

Discussion on
Commission's
Questions about
CAM

Breakout Session I
or
Discussion Group I

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Discussion Group I

DISCUSSION GROUP I

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Tab 1



White House Commission on Complementary and Alternative Medicine Policy

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E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

January 31, 2001

Murray Kopelow, M.D.
Executive Director
American Council for Continuing Medical Education
515 North State Street, Suite 2150
Chicago, IL 60610

Dear Dr. Kopelow:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

The Commission will meet on February 22-23 to discuss complementary and alternative medicine in terms of education and training of health care practitioners, quality of care, and accountability. To accomplish its goal, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments on these issues (as relevant to your organization) by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before the February 22-23 meeting.

The questions that follow were developed to guide the Commission's deliberations.

1. 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?

2. 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?

3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in CME curricula?

4. What should every practicing physician--irrespective of specialty--know about CAM? How and by whom should that level of knowledge be determined?

5. What should physicians know when referring patients to CAM practitioners? How and by whom should that level of knowledge be determined?

6. What information should conventional physicians communicate to a CAM practitioner? What information should a conventional physician expect to receive from a CAM practitioner?

7. How can conventional physicians minimize the risks of dietary supplement-drug; dietary supplement-dietary supplement; and dietary supplement-food interactions?

Chair

James Gordon, MD

Commissioners

George Bernier, Jr., MD

David Bresler, PhD, LAc, OME

Thomas Chappell

Elle Cho, PhD, RN, DiplAc

George DeVries, III

William Fair, MD

Joseph Fins, MD, FACP

Veronica Gutierrez, DC

Wayne Jonas, MD

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Pierona Low Dog, MD, AHG

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Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: polleng2@mail.nih.gov <<mailto:polleng2@mail.nih.gov>>), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,

A handwritten signature in black ink that reads "Stephen C. Groft". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy



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 your 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 accreditors 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

February 14, 2001

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

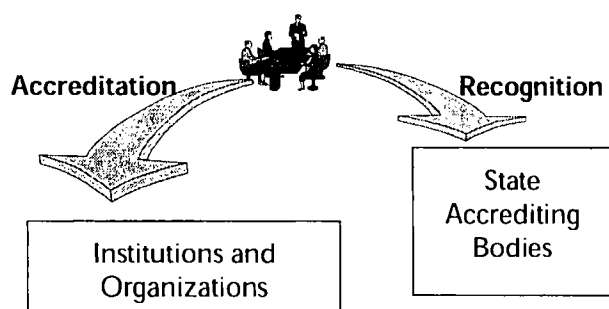
THE ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION

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

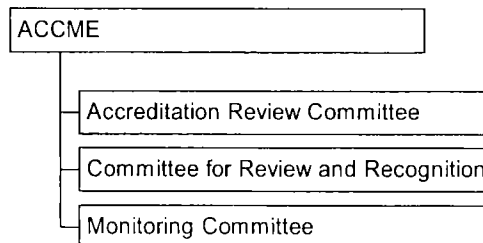


The ACCME provides the direct **accreditation** of CME providers whose programs of CME attract a national audience (more than 30% of participants in the overall program come from beyond the state/territory or contiguous states/territories).

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

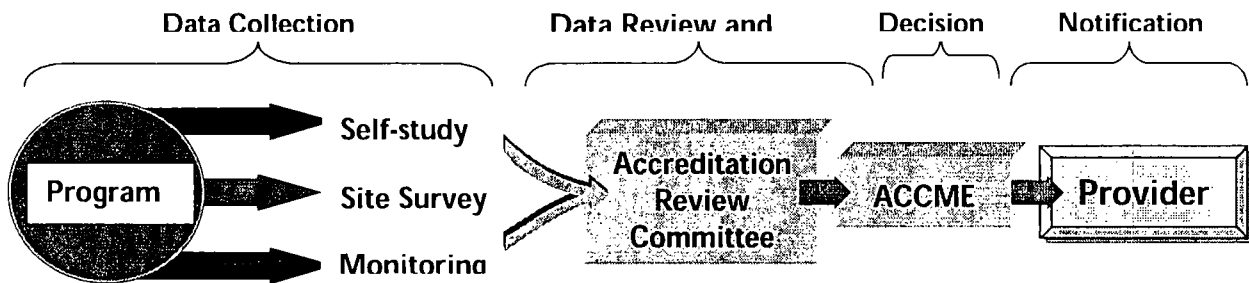
Element x.y: In the course of provision of CME, the provider will...

Classification of Findings	Noncompliance	The provider does not	Measurement Criteria
	Partial compliance	The provider sometimes/partially	
	Compliance	The provider always/consistently	
	Exemplary	The provider exceeds expectations	

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 report¹ 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 <u>the providers</u> 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 <u>the ACCME</u> 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 <u>application</u> 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 <i>questionnaire</i> 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.

Tab 2



White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

January 31, 2001

David C. Leach, M.D.
Executive Director
Accreditation Council of Graduate Medical Education
Suite 2000
515 North Sate Street
Chicago, IL 60610

Dear Dr. Leach:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

The Commission will meet on February 22-23 to discuss complementary and alternative medicine in terms of education and training of health care practitioners, quality of care, and accountability. To accomplish its goal, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments on these issues (as relevant to your organization) by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before the February 22-23 meeting.

The questions that follow were developed to guide the Commission's deliberations.

1. What is the status of CAM in graduate medical education? To what extent is CAM included in graduate medical education? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in graduate medical education?
2. What are the barriers to inclusion of CAM in graduate medical education, for example, science, resources, expertise, qualified faculty, interest? Conversely, what are the incentives for inclusion of CAM in graduate medical education?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM into graduate medical education?

Chair

James Gordon, MD

Commissioners

George Bernier, J., MD

David Bresler, PhD, LAc, OME

Thomas Chappell

Ellie Gray, PhD, RN, DPA

George DeVries, III

William Fair, MD

Joseph Rins, MD, FACP

Arconica Gutierrez, DC

Wayne Jonas, MD

Lianca Larson, LCSW, LMFT

Tierauna Low Dog, MD, AHG

Charlotte Kerr, RSM

Dean Ormish, MD

Conchita Paz, MD

Joseph E. Pizzorno, Jr., ND

Burford Robin

Julia Scott

Xiaoming Tian, MD, LAc

Donald Warren, DDS

Executive Staff

Stephen Groff, PharmD

Executive Director

Michele Chang, CMT, MPH

Executive Secretary

Joan Albrecht

Corinne Axelrod, MPH

Joseph Kaczmarczyk, DO, MPH

Doris Kingsbury

Cecaldine Pollen, MA

Consultant Staff

Kenneth Fisher, PhD

Maurice Miller, MPH

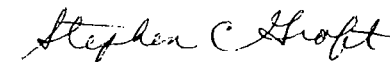
James Swyers, MA

4. What should every resident-irrespective of specialty-know about CAM? How should that level of knowledge be determined?
5. What should every fellow-irrespective of specialty-know about CAM? How should that level of knowledge be determined?
6. Should integrative residency programs be developed? If not, why? If so, what would the most important elements be, and how could such programs be most effective?
7. 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?
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10. What should every practicing physician--irrespective of specialty-know about CAM? How and by whom should that level of knowledge be determined?
11. What should physicians know when referring patients to CAM practitioners? How and by whom should that level of knowledge be determined?
12. What information should conventional physicians communicate to a CAM practitioner? What information should a conventional physician expect to receive from a CAM practitioner?
13. How can conventional physicians minimize the risks of dietary supplement-drug; dietary supplement-dietary supplement; and dietary supplement-food interactions?

Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: (polleng2@mail.nih.gov [<mailto:polleng2@mail.nih.gov>](mailto:polleng2@mail.nih.gov)), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,



Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

Thanks for your note. Your topic is an important one. The ACGME has begun a major new initiative -the Outcome Initiative - which is designed to enhance the accreditation process by the use of educational outcomes.

With support of RWJ we conducted an extensive community deliberation to identify those competencies crucial for all physicians, independent of specialty. The original list of competencies was generated after a review of over 2500 articles, and included the competencies of complementary medicine. After an extensive vetting process that included residents, Residency Review Committee (RRC) members, Program Directors, CEOs of major corporations, presidents of major university, and the the public the following six competencies were identified as core to all disciplines. Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-based Practice.

Residents will have to demonstrate that they have acquired skills in each of these domains. This has the great advantage of being inclusive of all potential types of therapeutic intervention while holding each to established standards of scientific rigor.

The former accreditation model focused on whether residents were exposed to potential opportunities to learn - we are finding it much more effective to ask programs to demonstrate that residents have actually learned something.

I think that it is quite likely that complementary medicine will eventually develop enough to merit accreditation as a subspecialty of medicine. If your group is interested in that I would refer you to our web site www.acgme.org for information on how to apply for accreditation. I hope you find this helpful.

David C. Leach, MD
Executive Director, ACGME

Tab 3



White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

February 1, 2001

Douglas Henley, M.D.
Executive Vice President
American Academy of Family Physicians
11400 Tomahawk Creek Parkway
Leawood, KS 66211

Dear Dr. Henley:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

The Commission will meet on February 22-23 to discuss complementary and alternative medicine in terms of education and training of health care practitioners, quality of care, and accountability. To accomplish its goal, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments on these issues (as relevant to your organization) by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before the February 22-23 meeting.

The questions that follow were developed to guide the Commission's deliberations.

1. What is the status of CAM in undergraduate and/or graduate medical education? To what extent is CAM included in medical school curricula and/or graduate medical education? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed?
2. What are the barriers to inclusion of CAM in medical school curricula and/or graduate medical education, for example, science, resources, expertise, qualified faculty, interest? Conversely, what are the incentives for inclusion of CAM in medical school curricula and/or graduate medical education?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in medical school curricula and/or graduate medical education?
4. What should every medical student know about CAM? How should that level of knowledge be determined?
5. What should every resident-irrespective of specialty-know about CAM? How should that level of knowledge be determined?
6. What should every fellow-irrespective of specialty-know about CAM? How should that level of knowledge be determined?

Chair

James Gordon, MD

Commissioners

George Bernier, Jr., MD

David Bresler, Ph.D., LAc, OME

Thomas Chappell

Effie Clay, Ph.D., RN, DiplAc

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James Swyers, MA

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

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

9. 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?

10. 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?

11. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in CME curricula?

12. What should every primary care physician and every specialist know about CAM? How and by whom should that level of knowledge be determined? Should core competencies demonstrated by physicians include CAM?

13. What should physicians know when referring patients to CAM practitioners? How and by whom should that level of knowledge be determined? What information should conventional physicians communicate to a CAM practitioner? What information should a conventional physician expect to receive from a CAM practitioner? How can conventional physicians minimize the risks of dietary supplement-drug; dietary supplement-dietary supplement; and dietary supplement-food interactions?

14. Should there be national, state, or local, standards and credentialing to provide CAM practices and products, and why or why not? If so, how and by whom should standards and credentialing be established, to whom should they apply, and how should they be implemented?

Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: polleng2@mail.nih.gov <<mailto:polleng2@mail.nih.gov>>), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,



Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

From: Doug Henley [dhenley@aafp.org]
Sent: Thursday, February 01, 2001 10:38 AM
To: Pollen, Geraldine (NCCAM)
Cc: Marge Downey; Norman Kahn
Subject: Re: White House Commission

Thank you very much for asking for the Academy's input and counsel on this very important topic. I will refer your message to Norman Kahn, M.D. who is our Vice President for Science and Education. He will review this matter with his staff and will respond to you.

Douglas E. Henley, M.D.
Executive Vice President
American Academy of Family Physicians
11400 Tomahawk Creek Parkway
Leawood, Kansas 66211
913-906-6200
800-274-3949, ext 6400
913-906-6093 - FAX
dhenley@aafp.org

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

According to the AAMC, teaching about CAM is increasingly a part of the mainstream curriculum. Within family practice residencies, likewise, teaching about CAM is occurring more frequently to help orient residents to the therapies their patients may be using.

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

The primary barrier is the responsibility of medical schools and GME programs to teach scientifically-based, allopathic and osteopathic medicine, and to decide within that framework, what their curricula should include. Reliable sources of information and faculty with the expertise to teach about CAM are significant limiting factors. With the expansion of medical knowledge (genetics, etc.) medical educators are faced with the challenge of identifying what is most important for the physicians of tomorrow to know. The incentives for inclusion of CAM are student interest and the need to orient physicians to the risks/benefits/costs of CAM as it impacts their patients.

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

Teach about those CAM modalities that the physicians of tomorrow are most likely to encounter...not how to do them, but what is the evidence for/against them, what is involved in their delivery, appropriate and inappropriate use, risks, etc. Also, warn trainees about CAM that is without a scientific basis, dangerous, useless (but costly), or might delay appropriate medical care.

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

See #3 If part of the curriculum, the trainee should be tested on its content.

5. What should every resident-irrespective of specialty-know about CAM? How should that level of knowledge be determined? See #4
6. What should every fellow-irrespective of specialty-know about CAM? How should that level of knowledge be determined? See #4
7. Should integrative residency programs be developed? If not, why? If so, what would the most important elements be, and how could such programs be most effective?

No. Medical educators should teach allopathic or osteopathic medicine. Teaching about CAM is appropriate to include in residency curricula because it is part of the clinical environment in which residents, and ultimately practicing physicians, will find themselves. The most important elements are those noted in #3.

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

Education about CAM could very appropriately be funded by the NIH or other agencies concerned with the future health of the American public.

9. 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?

Many CME providers are including some aspects of CAM in their CME activities and a few are providing activities that are solely on CAM topics. A broad range of CAM topics are represented in these activities, including dietary supplements and herbs most frequently, but also homeopathy, naturopathy, traditional oriental medicine, and mind body interventions as well as manipulative and energy therapies. Faculty for CAM courses are varied. Many topics are presented by physicians, some by dietitians, homeopaths, naturopaths, various therapists and native healers. The AAFP believes that it is important for family physicians to be able to appropriately counsel their patients on the use of CAM. The AAFP accredits topics relating to CAM as long as the stated purpose is to teach the learners "about" the subject rather than teaching them how to "use or integrate" the information.

10. 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?

The barrier to including CAM in CME programs is the difficulty in trying to show that the information falls into the "usual and customary" practice area. Under current accreditation criteria, only those practices deemed "usual and customary" may be designated for CME credit unless there is evidence to support the use of a particular therapy or practice. Our experience, at the AAFP has been that family physicians do have an interest in the topic and are seeking CME opportunities to learn more about CAM. However, it appears as though they are seeking such opportunities within the programming of more traditional topic areas rather than seeking out CME opportunities solely on CAM topics.

11. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in CME curricula?

The AAFP is in the first phase of a plan to modify its CME accreditation guidelines so that if there is appropriate evidence to support the use of an area of CAM, it may be approved for AAFP Prescribed credit hours. If a CAM therapy is taught for which there is no evidence to support its use, it may be eligible to receive Elective credit providing it is not harmful to patients.

12. What should every primary care physician and every specialist know about CAM? How and by whom should that level of knowledge be determined? Should core competencies demonstrated by physicians include CAM?

See #3 & 4. CAM does not seem to be a "core" competency, except, in the context of overall patient care, to the extent that physicians should know what works, what doesn't, what's dangerous, how so, etc. However, family physicians have a responsibility to learn what they need to know in order to be able to counsel patients who are using these therapies.

13. What should physicians know when referring patients to CAM practitioners? How and by whom should that level of knowledge be determined? What information should conventional physicians communicate to a CAM practitioner? What information should a conventional physician expect to receive from a CAM practitioner? How can conventional physicians minimize the risks of dietary supplement-drug; dietary supplement-dietary supplement; and dietary supplement-food interactions?

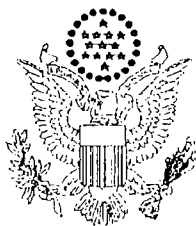
See # 3 & 4. Conventional physicians should, with patient permission, communicate the essentials of the patient's medical conditions, especially those elements most pertinent to or at risk from CAM treatment. Conversely, the physician should expect communication from the CAM provider about what was done, and the patient's response to it. Physicians need to learn to include dietary supplements and over-the-counter drugs in their review of the "medications" being taken by their patients.

14. Should there be national, state, or local, standards and credentialing to provide CAM practices and products, and why or why not? If so, how and by whom should standards and credentialing be established, to whom should they apply, and how should they be implemented?

CAM practices and products should be regulated like any other practice or product that bears a risk to people's well-being and health. Standards and credentialing should be established by multidisciplinary public bodies based on credible, reliable scientific principles. Applied to providers of CAM, they should be implemented and controlled by law.

Norman B. Kahn, Jr., MD
Vice President
Science and Education
American Academy of Family Physicians

Tab 4



White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

February 1, 2001

Richard Muir
Executive Director
American Academy of Hospice
and Palliative Medicine
4700 W. Lake Avenue
Glenview, IL 60025-1485

Dear Mr. Muir:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

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Chair

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7. Should integrative residency programs be developed? If not, why? If so, what would the most important elements be, and how could such programs be most effective?
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Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: polleng2@mail.nih.gov <<mailto:polleng2@mail.nih.gov>>), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

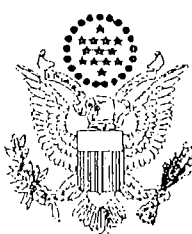
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Sincerely,



Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

Tab 5



White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

February 1, 2001

Joe M. Sanders, M.D.
Executive Director
American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007

Dear Dr. Sanders:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

The Commission will meet on February 22-23 to discuss complementary and alternative medicine in terms of education and training of health care practitioners, quality of care, and accountability. To accomplish its goal, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments on these issues (as relevant to your organization) by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before the February 22-23 meeting.

The questions that follow were developed to guide the Commission's deliberations.

1. What is the status of CAM in undergraduate and/or graduate medical education? To what extent is CAM included in medical school curricula and/or graduate medical education? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed?
2. What are the barriers to inclusion of CAM in medical school curricula and/or graduate medical education, for example, science, resources, expertise, qualified faculty, interest? Conversely, what are the incentives for inclusion of CAM in medical school curricula and/or graduate medical education?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in medical school curricula and/or graduate medical education?
4. What should every medical student know about CAM? How should that level of knowledge be determined?
5. What should every resident-irrespective of specialty-know about CAM? How should that level of knowledge be determined?
6. What should every fellow-irrespective of specialty-know about CAM? How should that level of knowledge be determined?

Chair

James Gordon, MD

Commissioners

George Bernier, Jr., MD

David Bresler, PhD, LAc, OME

Thomas Chappell

Ellie Chou, PhD, RN, DiplAc

George DeVries, III

William Fan, MD

Joseph Fins, MD, FACP

Veronica Gutierrez, DC

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Tieraona Low-Dog, MD, AHG

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Burford Rolin

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Xiaoming Tian, MD, LAc

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Consultant Staff

Kenneth Fisher, PhD

Maureen Miller, MPH

James Swyers, MA

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

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

9. 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?

10. 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?

11. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in CME curricula?

12. What should every primary care physician and every specialist know about CAM? How and by whom should that level of knowledge be determined? Should core competencies demonstrated by physicians include CAM?

13. What should physicians know when referring patients to CAM practitioners? How and by whom should that level of knowledge be determined? What information should conventional physicians communicate to a CAM practitioner? What information should a conventional physician expect to receive from a CAM practitioner? How can conventional physicians minimize the risks of dietary supplement-drug; dietary supplement-dietary supplement; and dietary supplement-food interactions?

14. Should there be national, state, or local, standards and credentialing to provide CAM practices and products, and why or why not? If so, how and by whom should standards and credentialing be established, to whom should they apply, and how should they be implemented?

Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: polleng2@mail.nih.gov <<mailto:polleng2@mail.nih.gov>>), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,



Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

The American Academy of Pediatrics is pleased to have the opportunity to comment on the various complementary and alternative medicine (CAM) issues that will be addressed by the White House Commission. The Academy and its 55,000 members applaud the Commission's efforts to explore CAM research, education, training, and delivery. Given the increasing utilization of CAM therapies and treatments, it is crucial that public policy and comprehensive research be developed in order to maintain quality care.

The Academy currently does not have policy on CAM; however, the Academy is addressing this issue through its Task Force on Complementary and Alternative Medicine and Committee on Pediatric Workforce (COPW). The Task Force was established in the spring of 2000 to address the growing interest and utilization of CAM and to identify multiple strategies to educate pediatricians and the public on CAM in the pediatric population. The Task Force is developing a technical report and a patient education brochure, which will encourage patients and parents to communicate with pediatricians about their interest in and their use of CAM. The Task Force is tentatively scheduled to meet June 29-30, 2001 at the Pediatric Integrative Medicine Conference in St Paul, Minnesota.

Additionally, the COPW is working on a policy statement that will include a discussion of the role of CAM providers in the delivery of pediatric care. More specifically, the statement will examine the education, licensing, and practice characteristics of CAM providers. The COPW also stays abreast of CAM education. Currently, CAM content in GME is not mandated by the Residency Review Committee for Pediatrics in the Program Requirements for Residency Education in Pediatrics. However, many medical students, pediatric residents, and pediatric fellows are seeking training in CAM to respond to changing workforce needs and the evolution of health care delivery. The following article offers a comprehensive overview of CAM education: Bhattacharya B. "M.D. programs in the United States with complementary and alternative medicine education opportunities: an ongoing listing." *J Complement Altern Med* 2000;6(1):77-90.

Again, the Academy appreciates the opportunity to provide comments on the various issues surrounding complementary and alternative medicine. Please feel free to contact me with any questions or concerns regarding the Academy's progress in this area.

Junelle Speller
Senior Health Policy Analyst
AAP Division of Health Care Finance and Practice

M.D. Programs in the United States with Complementary and Alternative Medicine Education Opportunities: An Ongoing Listing

BHASWATI BHATTACHARYA, M.A., M.P.H., M.D.

***T**here is a steadily growing interest in providing education to physicians about complementary and alternative medicine (CAM) not only during their time in medical school, but also as part of their continuing education in the practice of medicine. This listing aims to provide educators, medical students, physicians, and surgeons with information about the increasing number of courses and programs about therapies and modalities of healing that are not conventionally taught in the 125 American Association of Medical Colleges (AAMC)-accredited M.D. programs. Doctor of Osteopathy (D.O.), Doctor of Chiropractic (D.C.), and Naturopathic Doctor (N.D.) programs are not included in this listing because CAM components are integrated throughout their curricula. Our goal is to track the evolution of courses and to aid the effort toward an integrated cohesive national curriculum in all medical schools.*

GROUPS WITH CURRICULUM INITIATIVES

AAMC GEA Alternative & Complementary Medicine Special Interest Group

Patricia A. Muehsam, M.D., Convener
2 East 75th Street
New York, NY 10021
212-946-5700
Fax: 212-861-1155
E-mail: pm2@doc.mssm.edu
Web site: www.aamc.org

American Holistic Medical Association

John Graham-Pole, M.D.
6728 Old McLean Village Drive
McLean, VA 22101-3906
703-556 9245
Fax: 703-556-8729
E-mail: grahajr@peds.ufl.edu
Web site: www.holisticmedicine.org

The Society of Teachers of Family Medicine Group on Alternative Medicine

Andrea Gordon, M.D.
11400 Tomahawk Creek Parkway, Suite 440

Leawood, KS 66211

816-333-9700, extension 4504

E-mail: admstaff@stfm.org or
agord@u.washington.edu

American Public Health Association

*Alternative & Complementary Health Practices
SPIG*

Joan Bagnall Ryan, Director
847-938-9744

E-mail: joan.ryan@abbott.com
Web site: www.apha.org

American Medical Student Association

Humanistic Medicine Committee
1902 Association Drive
Reston, VA 20191-1502
703-620-6600
Web site: www.amsa.org

American Association of Physicians from India

Committee on Integrated Medicine
Krishna R. Gujavarty, M.D.
116 Peninsula Drive
Port Jefferson, NY 11777

510-444-6005
Fax: 516-444-7534
Web site: www.aapiusa.org

**National Institutes of Health National
Center for Complementary & Alternative
Medicine**

William R. Harlan, M.D., Acting Director
Information Clearinghouse
888-644-6226
Web site: <http://nccam.nih.gov/nccam/>

CONTINUING MEDICAL EDUCATION

**University of California Los Angeles School
of Medicine**

CME—Medical Acupuncture for Physicians†
Joseph M. Helms, M.D.
2520 Milvia Street
Berkeley, CA 94704
510-649-8488
Fax: 510-649-8692

**University of California Los Angeles School
of Medicine**

CME—Integrative East-West Medicine
Ka Kit Hui, M.D., F.A.C.P.
200 UCLA Medical Plaza, Suite 420
Los Angeles, CA 90095
310-206-1895
Fax: 310-794-1896

University of Arizona School of Medicine
Program in Integrative Medicine

Andrew Weil, M.D./Tracy Gaudet, M.D.
Department of Medicine, Box 245153
Tucson, AZ 85724-5153
520-626-5077
Fax: 520-626-2757

Wayne State University School of Medicine

CME—A Course in Clinical Hypnosis: Basic Level
Marilyn P. Laken, Ph.D., R.N.
Department of Obstetrics/Gynecology
Hutzel Hospital
4707 St. Antoine
Detroit, MI 48201
313-577-1147
Fax: 313-577-2045
E-mail: mlaken@med.wayne.edu

**University of New Mexico School of
Medicine**

CME—Alternative Medicine
Martin Kantrowitz, M.D./Lee Stephenson
Office of CME
Box 517
Albuquerque, NM 87131
505-277-6611
Fax: 505-277-7087
E-mail: lstephen@medusa.unm.edu

University of Minnesota—Minneapolis

*CME—Complementary Care: From Principles to
Practice 2817*
*CME—The Scientific Basis for the Holistic
Treatment of Chronic Disease*
William Manahan, M.D.
University of Minnesota CME
308 Harvard Street SE, Suite 6-101
Minneapolis, MN 55455
800-776-8636 or 612-626-4772
Fax: 612-626-7766

George Washington University

*CME—Primary Care for the 21st Century:
Holistic Medicine*
American Holistic Medical Association
6728 Old McLean Village Drive
McLean, VA 22101
703-556-9245

**Columbia University College of Physicians
and Surgeons**

*CME—Botanical Medicine in Modern
Clinical Practice*
Fredri Kronenberg, Ph.D./Daniel Eskinazi,
D.D.S., Ph.D.
Center for Continuing Education
630 West 168th Street, Unit 39
New York, NY 10032
212-781-5990
E-mail: cme@columbia.edu
Web site: [http://cpmcnet.columbia.edu/
dept.cme](http://cpmcnet.columbia.edu/dept.cme)

**University of Colorado Health Sciences
Center**

*CME—The Scientific Basis for Using Holistic Med-
icine to Treatment Chronic Disease*
Robert S. Ivker, D.O./Louise Kosenski
A.F. Williams Family Medicine Center

5250 Leetsdale Drive, Suite 304
Denver, CO 80222
303-388-0965, extension 108

University of Massachusetts Medical School
CME—Evidence-Based Botanical Medicine
Cambridge Health Resources
1037 Chestnut Street
Newton, MA 02464
617-630-1330
Fax: 617-630-1325

Rush Medical College
CME—Annual Mind-Body Medicine Conference
William Schwer, M.D.
Department of Family Medicine
Rush-Presbyterian-St. Luke's Medical Center
600 South Paulina, Suite 749
Chicago, IL 60612
312-942-7083

University of Vermont College of Medicine
CME—The Scientific Basis for Using Holistic Medicine to Treat Chronic Disease
Richard B. White, M.D.
Family Practice Health Care Service
Office of Continuing Medical Education
One South Prospect Street
Burlington, VT 05401-3444
802-656-2292

Harvard Medical School
CME—Alternative Medicine: Implications for Clinical Practice
Norman Shostak
Harvard Medical School—CME
641 Huntington Avenue
Boston, MA 02215
617-432-0196
Fax: 617-432-1562
E-mail: nshostak@warren.med.harvard.edu

Harvard Medical School
CME—Clinical Training in Mind/Body Medicine
Herbert Benson, M.D.
Harvard Medical School—CME
641 Huntington Avenue
Boston, MA 02215
617-432-1525
E-mail: hms-cme@warren.med.harvard.edu

POSTGRADUATE OPPORTUNITIES

University of Arizona School of Medicine
Fellowship Program in Integrative Medicine
Andrew Weil, M.D./Tracy Gaudet, M.D.
Department of Medicine, Box 245153
Tucson, AZ 85724-5153
520-626-5077
Fax: 520-626-2757

Montefiore Medical Center
Residency Program in Social Medicine
Ellen Tattelman, M.D.
Valentine Lane Family Practice
503 South Broadway
Bronx, NY 10705
914-965-9771
Fax: 914-965-4724

University of Maryland School of Medicine
Fellowship in Pain/Complementary Medicine
Brian Berman, M.D.
Division of Complementary Medicine
Kernan Hospital Mansion
2200 Kernan Drive
Baltimore, MD 21207-6697
410-448-6872
Fax: 410-448-6875

University of Washington
Residency Program in Family Medicine
Ambulatory Pediatric Medicine
Joseph N. Scardapane, M.D.
Swedish Medical Center
747 Broadway, P.O. Box 14999
Seattle, WA 98114-0999
206-386-3162

Beth Israel Medical Center
Residency in Urban Family Practice
Red Schiller, M.D./Francine Rainone, D.O.
Phillips Family Practice
16 East 16 Street
New York, NY 10010
212-206-5233

EDUCATION

Arizona

University of Arizona School of Medicine
Program in Integrative Medicine
Andrew Weil, M.D./Tracy Gaudet, M.D.
Department of Medicine, Box 245153
Tucson, AZ 85724-5153
520-626-5077
Fax: 520-626-2757

California

University of California, Los Angeles School of Medicine
Psychoneuroimmunology
Fawzy I. Fawzy, M.D.
Department of Psychiatry & Biobehavioral Science
760 Westwood Plaza, C8-861 NPI
Los Angeles, CA 90024
310-825-0249
Fax: 310-825-0323

Introduction to Complementary Medicine—MD199.06

David L. Diehl, M.D.
Department of Medicine
Olive View Drive, 2B-182
Sylmar, CA 91342
Fax: 818-364-3205/818-364-4573

University of California—San Francisco School of Medicine

The Healer's Art: Reclaiming the Heart of Medical Practice—FCM170.01
The Care of the Soul: Spiritual Values in Medical Practice
Rachel Naomi Remen, M.D.
Commonweal, P.O. Box 316
Bollinas, CA 94924
415-868-2642
Fax: 415-868-2230

Introduction to Homeopathic Medicine

Michael Carlston, M.D.
987 Airway Court, Suite 14
Santa Rosa, CA 95403
707-545-1554
Fax: 707-545-1595

Complementary Medicine Overview

Delia Pratt, M.D.
Community Hospital at Sonoma County
3124 Chanote Road
Santa Rosa, CA 95403
707-545-5226
Fax: 707-575-1513

Complementary Ways of Healing
Ellen Hughes, M.D.
400 Parnassus Avenue, A-405
San Francisco, CA 94143-0320
415-476-3185
Fax: 415-502-4189

University of Southern California School of Medicine

Society and Medicine—Overview of CAM
Ayurvedic Medicine Elective
Shrikant Mishra, M.D., M.A.
Department of Neurology
376 Caribeth Drive
Encino, CA 91436
818-895-9473
Fax: 818-981-9659
E-mail: smishra@chp.hsc.usc.edu

Colorado

University of Colorado Health Sciences Center
Integrated Holistic Family Medicine
Jacqueline Fields, M.D.
203 Wayne Street
Fort Collins, CO 80521
303-333-6743

Connecticut

University of Connecticut School of Medicine
Alternative Medicine Series
Albert E. Holt
145 Dover Road
West Hartford, CT 06119
860-679-7699

Yale University School of Medicine

Alternative Medicine in Historical Perspectives
Maria Trumpler, Ph.D.
History of Medicine
P.O. Box 208015
New Haven, CT 06520-8015
203-785-4338
Fax: 203-737-4130

The Mind and Medicine

Hoard P. Kahn, Ph.D.
436 Orange Street
New Haven, CT 06511
203-624-9411
Fax: 203-624-9411
E-mail: hpkahn@aol.com

District of Columbia

Georgetown University School of Medicine

The Program of Mind—Body Studies

James S. Gordon, M.D.
Center for Mind-Body Medicine
5225 Connecticut Avenue, NW, Suite 414
Washington, DC 20015
202-966-7338
Fax: 202-966-2589

The Institute for New Medicine

Candace B. Pert, Ph.D., Michael Ruff, Ph.D.
Department of Physiology & Biophysics
3900 Reservoir Road
Washington, DC 20007
202-687-4649
E-mail: in4newmed@aol.com

*Spirituality and Medicine**

Keith Muccino, S.J., M.D./Daniel P. Sulmasy, M.D.
George Washington University School of Medicine & Health Sciences

Complementary and Alternative Health Practices

Alan I. Trachtenberg, M.D., M.P.H.
Department of Preventive & Community Health
E-mail: ATracte@samhsa.gov

*Spirituality and Medicine**

Christina Puchalski, M.D.
202-994-2202

Integrative Medicine

John Pan, M.D.
GW Center for Integrative Medicine
Ambulatory Care Center, 2-105
2150 Pennsylvania Avenue, NW
Washington, DC 20037
202-994-8870

Howard University College of Medicine

Alternative Medicine, Preventive Medicine and Decision Making

Adnan H. Eldadah, M.D., Dr.P.H.
520 West Street, NW
Washington, DC 20059
202-806-6300

Community Health & Family Practice Clerkship

Lalita Kaul, Ph.D.
Department of Community Health & Family Practice
520 W Street, NW
Washington, DC 20059
202-806-7835

*Spirituality and Medicine**

Martin Jones, M.D.
202-806-9726
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Florida

University of Miami School of Medicine

Art and Science of Acupuncture

Janet Konefal, Ph.D.
P.O. Box 016960 (D-79)
Miami, FL 33101
305-243-4751
Fax: 305-243-3648
E-mail: jkonefal@med.miami.edu

Georgia

Emory University School of Medicine

Complementary Medical Practices

Linda R. Gooding, Ph.D.
Department of Microbiology and Immunology
3107 Rollins Research Center
Atlanta, GA 30322
404-727-5948
Fax: 404-727-0293

Spirituality and Medicine—MEDI 625*

Mary Lynn Dell, M.D., M.T.S., Th.M.
Department of Psychiatry and Behavioral Sciences
Atlanta, GA 30322
404-727-5660

*Nutritional Approaches to Complementary
Medicine*

Marjorie Smith, M.D.
Department of Pathology
720 Westview Drive, SW
Atlanta, GA 30310
404-752-1770

*Spirituality and Medicine**

Valencia Clay, M.D./Marvin Crawford, M.D.
720 Westview Drive, SW
Atlanta, GA 30310
404-752-1650

Illinois

**Finch University of Health Sciences/The
Chicago Medical School**

Complementary Medicine

David B. Jacobs, Ph.D.
Departments of Biological Chemistry &
Medicine

3333 Green Bay Road
North Chicago, IL 60064
847-578-3235
Fax: 847-578-3240

Loyola University of Chicago

*Spirituality and Medicine**

Myles Sheehan, S.J., M.D.
Maywood, IL 60153
708-216-9000

**University of Chicago Pritzker School of
Medicine**

*Spirituality and Medicine**

Lawrence Wood, M.D., Ph.D.
Chicago, IL 60637

University of Illinois at Chicago

Complementary Medicine/Therapeutic Touch

Mary Sinclair, L.Ac.
914 South Wood Street
Chicago, IL 60612
312-996-2418

**University of Illinois College of Medicine at
Rockford**

Essentials of Patient Care—M2

Elective in Holistic Medicine—M4

Eric Henley, M.D., M.P.H.

Department of Family and Community Medicine

1601 Parkview Avenue
Rockford, IL 61107-1897
815-395-5804
E-mail: EHenley@uic.edu

Northwestern University

David Edelberg, M.D./Keith Berndtson, M.D.
American WholeHealth/Columbus Hospital
1055 West Belden Avenue
Chicago, IL 60614
312-296-6700

Rush Medical College

Herbal Pharmacology

Arthur Prancan, Ph.D.
Department of Pharmacology
600 South Paulina, 7th Floor
Chicago, IL 60612
312-942-5561
E-mail: aprancan@rush.edu

Elective in Holistic Family Medicine

Mary Meengs, M.D.
University Family Physicians Lincoln Park
1953C North Clybourn Avenue
Chicago, IL 60614
773-348-1414

Preceptorship in Wholistic Health Care—FAM644

Stephen Humowiecki, M.D.
Department of Family Medicine
708-848-4188

Spirit/Mind/Body

Joanne O'Reilly, Ph.D.
Department of Religion, Health and Human
Values
312-942-5571

**Southern Illinois University School of
Medicine**

Chinese Acupuncture

Terrill Mast, Ph.D.
801-3 Rutledge, P.O. Box 19230
Springfield, IL 62794-1217
217-782-7765
Fax: 217-524-0192

Chinese Traditional Medicine

(course taught to Southern Illinois University
students in the PRC)

Contact: Terrill Mast, Ph.D.
217-782-7711

Comparative Systems of Healing
Phillip Davis, Ph.D.
P.O. Box 19230
Springfield, IL 62794-9230
217-782-5770
Fax: 217-785-2024

Indiana

Indiana University School of Medicine
Complementary Medicine, Developing New Health Paradigms
Vimal Patel, Ph.D.
635 Barnhill Drive, MS 128
Indianapolis, IN 46202
317-274-4662
Fax: 317-278-2018

Holistic Family Practice Clerkship
(strong emphasis on nutritional medicine)
Dale Guyer, M.D.
8402 Harcourt Road, Suite 128
Indianapolis, IN 46260
317-338-6650

Holistic Medicine Clerkship
Kathleen L. Auen Stienstra, M.D.
51 West Lawrin
Terre Haute, IN 47803
812-238-7631

Iowa

University of Iowa College of Medicine
Alternative Medicine
Kristin Sagert, Ph.D.
Iowa City, IA 52242
319-351-7666

Practical Clinical Nutrition
Dr. Charles Driscoll
Iowa City, IA 52242
319-337-9876

Kansas

University of Kansas School of Medicine,
Kansas City
Introduction to Clinical Medicine

David Calkins, M.D.
3901 Rainbow Boulevard
Kansas City, KS 66160
913-588-5289

Unconventional Medicine
Jane Murray, M.D./Jeanne Drisko, M.D.
3901 Rainbow Boulevard
Kansas City, KS 66160
E-mail: jmurray@kumc.edu

Kentucky

University of Louisville School of Medicine
A Scientific Look at Alternative Medicine
Thomas Wheeler, Ph.D.
319 Abraham Flexner Way
Room 515, Building A
Louisville, KY 40292
502-852-6287
Fax: 502-852-6222
E-mail: tjwhee01@ulkyvm.louisville.edu

Behavioral Medicine
Alternative Medicine
Leah Dickstein, M.D.
Department of Psychiatry & Behavioral Sciences
Abell Administration Center, Room 202
Louisville, KY 40292
502-852-6185
Fax: 502-852-8937

University of Kentucky College of Medicine
*Spirituality and Medicine**
Louis Nora, M.D., J.D.
Chandler Medical Center
800 Rose Street
Lexington, KY 40536
606-323-6161

Maryland

Johns Hopkins School of Medicine
The Philosophy and Practice of Healing
Gail Geller, Sc.D./Robert M. Duggan
Department of Pediatrics
550 North Broadway, Suite 511
Baltimore, MD 21205-2004
410-955-7894
Fax: 410-955-0241
E-mail: ggeller@welchlink.welch.jhu.edu

Spirituality and Medicine
Stuart R. Varon, M.D.
720 Rutland Avenue
Baltimore, MD 21205
410-955-3182

University of Maryland School of Medicine
Introduction to Complementary (Alternative) Medicine

Brian Berman, M.D.
Division of Complementary Medicine
Kernan Hospital Mansion
2200 Kernan Drive
Baltimore, MD 21207-6697
410-448-6872
Fax: 410-448-6875

Uniformed Services University of the Health Sciences

Complementary & Alternative Medicine Series
Eron G. Manusov
Uniformed Services University of the Health Sciences
4301 Jones Bridge Road
Bethesda, MD 20814-4799
301-295-3632
Fax: 301-295-3100
E-mail: Manusov@USUHSB.USUHS.MIL

Massachusetts

Boston University School of Medicine
Public Health Perspectives on Alternative Health Care

Allan R. Meyers, Ph.D.
School of Public Health
80 East Concord Street, Room A302
Boston, MA 02118
617-638-5042
Fax: 617-638-5374

Harvard Medical School

Spirituality and Medicine
Herbert Benson, M.D./Gregory Fricchione
Deaconess Hospital
Boston, MA 02115
617-432-1550

AltMed: Implications for Clinical Practice & Research—ME549.J
(for Harvard students only)

David M. Eisenberg, M.D.
HMS Office of Educational Development
MEC 384
260 Longwood Avenue
Boston, MA 02115
617-432-1315

Medical Hypnosis and Behavioral Therapy
Owen Surman, M.D.

Massachusetts General Hospital
ACC 815
15 Parkman Street
Boston, MA 02114
617-726-2991
Fax: 617-726-7541

Tufts University School of Medicine

Survey Course in Alternative Medicine
Glenn Rothfeld, M.D.
Spectrum Medical Arts, Suite 303
Arlington, MA 02174
617-641-1901
Fax: 617-641-3963

Michigan

Michigan State University

Holistic Medicine in Ob/Gyn—Clerkship
Molly Guerin, M.D.
1700 Lindbergh
Lansing, MI 48910
517-353-4740

University of Michigan School of Medicine

Holistic Internal Medicine Clerkship
E. Jonas Linker, M.D.
2345 South Huron Parkway
Ann Arbor, MI 48104
313-973-1010

Wayne State University School of Medicine

Introduction to Alternative Medicine
Robert R. Frank, M.D.
540 East Canfield
Detroit, MI 48201
313-577-1450

Introduction to Alternative/Complementary Medicine

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Department of Obstetrics/Gynecology

4707 St. Antoine
Detroit, MI 48201
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Qi Gong in Medicine—MDE 051

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Complementary Medicine*
*Fieldwork in Alternative & Complementary
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Program on Aging
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University of Virginia School of Medicine
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Bhaswati Bhattacharya, M.D., M.P.H., is a member of the Richard and Hinda Rosenthal Center for Complementary and Alternative Medicine, Department of Rehabilitation Medicine, at Columbia University College of Physicians and Surgeons. The listing is regularly updated on the Rosenthal Center Web site: http://cpmcnet.columbia.edu/dept/rosenthal/Med_Courses.html

Please contact the Center with updates/changes/feedback, by calling: 212-543-9532, or via e-mail, to: bb213@columbia.edu or amfi@foundation.org

ACKNOWLEDGEMENTS: Drs. Paula Gardiner, Jeremy Tompkins, Chanel Helgason, Cheryl Giles, Francine Rainone, and the National Institute for Healthcare Research for assistance in obtaining contact information.

*Courses listed under Spirituality and Medicine were obtained from John Templeton Foundation Awards in curriculum development for spirituality in medical education.

*Recognized by the New York State Medical Board.

Tab 6



White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

January 30, 2001

Douglas Wood, D.O., President
American Association of Colleges of Osteopathic Medicine
5550 Friendship Blvd.
Chevy Chase, MD 20814

Dear Dr. Wood:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

The Commission will meet on February 22-23 to discuss complementary and alternative medicine in terms of education and training of health care practitioners, quality of care, and accountability. To accomplish its goal, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments on these issues (as relevant to your organization) by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before the February 22-23 meeting.

The questions that follow were developed to guide the Commission's deliberations.

1. What is the status of CAM in undergraduate and/or graduate medical education? To what extent is CAM included in medical school curricula and/or graduate medical education? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed? To what extent should CAM be included in medical school curricula and graduate medical education?
2. What are the barriers to inclusion of CAM in medical school curricula and/or graduate medical education, for example, resources, expertise, interest? Conversely, what are the incentives for inclusion of CAM in medical school curricula and/or graduate medical education?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in medical school curricula and/or graduate medical education?
4. What should every medical student know about CAM? How should that level of knowledge be determined?
5. What should every resident-irrespective of specialty-know about CAM? How should that level of knowledge be determined?
6. What should every fellow-irrespective of specialty-know about CAM? How should that level of knowledge be determined?

Chair

James Gordon, MD

Commissioners

George Bernier, Jr, MD

David Bresler, PhD, LAc, OMB

Thomas Chiappell

Effic Chow, PhD, RN, DiplAc

George DeVries, III

William Fair, MD

Joseph Fins, MD, FACP

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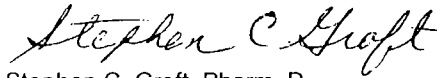
7. Should integrative residency programs be developed? If not, why? If so, what would the most important elements be, and how could such programs be most effective?

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

Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: polleng2@mail.nih.gov <<mailto:polleng2@mail.nih.gov>>), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,

A handwritten signature in cursive script that reads "Stephen C. Groft".

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

Tab 6 AND Tab 25 (co-response): American Association of Colleges of
Osteopathic Medicine; Council of Osteopathic Student Government Presidents

The American Association of Colleges of Osteopathic Medicine (AACOM) and the Council of Osteopathic Student Government Presidents (COSGP) are pleased to be able to respond to the questions you posed on behalf of the White House Commission on Complementary and Alternative Medicine Policy. We feel that the mission of the Commission is laudatory examining an area where there is much interest within the medical education community as well as within the population in general.

Our responses will be in the same order as in your letter of January 30, 2001. We note, however, that the letter that was sent asks eight questions and the email that was sent poses eleven questions. Because of the importance of all of the questions we will answer all eleven.

1. The status of CAM in undergraduate medical education is relatively minimal except for a few schools which are more involved in CAM offerings such as the University of Maryland, the University of Arizona, and the University of California San Francisco. In osteopathic medical education generally the introduction of CAM concepts is minimal with the exception of osteopathic manipulative treatment which is considered to be a complementary/alternative form of therapy by the National Institutes of Health. In the Graduate Medical Education arena we know of no course offerings per se in the area of CAM. However, we know that CAM concepts are mentioned occasionally in such fora as clinical conferences or on medical rounds. When CAM concepts are addressed, we find that those most commonly mentioned are Mind-Body Medicine, the use of botanicals, Acupuncture, diet and exercise. These concepts are introduced in the classroom, on general medical rounds, and on grand rounds. We feel that it is important that CAM be included in both the medical school and graduate medical education curricula because patients are asking about CAM, these modalities continue to gain in popularity, and therefore should be integrated where appropriate. Our view is consistent with the recommendations of Healthy People 2010 and the Advisory Committee on Training and Primary Care Medicine and Dentistry.
2. There are several barriers relative to the inclusion of CAM in both undergraduate and graduate medical education. One of the primary barriers is that many CAM practices are not evidence-based. There is also bias among many physicians relative to CAM practice; e.g., a lack of research in many areas; a lack of expertise and willingness on the part of many practitioners to be open to CAM, etc. Resources are also a problem, as is the fact that both graduate and undergraduate curricula are already "packed" with much information. It is also the case that students are very reluctant to try and learn information when they know there maybe no proven benefit to using it. Incentives for inclusion of CAM lie in such areas as public interest; the possibility of decreasing the cost of medical care with inclusion of CAM modalities; and the recognition that we have a multi-cultural society that demands diversity in treatment.
3. Policy recommendations are difficult relative to the inclusion or expansion of medical school curriculum because in most medical schools the faculty controls the curriculum. When outside bodies attempt to intervene, the issue of academic freedom is raised. Those bodies that control the curriculum must be convinced via research, experience, and public interest that CAM modalities should be included in the curriculum. Federal programs such as Title VII of the PHS

Act, project grants and graduate medical education might be vehicles for incentives to the inclusion of CAM in the medical school curriculum.

4. We believe that every medical student should have knowledge of the philosophy of each CAM modality. Students should leave medical school with a firm grounding in such areas as diet and its effects on health and disease, as well as knowledge of botanicals, Chinese and other alternative forms of health care, exercise, and Mind-Body medicine. Examination questions regarding CAM should be designed by CAM practitioners both at the medical school level as well as the level of licensing boards.
5. We feel that the same modalities should be included in the residency years except that the level of teaching these modalities should be increased.
6. Again the same topics should be included, however, the level should be higher than that of the residency.
7. We feel that residency programs should be developed but equally important is the "inclusion" of integrated medicine principles into all medical education programs. The most important concepts to be integrated would be those of holistic medicine and the ability of the person to heal him/herself. Other elements that were mentioned in the answer to question 4 above should also be integrated. We believe that the concepts of osteopathic manipulative treatment should also be a part of CAM programs.
8. The issue of the funding of the inclusion or expansion of CAM in medical education is a problem. It is obvious that there are difficulties currently in the funding of both undergraduate and graduate medical education and as time goes by these will become more significant problems. We feel that the federal government should be involved in this funding particularly through demonstration projects. Certain foundations such as the Fetzer Foundation also might well be interested in such funding.
9. The question of what every practicing physician should know about CAM is also somewhat difficult. It is our view that a fundamental knowledge of philosophy of each CAM modality should be possessed by every practicing physician. He/she should also have knowledge of the various modalities which have previously been mentioned, such as nutrition, exercise, Mind-Body medicine, acupuncture, and Chinese and other alternative forms of health care. It might be that this level of knowledge could be determined by voluntary CME types of examination.
10. Relative to referring to CAM practitioners, physicians should certainly have fundamental knowledge of the principles and philosophy of CAM and also should be willing to ascertain whether the patient is willing to see a CAM practitioner. The referring physician should have knowledge about the particular CAM treatment methods and also the competency of the practitioner.
11. There currently are national standards and certification relative to the practice of health care in this country. Therefore, we feel there should be national standards and certification to allow practitioners to provide CAM practices and products in order to ensure safety to the public. We also believe that national standards or certification for each CAM modality be developed and administered by experts within each area of CAM.

12. As in any type of physician-to-physician communication, all available information should be conveyed from one physician to another. It is expected that this should be two way communication wherein all diagnostic and treatment modalities are transferred back and forth between the physician and the CAM practitioner.

Once again, we sincerely appreciate the opportunity to comment on the questions that you have posed and trust if our answers need further explanation you will contact us.

Douglas L. Wood, D.O., Ph.D.
President, AACOM

Darin Haug
Chair, Council of Osteopathic
Student Government Presidents

Tab 7



White House Commission on Complementary and Alternative Medicine Policy

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E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

February 6, 2001

Robert Avant, M.D.
Executive Director
American Board of Family Practice
2228 Young Drive
Lexington, KY 40505-4294

Dear Dr. Avant:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

The Commission will meet on February 22-23 to discuss complementary and alternative medicine in terms of education and training of health care practitioners, quality of care, and accountability. To accomplish its goal, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments on these issues (as relevant to your organization) by **February 15, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before the February 22-23 meeting.

The questions that follow were developed to guide the Commission's deliberations.

1. To what extent is CAM included in graduate medical education?
2. What are the barriers to inclusion of CAM in medical school curricula and/or graduate medical education, for example, science, resources, expertise, qualified faculty, interest? Conversely, what are the incentives for inclusion of CAM in medical school curricula and/or graduate medical education?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in medical school curricula and/or graduate medical education?

Chair

James Gordon, MD

Commissioners

George Bernier, Jr, MD

David Bresler, PhD, LAc, OME

Thomas Chappell

Effie Chow, PhD, RN, DiplAc

George DeVries, III

William Fair, MD

Joseph Fins, MD, FACP

Veronica Gutierrez, DC

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Linnea Larson, LCSW, LMFT

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Corinne Axelrod, MPH

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Doris Kingsbury

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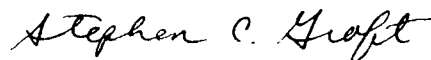
Les Sowers, MA

4. Should integrative residency programs be developed? If not, why? If so, what would the most important elements be, and how could such programs be most effective?
5. How and by whom should the inclusion or expansion of CAM in medical education be funded?
6. What is the status of CAM in continuing medical education (CME)? To what extent is CAM included in CME curricula? To what extent should CAM be included in CME curricula?
7. What are the barriers (expertise, interest, resources) to inclusion of CAM in CME curricula? Conversely, what are the incentives for inclusion of CAM in CME curricula?
8. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in CME curricula?
9. What should every primary care physician know about CAM? How and by whom should that level of knowledge be determined? Should core competencies demonstrated by physicians include CAM?
10. What should physicians know when referring patients to CAM practitioners? How and by whom should that level of knowledge be determined? What information should conventional physicians communicate to a CAM practitioner?
11. What information should a conventional physician expect to receive from a CAM practitioner?
12. Should there be national, state, or local, standards and credentialing to provide CAM practices and products, and why or why not? If so, how and by whom should standards and credentialing be established, to whom should they apply, and how should they be implemented?

Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: polleng2@mail.nih.gov <<mailto:polleng2@mail.nih.gov>>), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

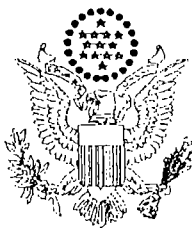
The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,



Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

Tab 8



White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

January 31, 2001

Harry R. Kimball, M.D.
President
American Board of Internal Medicine
510 Walnut Street, Suite 1700
Philadelphia, PA 19106-3699

Dear Dr. Kimball:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

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The questions that follow were developed to guide the Commission's deliberations.

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

James Gordon, MD

Commissioners

Geroge Bernier, Jr, MD
David Bresler, PhD, LAc, OMD
Thomas Clappell
Effic Chow, PhD, RN, DiplAc
George DeVries, III
William Fair, MD
Joseph Eins, MD, FACP
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Joseph Kaczmarczyk, DO, MPH
Doris Kingsbury
Geroldine Pollen, MA

Consultant Staff

Kenneth Eisher, PhD
Maureen Miller, MPH
James Swyers, MA

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

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14. Should there be national, state, or local, standards and credentialing to provide CAM practices and products, and why or why not? If so, how and by whom should standards and credentialing be established, to whom should they apply, and how should they be implemented?

Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: polleng2@mail.nih.gov <<mailto:polleng2@mail.nih.gov>>), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

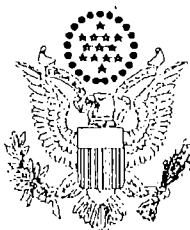
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Sincerely,



Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

Tab 9



White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

January 31, 2001

Stephen H. Miller, M.D., Ph.D.
Executive Vice President
American Board of Medical Specialties
1007 Church Street, Suite 404
Evanston, IL 60201

Dear Dr. Miller:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

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

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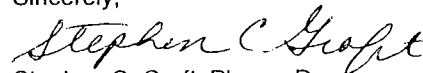
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Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: polleng2@mail.nih.gov <<mailto:polleng2@mail.nih.gov>>), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

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Sincerely,



Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

ABMS

From: Stephen H. Miller [smiller@ABMS.org]
Sent: Friday, February 02, 2001 9:01 PM
To: Pollen, Geraldine (NCCAM)
Subject: Your survey

I am afraid that the questions you pose and the time frame prevent me from addressing the issues. I have just received the e-mail, having been out of town at a meeting. We have meetings all next week and I leave again for meetings on Feb. 8-18. To my knowledge, the issues have not been addressed by the ABMS as a whole during my three year tenure. I am sure, that some individual ABMS Boards may have done so, but quite honestly am unsure of which ones they might be. My only suggestion is for you to contact the American boards of Internal Medicine, Pediatrics, Family Practice and Psychiatry and Neurology for starters.

Stephen H. Miller, M.D. M.P.H.
Executive Vice President
American Board of Medical Specialties
847.491.9091
Fax: 847.328.3596

Tab 10



White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

February 6, 2001

Norman F. Gant, M.D.
Executive Director
American Board of Obstetrics
and Gynecology
2915 Vine Street
Dallas, TX 75204

Dear Dr. Gant:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

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The questions that follow were developed to guide the Commission's deliberations.

1. To what extent is CAM included in graduate medical education?
2. What are the barriers to inclusion of CAM in medical school curricula and/or graduate medical education, for example, science, resources, expertise, qualified faculty, interest? Conversely, what are the incentives for inclusion of CAM in medical school curricula and/or graduate medical education?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in medical school curricula and/or graduate medical education?

Chair

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Doris Kingsbury

Geraldine Pollen, MA

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Les Swyers, MA

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

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

6. What is the status of CAM in continuing medical education (CME)? To what extent is CAM included in CME curricula? To what extent should CAM be included in CME curricula?

7. What are the barriers (expertise, interest, resources) to inclusion of CAM in CME curricula? Conversely, what are the incentives for inclusion of CAM in CME curricula?

8. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in CME curricula?

9. What should every primary care physician know about CAM? How and by whom should that level of knowledge be determined? Should core competencies demonstrated by physicians include CAM?

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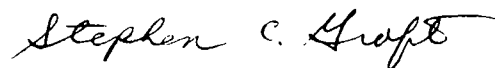
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Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: (polleng2@mail.nih.gov ~~<mailto:polleng2@mail.nih.gov>~~), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

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Sincerely,



Stephen C. Graft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

Tab 11



White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

February 1, 2001

Ralph W. Hale, M.D.
Executive Vice President
American College of Obstetricians and Gynecologists
409 12th Street SW
Washington, DC 20024-2188

Dear Dr. Hale:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

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

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Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: polleng2@mail.nih.gov <<mailto:polleng2@mail.nih.gov>>), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

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Sincerely,



Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

From: Ralph Hale [RHale@acog.org]
Sent: Thursday, February 01, 2001 10:46 AM
To: Pollen, Geraldine (NCCAM)
Cc: DNehra@acog.org; DWachter@acog.org; GHolzman@acog.org
Subject: Re: White House Commission

thank you for your inquiry. I am referring your requests regarding undergraduate education to the Association of Professors of Obstetrics and Gynecology (APGO) as they are the organization in our specialty that deals with undergraduate education. For the residency Curricula, I am forwarding your requests to the Council of Resident Education in Obstetrics and Gynecology (CREOG) as they work on the educational objectives and Curricula for our training programs. However it is the Residency Review Committee of the ACGME which sets the standards. I am unsure as to whether any of these organizations can respond in the short time frame you have given them as they are preparing for their annual meeting in four weeks.

✓ (See tab #20 for the response from Association of Professors of Obstetrics and Gynecology (APGO) referenced above by Ralph Hale)

From: DeAnne Nehra [DNehra@acog.org]
Sent: Thursday, February 01, 2001 12:11 PM

Dr. Hale forwarded your request to me for a response regarding resident education and curricula. You should contact the Accreditation Council for Graduate Medical Education (ACGME) DCL@acgme.org. The ACGME is the regulatory body that gives delegated accreditation authority to the RRCs. The RRCs have the authority to accredit residency programs in the specialty they represent. The Residency review Committee (RRC) for Ob-Gyn can be reached at poc@acgme.org. To be accredited, a residency program must meet the "Institutional Requirements" and "Program Requirements." I hope this assists you.

DeAnne Nehra
CREOG Associate Director

(See tab #2 for the response from Accreditation Council for Graduate Medical Education (ACGME) referenced above by DeAnne Nehra)

Tab 12



White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

February 1, 2001

Betty A. Warner
Executive Director
American College of Osteopathic Family Physicians
330 E Algonquin Road
Arlington heights, IL 60005

Dear Ms. Warner:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

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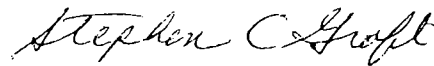
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Sincerely,



Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

Tab 13



White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

February 5, 2001

Steve P. Buchanan, D.O., FACOOG
Executive Director
American College of Osteopathic
Obstetricians and Gynecologists
900 Auburn Road
Pontiac, MI 48342-3365

Dear Dr. Buchanan:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

The Commission will meet on February 22-23 to discuss complementary and alternative medicine in terms of education and training of health care practitioners, quality of care, and accountability. To accomplish its goal, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments on these issues (as relevant to your organization) by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before the February 22-23 meeting.

The questions that follow were developed to guide the Commission's deliberations.

1. What is the status of CAM in undergraduate and/or graduate medical education? To what extent is CAM included in medical school curricula and/or graduate medical education? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed?
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4. What should every medical student know about CAM? How should that level of knowledge be determined?
5. What should every resident-irrespective of specialty-know about CAM? How should that level of knowledge be determined?
6. What should every fellow-irrespective of specialty-know about CAM? How should that level of knowledge be determined?

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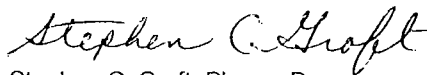
James Swyers, MA

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14. Should there be national, state, or local, standards and credentialing to provide CAM practices and products, and why or why not? If so, how and by whom should standards and credentialing be established, to whom should they apply, and how should they be implemented?

Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: polleng2@mail.nih.gov <<mailto:polleng2@mail.nih.gov>>), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

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Sincerely,



Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
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Thank you for your kind invitation to the American College of Osteopathic Obstetricians and Gynecologists (ACOOG) to comment on the 14 questions about Complementary and Alternative Medicine (CAM). This issue has the potential to touch the patient-doctor relationship in so many ways, both seen and unforeseen. Your letter request dated February 05, 2001 has been circulated to the Executive Committee and chairpersons of the Residency Evaluating Committee and Continuing Medical Education Committee of the ACOOG. The comments that follow each of your questions represent a short compilation of opinions, by no means a consensus statement. These diverse responses will obviously reflect the expected biases of clinicians with long experience in the direct patient care of women. With the exception of one associate dean for Clinical Affairs of a state medical school, all are involved in daily patient care, resident and medical student teaching with medical education in OB-GYN as their undeniable common career mission.

The ACOOG is a national organization, a Specialty College and affiliate of the American Osteopathic Association.

The mission of this College is to maintain an organizational framework committed to the physical, mental and spiritual health of women by

- promoting the practice of obstetrics and gynecology according to acceptable standards in the community
- adherence to the Code of Ethics of the AOA
- representation on appropriate AOA committees
- adopting, implementing and maintaining standards for post graduate obstetrical and gynecologic education
- providing and promoting obstetrical and gynecologic continuing medical education according to acceptable standards
- promoting and providing public awareness of women's health issues

Given the very short time constraints imposed in your letter in order to provide comment to the Commission, please accept these observations in the spirit in which they are rendered; as an attempt to improve health care for women.

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

The ACOOG per se does not formulate curriculum at the undergraduate level. However, from our post CME evaluation tools, one-third of our CME attendees admits to resident and medical school teaching responsibilities and predominantly as volunteer clinical faculty. The ACOOG comments are most relevant to graduate education and we would responsibility for the undergraduate curriculum to other organizations, such as the American Association of Colleges of Osteopathic Medicine as an example.

Presently, there is no standard for teaching CAM in undergraduate or graduate medical education. There is no defined set of learning objectives on CAM that are widely distributed among the variable medical schools. The Association of Professors of Gynecology and Obstetrics (APGO) has learning objectives that are widely used in undergraduate medical education. These learning objectives do not include CAM.

Curriculum and systems of care, therefore, vary widely by school. Each course or clerkship director will introduce CAM from their own beliefs into where it fits in their curriculum.

The American Osteopathic Association's Women's Health Advisory Committee has included complementary and alternative medicine in their programs regarding Women's Health. These programs include undergraduate and graduate medical education as well as continuing medical education. However, there has been no standardization across the profession. Again each course director will incorporate CAM as s/he sees fit.

As to graduate education, specifically the 31 OB/GYN residency programs that are AOA approved and inspected with the input of the Residency Evaluating Committee of the ACOOG, we can state that the Basic Standards for the residency programs do not specifically mention CAM. CAM training as a goal, objective or accreditation standard is not currently in the language of the basic standards documents.

While we believe that CAM is addressed, in fact, in both medical schools and in graduate medical education, the problem in answering this question is extremely variable from one school to another as well as from one residency program to another. There is, in fact, no standard answer to this question at this time.

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

Again, addressing only resident education, CAM would have to be defined in each particular discipline to be addressed in the scientific and (hopefully) evidence-based model of resident training. This would most likely be an accepted methodology for residency training faculty. Modalities with outcome studies showing favorable risk-benefit ratios, and cost effectiveness as it relates to patient care, would stand the best chance of being included in the curriculum. Conversely, modalities that adversely interact with conventional therapies must be publicized and included in programs for house officers so as to assist them in their patient-care duties in both hospital and clinic.

The greatest barrier to inclusion of CAM in medical school curricula is the lack of an appropriate database of clinical trials regarding the effectiveness of complementary and alternative medicine. Most medical schools use a scientific approach to data, the evidence based medicine movement has enhanced this. The lack of strongly designed, randomized control trials for much of complementary and alternative medicine makes faculty and curriculum committees reluctant to spend precious contact hours on CAM.

The usual argument for teaching CAM is that " ... your patients are using this so you need to know about it." This leads to discussions without the usual scientific rigor of most medical school curricula.

Other barriers include lack of truly qualified faculty and a minimal amount of research dollars presently being funded on most campuses towards complementary alternative medicine. Financial support from this research could enhance the entry of CAM into the curriculum.

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

It makes one nervous to dictate what should and what should not be taught in medical schools and graduate medical education. Certainly, from a disease model, we believe that all options of treatment should be explored, but to highlight a specific CAM modality as being required to be taught, we believe misses the mark.

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

American College of Osteopathic Obstetricians and Gynecologists believe that broad-based learning objectives regarding complementary alternative medicine need to be developed.

The White House Commission should lead this effort, however, broad consortium of organizations, including ACOOG, ACOG, APGO and similar organizations in other field need to be included. A Delphi panel could develop the learning objectives that could then be widely distributed to medical schools and graduate medical education programs. These should include recommendations regarding student evaluation.

Once these learning objectives are established, the level of knowledge should be evaluated in the same ways that most learning objectives are evaluated in medical and graduate medical education:

- a. Testing of these learning objectives in graduate examinations including practical examinations such as OSCI.
- b. Inclusion on board examinations such as NBOME and USMLE

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

The resident curriculum should include information on the current alternative medicines, the modalities that these medications are being recommended for, and the effects that these medications are having in treatment of specific disease states. Additionally, all adverse effects that the utilization of these medications may have on a patient with a specific disease or with a combination of medications in that treatment of that specific disease, needs to be discussed. The resident should have the knowledge of the utilization of alternative medications by the public so that it is part of the routine information gathering skills required of residency training.

Determining knowledge is best done in testing through the basic science examinations and the in-training examinations process currently in effect. Questions can be developed that test current utilization of alternative medications and adverse effects of these medications alone or in combination with other medications in certain disease states. Graduate examinations are currently being developed to cover a broad range of this type of knowledge. Questions on alternative medications and complementary medicine can easily be incorporated into the matrix of such exams. Once questions are being asked on any topic, this topic will then become something about which the graduate student (resident) will, of course, want more information.

6. *What should every fellow, irrespective of specialty know about CAM, how should that level of knowledge be determined?*

The comments in question 5 above for resident training would certainly be pertinent to fellows in training as well.

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

Where a particular CAM modality has relevance to existing residency programs, knowledge should be explored, opportunities for collaboration discussed, and health care could benefit. Where patient care is affected, however, integration into conventional programs within the ethical framework of the patient-doctor relationship is one possible fruitful scenario. However, in such an integrated format involving a specific patient in a specific disease state, one practitioner will have to be the "captain of the ship". If liability should be an issue and if standard of care must be met, then captaincy of the team might ultimately default to that practitioner with the highest skills. But at the same time, however, we must recognize that integration into conventional programs also sets that CAM modality up to the same standard of scrutiny as is found in conventional medicines (e.g. standard of care issues, malpractice liability, and accreditation standards of health care organizations).

The American College of Osteopathic Obstetricians and Gynecologists feels that an integrative residency program is not the appropriate approach until their own specialty board could recognize graduates from such programs and until these boards are recognized by managed care organizations.

ACOGG believes that CAM is best integrated throughout existing programs. We believe the barriers to new training programs include:

- a. Difficulties in funding new residency spots –and the effects of the 1997 Budget Reconciliation Act.
- b. Lack of a recognized specialty board
- c. Lack of recognition for graduates of such programs by managed care organization. Thus work involving complementary alternative medicine would be considered part of the capitated programs. This creates a disincentive for the appropriate use of complementary and alternative medicine.
- d. Lack of a well-trained faculty
- e. Lack of a program for practitioners presently interested in and/or practicing CAM to become certified.

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

Good question. If one takes the stand that medical schools are independent, then the medical school should pay for CAM medical education. If this is going to be a government mandated requirement, then the government should have the burden of cost to provide the education.

The Balanced Budget Act of 1997 has, in some cases, disseminated the residency programs throughout the country. These residency programs have oftentimes been providing health care to the public for decades. When CAM practitioners have risen to the level of meeting licensing, legal, ethical and moral

standards of the practice of medicine in its traditional sense of the word, then CAM practitioners should be encouraged to compete for federal and state tax dollars to further their interests and their own training programs. Certainly, commensurate with such access to federal dollars would come participation in health care at the level of the uninsured patient as well as the emergent patient, wherever it would be relevant.

9. *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?*

CAM is being integrated into CME provided by the ACOOG. Over the last 3 or 4 years the following topics been included in our CME offerings which occur twice a year to osteopathic obstetricians and gynecologists and residents in training:

- Hormone replacement therapy
- Alternatives to conventional hormone replacement therapy by complementary and alternative medicine modalities
- CAM for common GYN therapies
- Homeopathic remedies for GYN problems

Osteopathic manual medicine, at one time considered an alternative therapy, also remains a focus of the CME offerings of the ACOOG. Hands-on workshops as well as didactic lectures remain the preferred modalities for assisting osteopathic obstetricians and gynecologists in maintaining their manipulative medicine skills.

Of course osteopathic manipulative treatment remains a centerpiece of the curriculum in the first two years of training at most all of the 19 colleges of osteopathic medicine. Required rotations in the third or elective rotations in the fourth years are also an offering of some of the colleges as well. As this issue relates to undergraduate training, the ACOOG will defer to AACOM and the AOA for further comment. Any avenue that adds to the education and training of physicians in practice about CAM should be explored. The potential for internet based technologies as well as meetings, monographs and manuals to inform practitioners of conventional medicines about what CAM modalities their female patients are currently using would be invaluable. The female patient is more likely to be purchasing products and participating in complementary and alternative medicines and the need for physicians to be educated as to the effects, side effects, drug interactions and potential for synergy in conventional therapies is vital to the optimal provision of health care to women.

11. *What policy recommendations can you make to facilitate the inclusion or expansion of CAM in CME curricula?*

As an accredited sponsoring organization for osteopathic continuing medical education, the ACOOG must meet rather strict guidelines regarding the CME offerings. Among these are regulations about corporate sponsorship and CME programming. Any CAM presentation must meet the same standard for disclosure, noncommercial messaging and direct patient care benefit in order to be on the program. Many of the same standards that are set for any corporate or educational grant to support CME would be relevant to any CAM modality being presented.

If these policies and guidelines are not met for CAM as well as conventional modalities, CME would have the potential to become another infomercial opportunity to boost incomes with sometimes even

questionable patient benefit.

We have grave concerns regarding some of the unfounded and uncorroborated claims of certain CAM modalities as they are related in the print media and anecdotally related to us by our patients. Patients, by and large, still rely upon their doctors to help them filter the information explosion in most areas of healthcare if given access to those doctors.

Continuing high quality CME about CAM in the future is likely the best informed approach that doctors can utilize to help them help their patients.

12. *What should every primary care physician and every specialist know about CAM? How and by whom should that level of knowledge be determined? Should core competencies demonstrated by physicians include CAM?*

Primary care physicians should know about the CAM modalities that their patients are using. This knowledge should be acquired as is all new medical knowledge acquired by physicians in practice through utilizing techniques such as conferences, lectures, reading journals, internet browsing and additional formal schooling. Competency should be judged as other medical competencies are judged. There should not be a separate "test". We believe that all health care providers should have an understanding of what is considered best practice or at least what is within the realm of acceptable practices based on clinical evidence and evidence-based reviews. We believe all practitioners should have a concept as to what levels of evidence are supporting their practices, whether conventional or CAM.

13. *What should physicians know when referring patients to CAM practitioners? How and by whom should that level of knowledge be determined? What information should conventional physicians communicate to a CAM practitioner? What information should a conventional physician expect to receive from a CAM practitioner? How can conventional physicians minimize the risk of dietary supplement - drug; dietary supplement - dietary supplement; and dietary supplement - food interactions?*

This question goes to the heart of the issue of CAM as it relates to conventional - CAM practitioner interaction. Depending upon which modality is being addressed, referral from conventional MD or DO to CAM practitioner could open the MD - DO up to concerns about violation of standards of care in the community. The essence of conventional therapy should be illustrative of standard of care in the community by reasonable and prudent practitioners.

CAM, having "medicine" in the title, does confer some legitimacy in the eyes of the public. It is our hope that government would be able to balance the competing principle of protection of the public from potentially harmful or unethical exploitation with the principle of the self-determined autonomy of the patient.

Information that is reliable and predictable would be one way that government could facilitate, as a clearinghouse, the information that is known to both the lay public as well as to the practitioner of medicine. The explosion of the modalities available for patients to self-refer and self-treat is a modern day reality. The reaction by conventional medicine can only be improved by making information about all of the interactions listed available as soon as they are known. Recall of harmful products should occur as indicated for public protection. It is vital that practitioners, oftentimes responsible for prescribing multiple medications to any given patient, should be fully aware of known drug interactions.

between CAM products and those that they are prescribing. However, it is the purview of government to see to it that manufacturing standards and dosage accuracies should be formed and followed so that we, as practitioners, know what is in any given formulation that the patient admits to taking.

14. *Should there be national, state, or local standards in credentialing to provide CAM practices and products, and why or why not? If so, how and by whom should the standards in credentialing be established, to whom should they apply and how should they be implemented?*

There should be national standards for the individuals that are given the privilege and the responsibility of disseminating information and recommending alternative and complementary medications. The knowledge of the complications and adverse effects of the alternative medications in combination with other medications or in certain disease states should be known before recommending treatment with the agents. The credentialing could be incorporated under the pharmacy license with states having the right to establish statewide policies and examinations to credential those individuals or agents that could sell the product.

When a given CAM modality has met the weight of rigorous clinical trials and outcomes inquiries, has been duly licensed by a government body and has purchased product liability - malpractice insurance to protect the potentially injured, then basic standards will have been met for certain CAM modalities.

However, the principle of "let the buyer beware" in an open market for patients self-referring to CAM practitioners, is, in fact, sometimes in direct conflict with standard of care requirements established for health care providers and health care facilities. If nutraceuticals and herbal remedies are to be sold to the public, then exacting standards for manufacture and formulation, adverse event reporting protocols and prompt recall procedures should be implemented for the general welfare. Failure to meet standards, especially if fraud is involved, should open manufacturers and practitioners to legal liability.

We wish to thank the Commission for asking for our opinions. We wish to remind the Commissioners that health care is a common good and should be governed by principles of biomedical ethics including:

- beneficence,
- non-maleficence,
- personal autonomy,
- respect for the sanctity of the patient-doctor relationship including confidentiality, and
- the duty to distribute health care with justice.

As we are but a few of the almost 40,000 osteopathic physicians in the United States, 70% of whom are engaged in primary care, we hold certain principles at the core of our osteopathic belief system of health care. Among these principles include:

- The human being is a dynamic unit of function
- The body possesses self-regulatory mechanisms, which are self-healing in nature
- Structure and function are interrelated at all levels
- Rational treatment is based on these principles

A.T. Still, M.D. founded the osteopathic profession because he was dissatisfied with the practice of medicine as it existed in the latter part of the 19th century. One of his predominant views of the musculoskeletal system was that it could influence the health of the patient, primarily by affecting movement of air and fluids in the body, as well as by the delivery of oxygen and removal of waste

products from tissues. At the time, this philosophy was, in all likelihood, considered a complementary or alternative medicine depending upon one's perspective.

We believe that modalities of complementary and alternative medicine that would meet a "predictability as the criterion of truth" standard will stand the best chance of being with us a hundred years from now. CAM today, conventional tomorrow could become a familiar refrain in medicine.

The opinions expressed in these responses are those of individual clinicians within leadership roles of the ACOOG at the present time. These do not reflect the opinions of a surveyed membership or any research based data gathering exercise. These opinions do not reflect any ACOOG official policy on complementary and alternative medicine.

The ACOOG respectfully requests a copy of the executive summary of the final report of the Commission. We would also welcome a web site address or linkage to our ACOOG homepage for the completed report so that we may circulate this information electronically to our members as they seek continuing education and improvement in the health care of women.

Sheryl Bushman, D.O. FACOOG(Dist.)
President

Steve P. Buchanan, D.O.FACOOG(Dist.)
Executive Director

Receipt Acknowledged

Response Promised

Tab 14



White House Commission on Complementary and Alternative Medicine Policy

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February 1, 2001

Robert Doherty
Senior Vice President
American College of Physicians
American Society of Internal Medicine
2011 Pennsylvania Ave. NW - Suite 800
Washington, DC 20066

Dear Mr. Doherty:

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Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: polleng2@mail.nih.gov <<mailto:polleng2@mail.nih.gov>>), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,



Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

In response to your inquiry, may I offer a perspective from the American College of Physicians-American Society of Internal Medicine (ACP-ASIM). We are the second largest medical professional organization in the country, with well over 100,000 members at various stages of careers in internal medicine and its subspecialties. We have no explicit policy with respect to CAM, but the area is included in a number of our programs, as I will describe below. The numbered responses reflect the numbering of your questions.

1. With respect to undergraduate medical education, you might try the Association of American Medical Colleges, which collects curriculum data. The Accreditation Council for Graduate Medical Education's Residency Review Committees will be able to identify the extent to which CAM is mandated in residency and fellowship program requirements relative to accreditation. I suspect that you will find the coverage is limited but not absent.
2. The major barrier I suspect is curriculum time. With the explosive growth in content and skills in the past several decades, an hour of teaching time has become a precious commodity.
3. Facilitation should be part of a broader dialogue among the leaders of the education community about the curriculum as a whole and the requisite competencies to be gained. In internal medicine, for example, such a curriculum guide is being prepared by a coalition of our educational organizations. There is a need to identify such projects across the educational spectrum and include consideration of CAM in product development.
4. See #3. There are many models for developing a description of content domain. They usually involve collaborative efforts among advocates, experts, and the broad-based educational community.
5. See #4
6. See #4
7. There is a balance between the need for special expertise to be learned and the avoidance of fragmentation of health care delivery into so many pieces that the care of the patient as a whole suffers. Therefore, ACP-ASIM has been very, very cautious in endorsing the creation of new "specialties," as opposed to a sensible revisiting of educational content and expected competencies. The geriatrics model in internal medicine and family practice is a good one, moving towards broad based curriculum development and expertise.
8. The funding should be channeled through the usual funding sources for the various levels of education. While unintended, there's a risk of separate funding for CAM education having the consequence of displacing needed education in, for example, cancer or sickle cell disease.
9. There's a lot of attention currently being paid to CAM in CME. ACP-ASIM plays a major role in CME in internal medicine, and we cover CAM in a variety of programs and products, such as our Annual Session (which attracts over 6,000 physicians); the Medical Knowledge Self-Assessment Program (MKSAP), which

is subscribed to by over 40,000 physicians; our major journal, *Annals of Internal Medicine*, which reaches almost 100,000 physicians; and others. We think it's appropriate, and I'm sure other professional societies feel the same way, that CAM content be represented in CME programs.

10. Again, the major barrier is time. There is a lot of competition for a limited amount of exposure time. That's why our process for development of curriculum for our various products is based on a global, integrated perspective rather than a piecemeal response to various sources of specific advocacy.
11. I don't believe this is a matter that will be advanced by policy, for the reasons I've noted above.
12. We believe that most physicians, especially in primary care practice, should be knowledgeable about some aspects of CAM. We believe that there already exist processes for curriculum development and modification and that they already include CAM in their thinking. Support of educational programs and products, especially of the type shown by research to influence physician behaviors in practice, would be useful and would probably be welcomed by educational providers, such as specialty societies.
13. This is a complex set of questions that should be addressed within the broader framework of generalist-subspecialist referral and communication. This whole area needs additional attention, although a number of steps have been taken, including some by ACP-ASIM. The Agency for Healthcare Research and Quality might be a good source of information for you.
14. Again, it would be ill advised to treat CAM any differently from any other important content area in the practice of medicine. There seems to be already a considerable proliferation of specific CME requirements for relicensure in many jurisdictions. Too much reduction in flexibility for physicians to use their precious educational time to remedy deficiencies in knowledge and skills could be an unwelcome unintended consequence of attempts to go too far in mandating education, credentialing, etc.

I hope these thoughts, which, as I've noted, don't necessarily reflect formal policies of the ACP-ASIM are useful. If you'd like anything further, please let me know.

Herbert S. Waxman, MD, FACP

Senior Vice President, Education

ACP-ASIM

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Tab 15



White House Commission on Complementary and Alternative Medicine Policy

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E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

February 1, 2001

Michael Barry
Associate Executive Director
American College of Preventive Medicine
1307 New York Ave. NW, Suite 200
Washington, DC 20005

Dear Mr. Barry:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

The Commission will meet on February 22-23 to discuss complementary and alternative medicine in terms of education and training of health care practitioners, quality of care, and accountability. To accomplish its goal, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments on these issues (as relevant to your organization) by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before the February 22-23 meeting.

The questions that follow were developed to guide the Commission's deliberations.

1. What is the status of CAM in undergraduate and/or graduate medical education? To what extent is CAM included in medical school curricula and/or graduate medical education? What systems of care, modalities, and therapies are addressed? When, where, how, and by whom is CAM addressed?
2. What are the barriers to inclusion of CAM in medical school curricula and/or graduate medical education, for example, science, resources, expertise, qualified faculty, interest? Conversely, what are the incentives for inclusion of CAM in medical school curricula and/or graduate medical education?
3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in medical school curricula and/or graduate medical education?
4. What should every medical student know about CAM? How should that level of knowledge be determined?
5. What should every resident-irrespective of specialty-know about CAM? How should that level of knowledge be determined?
6. What should every fellow-irrespective of specialty-know about CAM? How should that level of knowledge be determined?

Chair

James Gordon, MD

Commissioners

George Bernier, Jr., MD

David Breder, PhD, LAc, OMB

Thomas Chappell

Elle Chow, PhD, RN, DiplAc

George DeVries, III

William Fair, MD

Joseph Fink, MD, FACP

Yeronica Gutierrez, DC

Wayne Jonas, MD

Linnée Larson, LCSW, LMFT

Pieraona Low Dog, MD, AHG

Charlotte Kerr, RSM

Dean Ornish, MD

Conchita Paz, MD

Joseph E. Pizzorno, Jr., ND

Burford Rolin

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Consultant Staff

Kenneth Fisher, PhD

Maureen Miller, MPH

Ann Sowers, MA

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

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

9. 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?

10. 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?

11. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in CME curricula?

12. What should every primary care physician and every specialist know about CAM? How and by whom should that level of knowledge be determined? Should core competencies demonstrated by physicians include CAM?

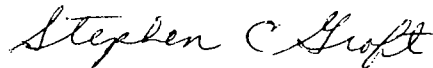
13. What should physicians know when referring patients to CAM practitioners? How and by whom should that level of knowledge be determined? What information should conventional physicians communicate to a CAM practitioner? What information should a conventional physician expect to receive from a CAM practitioner? How can conventional physicians minimize the risks of dietary supplement-drug; dietary supplement-dietary supplement; and dietary supplement-food interactions?

14. Should there be national, state, or local, standards and credentialing to provide CAM practices and products, and why or why not? If so, how and by whom should standards and credentialing be established, to whom should they apply, and how should they be implemented?

Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: polleng2@mail.nih.gov <<mailto:polleng2@mail.nih.gov>>), fax: (301-480-1691), phone: (301-435-6233 or 7592), and contact her with any questions you may have. A hard copy of this letter will be sent to you.

The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,



Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy