providers.**

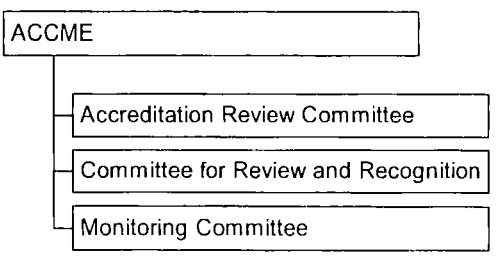
FUNCTIONS AND OVERSIGHT



The ACCME provides the direct **accreditation** of CME providers whose programs of CME attract a national audience (more than 30% of participants in the overall program come from beyond the state/territory or contiguous states/territories).

The ACCME, through its **recognition** process, recognizes state or territorial medical societies to accredit CME providers whose target audience is restricted to that state/territory and contiguous states/territories.

These functions are managed on behalf of the ACCME by the **Accreditation Review Committee (ARC - accreditation)** and the **Committee for Review and Recognition (CRR - recognition)**, with ACCME staff support and ACCME oversight. The Accreditation Review Committee (ARC) collects, reviews, and analyzes data from multiple sources about compliance with ACCME Essential Areas and policies; notes program improvements; and makes a recommendation to the ACCME for their final decision about accreditation of an applicant/provider. The Committee for Review and Recognition (CRR) makes the determination of compliance about recognition on behalf of the ACCME. To be recognized by the ACCME, a state medical society (SMS) must meet the requirements for recognition as determined by the ACCME. ACCME/CRR surveyors are tasked with collecting the data required by ACCME to make a recognition decision. CRR has the responsibility of collating and interpreting the information and arriving at a criterion-referenced recognition decision.



All providers within the ACCME system will be judged against the same standard. Accreditation decisions made by ACCME and those made by state medical societies will be made using the same basic requirements as described in this document.

To ensure quality and consistency in the accreditation system (accreditation and recognition), the Monitoring Committee will measure the success of the accreditation system through its assessment of compliance on the part of the providers during their accreditation.

The ACCME will review the ACCME's Essential Areas and policies on a continuing basis and will modify them as data and experience dictate.

DEFINITION OF CONTINUING MEDICAL EDUCATION

Continuing medical education consists of educational activities that serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public.

Providers can develop activities on their own (directly sponsored) or in collaboration with non-accredited providers (jointly sponsored). The use of the appropriate ACCME accreditation statement will indicate the relationships of the providers involved and which provider is accountable to the ACCME for the content, quality and scientific integrity of the activity.

ELIGIBILITY FOR ACCREDITATION

Institutions and organizations located in the United States and its Territories and developing and/or presenting a program of CME for physicians on a **regular and recurring** basis will be considered for eligibility to apply for accreditation by the ACCME system, either directly by the ACCME or through a recognized state accrediting body. An organization is not eligible to apply for accreditation if, in the judgment of the ACCME, its program is devoted to advocacy on unscientific modalities of diagnosis or therapy. The ACCME system reserves the right to make decisions on eligibility for accreditation. Where there is a question of eligibility, the applicant will be referred to the ACCME who will make a decision on the eligibility of the applicant.

The ACCME is the body that accredits the following institutions for the provision of CME (when and if they choose to seek accreditation)

- State medical societies,
- Liaison Committee for Medical Education (LCME)-accredited schools of medicine,
- National physician membership organizations
- National medical specialty societies and
- Certain other eligible institutions and organizations, as determined by ACCME in collaboration with the applicable state accrediting body, whose programs of CME serve physician learners, more than 30% of whom are from beyond the home or contiguous state(s) of the provider.

The ACCME does not accredit individual CME activities, but does accredit institutions or organizations based on their implemented overall program of CME. The overall program consists, at least in part, of one or more educational activities that have been developed in accordance with the Essential Areas and policies and are available for review by ACCME.

ACCME'S APPROACH TO ACCREDITATION

The ACCME system (ACCME and the recognized state medical societies) collects, reviews, and analyzes data for three Essential Areas: Purpose and Mission (Purpose), Educational Planning and Evaluation (Process and Assessment), and Administration (Structure).

- The **Purpose and Mission Area** describes *why* the organization is providing CME.
- The **Planning and Evaluation Area** explains *how* the organization provides CME activities and how well the organization is accomplishing its purpose in providing CME activities.
- The **Administration Area** defines *what* the organizational support and protocol are for the CME unit.

  Within each Essential Area are required *Elements* for which decision-making *Criteria* have been established.

- The **Elements** are descriptors of performance in the Essential Area.
- The **Criteria** describe the levels of performance and/or accomplishment for each Element.

To make accreditation decisions, the ACCME and the recognized state medical societies will review the data collected for the three Essential Areas to determine if the provider is in compliance with a basic level of performance. This process is repeated at the end of every term for accredited providers and more frequently where monitoring suggests possible areas for improvement.

THE ESSENTIAL AREAS AND THEIR ELEMENTS

The ACCME recognizes that the professional responsibility of physicians requires continuous learning throughout their careers, appropriate to the individual physician's needs. The ACCME also recognizes that physicians are responsible for choosing their CME activities in accordance with their perceived and documented needs, individual learning styles, and practice setting requirements and for evaluating their own learning achievements. The Essential Areas and policies, therefore, are designed to encourage providers to consider the needs and interests of potential physician participants in planning their CME activities and to encourage the physicians to assume active roles in the planning process.

In the Essential Areas and policies the ACCME has identified certain Elements of structure, method and organization which contribute to the development of effective continuing medical education. The Essential Areas and policies are the requirements that a provider must meet for accreditation. They provide a valuable resource for physicians planning their own CME and for providers designing CME activities and programs.

[Please refer to the separate "Essential Areas, Elements, and Decision-Making Criteria" document for the full text of the new requirements.]

CRITERIA

Measurement criteria have been developed for each *Element* in the *Essential Areas* to measure whether the accredited provider meets the basic level of accreditation. **A provider's documentation of the measurement criteria will be the ACCME's primary source of information for determining compliance with the Elements.**

The following classification of compliance will be used

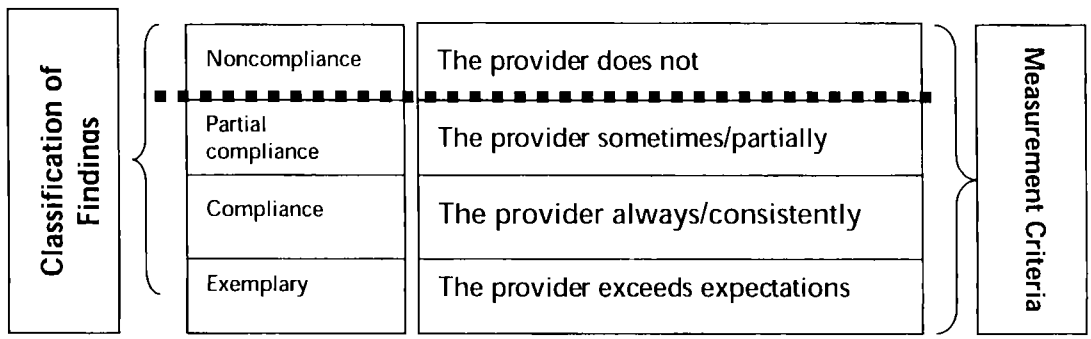
- Noncompliance
- Partial Compliance
- Compliance
- Exemplary Compliance

[Please refer to the separate "Essential Areas, Elements, and Decision-Making Criteria" document for the full text of the new criteria for decision-making.]

ACCME's Criterion-Referenced Approach to Accreditation

Essential Area X

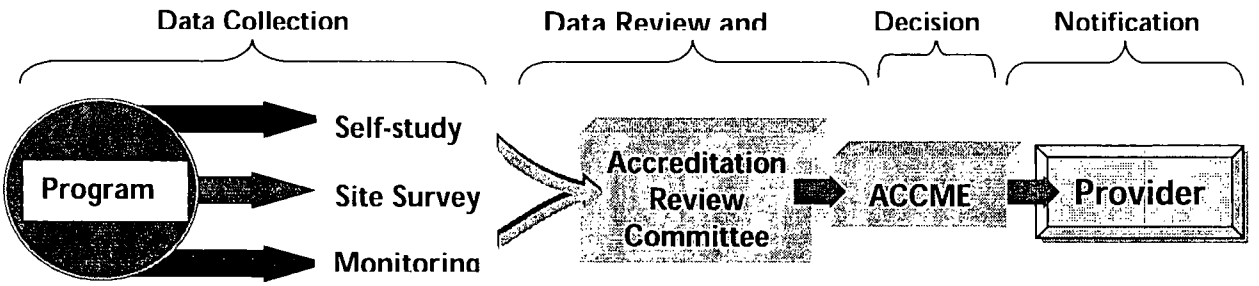
Element x.y: In the course of provision of CME, the provider will...



THE ACCREDITATION PROCESS: HOW THE ACCME DIRECTLY ACCREDITS PROVIDERS

ACCME'S PROCESS OF ACCREDITATION

The process of accreditation and reaccreditation is data-driven and uses multiple data sources. It involves four phases: data collection, data review and analysis, decision, and notification of the provider.



DATA COLLECTION

The applicant/provider is responsible for providing descriptive data about its CME program. The ACCME is responsible for receiving, clarifying, and analyzing the data provided so that valid inferences and reliable decisions can be made based on accurate and complete information. Three data sources will be used by the ACCME to accomplish its purposes and responsibilities. These include:

1. Application/Self-study allows ACCME to document accomplishments and improvements.
2. Site Survey
   a) Organizational Review allows ACCME to determine responsibility for the CME program.
   b) Document Review allows ACCME to assure appropriate documentation.
   c) Activity Review allows ACCME to review application of the Essential Areas.
3. Annual/Interval Monitoring Report allows ACCME to note changes in the program.

Initial Accreditation

1. Review of potential applicant's qualifications, experience, and appropriateness will occur when initial inquiry is received.
2. Applicant will be asked to complete an application.
3. Application will be reviewed/screened to determine completeness of application.
4. Opportunities for additional data collection through survey and activity review will be arranged.
5. For applicants that are already state accredited, continued ability to joint sponsor during provisional accreditation will be assessed.

Reaccreditation

1. At an appropriate time prior to the end of the accreditation period, the provider will be notified of a need to submit self-study to the ACCME.
2. Six months prior to the end of the accreditation period, the provider will submit the self-study to the ACCME and data collection opportunities will be arranged.

For Initial Accreditation and Reaccreditation, the ARC site surveyors will review the Application or Self-study data prior to the site visit. During the site survey, the surveyors will have as their goal to ensure that the ARC has complete and accurate data on all Elements of the Essential Areas and policies that can be accessed through the organizational and document reviews. In Reaccreditation, Annual Reporting/Monitoring data and Activity data will be available for review by the ACCME.

DATA REVIEW AND ANALYSIS

All data collected from the application/self-study, annual reporting/monitoring summaries, and the site visit (organization, document and activity reviews) will be reviewed and analyzed by the ARC to make a recommendation to the ACCME for a final decision. To make the recommendation, the ARC will review compliance with each Element in the three Essential Areas.

Criteria for Selection of an Accreditation Status

1. To achieve provisional accreditation, the applicant must be found in partial compliance or better in all Elements.
2. For accredited providers seeking full accreditation from provisional or reaccreditation from full accreditation, noncompliance with any element will result in the requirement for a progress report[1] and/or focused or full survey. Failure to demonstrate compliance in the progress report may result in probation.
3. For accredited providers seeking full accreditation from probation, noncompliance with any one of the Elements will be cause for nonaccreditation.

MAKING ACCREDITATION DECISIONS

The ARC will review data from the three sources and make a recommendation to the ACCME.

The ACCME will make the final decision about accreditation based on its careful review of the ARC recommendation.

A decision could be one of five options: Accreditation with Commendation, Accreditation, Provisional Accreditation, Probation, or Nonaccreditation, and will be criterion referenced (based on predetermined criteria).

[1] Requirements for follow-up on areas where change or improvement is necessary. The Council may ask for a written submission during the period of accreditation that describes the progress that the accredited provider has made in changing its program so that marginal or noncompliant practices improve. This structured, written submission is called a **Progress Report**.

NOTIFICATION OF THE PROVIDER

Within four weeks of the ACCME decision on an accreditation application, the ACCME will send a letter of notification of action to the applicant/accredited provider. The letter will include the following:

- Decision of the ACCME regarding status of the provider,
- Areas where provider exceeds compliance,
- Areas of noncompliance or partial compliance, and
- Requirements for follow-up in areas where change or improvement is necessary.

ACCREDITATION FOLLOW-UP

THE PROGRESS REPORT

Purpose

To communicate information about the changes accomplished by the accredited provider to validate its compliance with the Essential Areas and Elements that were perceived in partial compliance or noncompliance during the most recent accreditation review.

Format

This structured report will include the following:

- Listing of the Essential Areas and Elements that were partial or in noncompliance on the last review.
- Indication of changes made to correct or improve the Essential Areas, Elements, or Standards.
- Documentation providing evidence that changes have been made.

The Progress Report will be reviewed by ARC, which will formulate a decision recommendation that will be forwarded to the ACCME for a decision.

Decision Criteria

The same criteria for each Element in the Essential Areas will be used to assess the progress reports.

Decision Options

The Accreditation Council has the following options:

Accept: If the Progress Report is accepted, the provider has corrected the elements that were partial or in noncompliance.

Clarification Required: If the Progress Report requires clarification, the provider has corrected most of the elements that were partial or in noncompliance, but some additional information is required to be certain the provider is in compliance. An additional Progress Report may be required.

Reject: If the Progress Report is rejected, the provider has not corrected the elements that were partial or in noncompliance. Either a second report or a focused accreditation survey may be required. The ACCME will retain the right to place a provider on probation or nonaccreditation as the result of findings on a Progress Report.

THE FOCUSED ACCREDITATION SURVEY

Purpose

To collect data about a specific problem that has been reported or has not been corrected as a result of the Progress Report.

Format

A trained surveyor, who has been briefed about the condition that needs to be reviewed, will conduct a one-day visit. The problem will be reviewed with the provider and the provider will have an opportunity to present evidence that the condition has been changed/corrected and that the provider is now in compliance or has a plan to reach compliance. The surveyor will conclude the visit with a summary of what was learned to be sure that the provider's position can be reported accurately to the ACCME.

Decision Criteria

Same as Accreditation. Findings are reported in the context of "*exceptional compliance*" through "*not in compliance.*"

Decision Options

Same as Accreditation. A provider can have its accreditation status changed to probation as a result of a focused survey.

THE DATA SOURCES

	Goals	Objectives	Format
APPLICATION / SELF-STUDY	The application/self-study is the foundation for the accreditation process. The goals of the application/self-study are to provide an opportunity for the applicant or accredited provider to assess its commitment to and role in providing CME, analyze its past practices, identify areas for improvement, and determine its future direction.	• Analyze data collected about what, why, and how the CME program and its products and services are utilized, • Assess how well they are performing, and • Identify changes and improvements to be implemented to be a successful provider in the future.	How the self-study is accomplished is the responsibility of the provider. The report should address the goals and objectives noted earlier and the Essential Areas and Elements. A "Guide for the Self-study" with key questions for review and study by the provider will be available. The "Guide" will assist the provider in assessing its program thoroughly and preparing a report for use by the ACCME in its decision for reaccreditation.

	Goals	Objectives	Format
SITE SURVEY	The goals of the site survey are to gather data about administration, documentation, and practice; if appropriate, to verify and clarify compliance with the Elements in all Essential Areas and to recognize excellence whenever present.	• To give the providers the opportunity to clarify the information supplied in the application/self-study and demonstrate the adequacy of their administrative support and resources, which are in place to support the CME unit. • To give the ACCME the opportunity to audit documentation, ensure that any specific documentation required by the ACCME is present, and ensure that they have sufficient information about the provider and/or the applicant's educational program with which to formulate a report to the ACCME.	The format involves interviews between the representatives of the CME organization and the ACCME surveyors. The opportunity for document and activity (optional) review will exist. Components of the site survey generally include the following • Introductory Session • Meeting(s) with CME Principals/Administration /Physician CME Leadership • Document Review • Activity Review, when possible • Exit Interview • Tour of facilities

	Goals	Objectives	Format
DOCUMENT REVIEW (Part of the Site Survey)	The goal of the document review is to gather data about compliance with accreditation Essential Areas and Elements by accredited providers.	• Determine whether there is documentation to support that activities have been planned, presented, and evaluated in compliance with the Essential Areas and Elements, and in the manner that the provider has represented its CME practices; • Assess that specific documentation that is required by ACCME policy is present.	The ACCME will select a list of the activities on which a document review will be based. The providers will be notified to have the activity files available during the site visit. The provider also may be requested to have other documentation of compliance with ACCME policy available during the site visit.

	Goals	Objectives	Format
ACTIVITY REVIEW (May be part of the Site Survey)	The goal of the activity review of an applicant/accredited provider is to gather data about the application of the Elements in all Essential Areas that can only be measured through the direct observation of an activity. This will allow the applicant/provider to demonstrate performance in practice.	• Document compliance with those criteria of the ACCME Essential Areas and Elements that can only be measured by the observance of a live activity. • Get clarification from the applicant/accredited provider on questions that might arise as a result of observing the activity.	Normally the Activity Review is conducted at the same time as the site visit, but may be scheduled at an independent time from the site visit, if necessary. The process of the Activity Review includes • Direct observation of a live activity and its components, • Interview with staff of the applicant/accredited provider as required, • Completion of an Activity Review Form by the ACCME Surveyor.

	Goals	Objectives	Format
ANNUAL REPORTING AND MONITORING	The goal of the annual reporting and monitoring process is to gather data about the changes within an accredited provider's program and within the population of accredited providers.	• Provide an opportunity for providers to report on progress of changes and improvements in their programs. • Collect standardized data about the products, services, and processes of all accredited providers. • Receive feedback on the issues of accreditation that should be reviewed and improved.	Information will be exchanged through an annual *questionnaire* that can be completed and delivered on paper or electronically. Individual provider data will be maintained in a confidential manner. Information collected about an organization during the complaint and inquiry process will also be included.

ACCME'S RECOGNITION PROCESS

For information on the Recognition Process for State Medical Societies, please contact the ACCME.

RELEVANT ACCREDITATION POLICIES

Please see the separate Accreditation Policy Compendium for a full listing of relevant ACCME accreditation policies.

Size of the CME Enterprise Presented by ACCME Accredited Providers - 1999

Directly Sponsored	Activities	Hours	MD's	Non-MD's
Courses	23,194	200,280	1,262,682	820,233
Regularly Scheduled Conferences	12,027	273,014	1,722,784	426,335
Internet (Live)	168	854	9,744	23,106
Internet (Enduring Materials)	627	3,285	48,576	3,944
Other Enduring Materials	2,503	23,748	481,532	115,893
Journal CME	840	4,431	265,342	40,812
Total	**39,359**	**505,610**	**3,790,660**	**1,430,323**

Jointly Sponsored	Activities	Hours	MD's	Non-MD's
Courses	4,949	48,217	308,693	256,876
Regularly Scheduled Conferences	2,081	26,572	161,723	53,276
Internet (Live)	26	168	3,081	741
Internet (Enduring Materials)	191	728	18,155	2,353
Other Enduring Materials	423	3,605	121,709	12,986
Journal CME	100	546	32,177	3,950
Total	**7,770**	**79,836**	**645,538**	**330,182**

Grand Total	**47,129**	**585,446**	**4,436,197**	**1,760,504**

Eligibility

81-B-02 In order to be eligible for accreditation, the institution or organization must be located in the United States or its Territories. The ACCME limits site survey visits to the United States and U.S. Territories.

81-C-05 An organization is not eligible to apply for accreditation if, in the judgment of the ACCME, its program is devoted to advocacy of unscientific modalities of diagnosis or therapy.

81-C-06 Where there is a question of eligibility for survey, the application will be referred to the ACCME Executive Committee which will consider it and make a recommendation to the ACCME which will then vote upon the eligibility of the applicant.

82-B-04 Definition of an Organization Eligible for Accreditation

The ACCME, in an attempt to foster continuing medical education of high quality at reasonable cost, available to all physicians in the United States, specifies the following criteria of eligibility for accreditation: Institutions and organizations which are surveyed and accredited directly by the ACCME are generally defined as follows: state medical societies, schools of medicine, and other institutions and organizations providing continuing medical education activities on a regular and recurring basis and serving registrants, more than 30% of whom are from beyond bordering states.

Institutions and organizations not eligible for accreditation directly by the ACCME should seek accreditation from the state medical society (or state accrediting body in states where the medical society does not accredit alone) in the state in which they have their headquarters or in which they provide CME activities.

To be eligible for accreditation, a provider must offer a program of continuing professional education for physicians. An organization is not eligible to apply for accreditation if its program is devoted solely to advocacy of a modality of diagnosis or treatment which is not a subject for instruction in most medical schools whose programs of medical education are accredited by the Liaison Committee on Medical Education

The ACCME reserves the right to make decisions on eligibility for accreditation. (amended 7/98)

83-A-04 An organization applying for survey at its initial CME activity should be advised that it is very difficult to demonstrate its ability to comply with the Essential Areas, Elements and Policies until after at least one event has been completed. However, if the organization still wishes to proceed with an on-site survey during their first CME offering, the ACCME will comply. In order to complete the process, the organization must provide documentation of subsequent evaluation and of its use in planning future CME activities, before the ARC will consider the application.

94-C-02 Policy and procedure on dual accreditation:

A single provider of continuing medical education may not maintain accreditation by the ACCME and a state medical society at the same time. (It is recognized that short periods of overlap may occur when a provider transitions from one accreditation system to the other and continues to be listed as "accredited" by both.)

When a state medical society accredited provider alters its function and seeks and achieves accreditation from the ACCME, that provider should promptly notify the respective state medical society, withdraw from its accreditation system, and ask to be deleted from its list of accredited providers of CME. Should an ACCME-accredited provider change its role and become accredited by the state medical society, a similar procedure must be followed.

Annually, the ACCME will notify state medical societies of CME providers in their states which have been awarded accreditation by the ACCME. (amended 7/98)

97-A-20 The ACCME will not deny eligibility for accreditation solely on the basis that an organization produces and/or markets a product (device, biologic or pharmaceutical as regulated by the Food and Drug Administration) or activities about a product (device, biologic or pharmaceutical as regulated by the Food and Drug Administration) as long as the activities they develop and/or present are educational and not promotional.

The ACCME will consider an activity to be educational, rather than promotional, when the activity is deemed to have been, in all respects, created and presented in compliance with the ACCME's Standards for Commercial Support.

BIOGRAPHY

Murray Kopelow, MD, is the Executive Director of the Accreditation Council for Continuing Medical Education (www.accme.org). Dr. Kopelow is a graduate of the Faculty of Medicine, University of Manitoba and certified as a specialist in Pediatrics by the Royal College of Physicians and Surgeons of Canada. Prior to coming to the ACCME, Dr. Kopelow was in general pediatric practice, Associate Professor, Department of Pediatrics, and Associate Dean for Continuing Medical Education, Faculty of Medicine, for the University of Manitoba. Dr. Kopelow had been active in the development of programs to assess professional competence and has worked on developing standardized patient examinations and evaluation tools for medical schools and credentialing organizations in both Canada and the United States. In 1998 the Alliance for Continuing Medical Education awarded Dr. Kopelow the Frances Maitland Award citing his leadership and vision as Executive Director of the ACCME. Dr. Kopelow is an Associate Professor in the Department of Pediatrics at Northwestern University Medical School and a 2000 graduate from the Communication Systems Master's degree program within the School of Speech at Northwestern University.

Media Training 6

Media Training

Information to be provided at the meeting

Plenary Session III
CAM Credentialing & Licensure: Assuring Quality & Accountability in CAM Practice

Plenary Session III