Tab 16

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

Thomas Russell, M.D.
Executive Director
American College of Surgeons
633 North Saint Clair Street
Chicago, IL 60611

Dear Dr. Russell:

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?

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

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
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January 31, 2001

D. Ted Lewers, M.D.
Chairman of the Board
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Dr. Lewers:

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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a. How and by whom should "quality" be defined?
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Executive Director
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From: Mohamed Khan [mokhan@med.umich.edu]
Sent: Tuesday, February 06, 2001 11:32 PM
To: Ted_Lewers@gwise.ama-assn.org; Pollen, Geraldine (NCCAM)
Cc: ER_Anderson@gwise.ama-assn.org; Janet_Steffeter@gwise.ama-assn.org; Michael_Scotti@gwise.ama-assn.org; Todd_Vande-Hey@gwise.ama-assn.org
Subject: Re: White House Commission

Barry,

I'll look at this more carefully, but I wanted to give an initial reply.

They seem to be asking for answers to detailed questions, many of which seem to be jumping the boat. I would start by pulling AMA policy (and recent CSA reports on this issue). Perhaps some of this is already answered there.

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Without the research being done properly, the (2)education, (3) dissemination of information, and (3) health care delivery of CAM does not make much sense to me.

I would be supportive of beginning to think of useful methods/structures (for 2,3,4) that one may want developed for the time when appreciable research is done, and that may be a way to approach this. It might be a good idea to begin to think of the "quality" of CAM products (I would support evidence-based proven uses), and who should oversee this (FDA?).

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Mohamed

>>> "Ted Lewers" <Ted_Lewers@gwise.ama-assn.org> 01/31/01 06:02PM >>>

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>>> "Ted Lewers" <Ted_Lewers@gwise.ama-assn.org> 01/31/01 06:02PM >>>

Thanks for contacting me. I have forwarded your e-mail to the appropriate staff and a response will be sent to you by the deadline. DTL

Thank you for the opportunity to comment on the questions that the Commission has developed in order to establish a framework for enhancing the integration of complementary and alternative medicine (CAM) practices with conventional, evidence-based medicine. In addition to addressing the specific questions below, I would like to offer a few general comments. One concern is that the questions that have been supplied do not differentiate among complementary and alternative (CAM) practices that have been validated by appropriate scientific study, those that are promising, and those that are without foundation. It is not possible to consider all CAM practices equally in the questions that have been posed.

The distinction between conventional and alternative or complementary medicine can be viewed as somewhat artificial, because in the final analysis, there is only scientifically proven, evidence-based medicine supported by solid data, or unproven medicine, for which scientific evidence is lacking. Conventional or CAM practices can fall into either camp. As CAM practices develop an evidence base to support their efficacy, they tend to be embraced by physicians. For example, witness the widespread use and clinical evidence on the value of acupuncture in selected patients.

Physicians and CAM practitioners need to understand the conflict between standardization and individualization. Evidence-based medicine emphasizes reproducibility. It attempts to define a universal "best practice" based on large randomized controlled trials and meta analyses. This appears to be the antithesis of CAM, which focuses on the individual interaction between patient and practitioner. A concern for physicians then is the myriad CAM therapies, and a relative lack of exact therapeutic indications for CAM practices.

Nonspecific "complex effects" are claimed to be a crucial part of the healing process espoused by CAM practitioners. Randomized trials attempt to cancel out factors such as the therapeutic setting, the personality of the clinician, the amount of time given to patients, and even the very words spoken to them. Alternative and complementary medicine needs to be more evidence-based, by using standard methods and tools to investigate the contribution of those facets of CAM therapies that relieve suffering and contribute to symptom relief.
Specific responses to some of the questions that you have posed are provided below:

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?

   Providers of CME must ensure that the content of the educational activities that are designated for credit are scientifically based, accurate, current, and are presented in an objective manner. The objective of an activity should match the educational needs identified by expert opinion, a study, or analysis of evaluations or examination from earlier activities. Group needs can be determined from a practice profile, peer review, self-assessment, or case audit. New medical knowledge can serve as a basis for sponsoring a program.

   Education describing and explaining health care practices, including alternative health care practices, is an appropriate subject for CME provided there is a discussion of the level of scientific evidence to support the practices. Education that advocates specific therapies or

procedures and gives instructions on how to perform them in the absence of generally accepted knowledge that the therapies are efficacious and safe practices do not constitute CME that can be designated for the Physician's Recognition Award (PRA). Physicians and other individuals serving as faculty of CME should ensure that their presentation is scientifically accurate and uninfluenced by industry or financial contributors. They also must communicate any potential conflict or interest to providers and physician participants. Credit for PRA is awarded to physicians by organizations whose educational activities meet the American Medical Association (AMA) standards and who are accredited by the Accreditation Council for Continuing Medical Education (ACCME) or a state medical society recognized by the ACCME Committee for Review and Recognition (CRR).

Today, more than 2,500 organizations nationwide are accredited to provide CME. **We are not aware of survey data on the approximate number or percentage of accredited CME programs that are devoted to alternative or complementary practices.**

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

   Clearly, the greatest barrier is uncertainty about the science base, the lack of readily accessible training for certain alternative and complementary techniques, and the tendency for practitioners of CAM to have difficulty in easily extending their methods to untrained practitioners.

   The major incentives are patients' interest and willingness to utilize the services of CAM practitioners, media interest, and the growing trend of recognition and third party reimbursement of certain CAM practices.

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

   There are no shortcuts to appropriate CME activities. As described above, providers of Continuing Medical Education (CME) must ensure that the content of the educational activities that are designated for credit are scientifically based, accurate, current, and are presented in an objective manner. The objective of an activity should match the educational needs identified by expert opinion, a study, or analysis of evaluations or examination from earlier activities. As an initial step, efforts could be focused on the faculty and hospitals associated with medical schools.

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

   As a first step, practicing physicians should have a basic understanding of the terminology and definitions of techniques. The AMA recognizes the domains of CAM as described by the National Center for Complementary and Alternative Medicine (NCAMM). Actually, the previous definitions contained on the NCCAM website were more informative than the current domains, which are by comparison somewhat truncated. This vocabulary serves as the

foundation for practicing physicians to routinely ask their patients about the use of CAM whenever they take a comprehensive history.

Physicians need to be informed about CAM because their patients are using CAM and will continue to use CAM if they believe that these therapies are helpful to them. Approximately 7 in 10 patients using CAM for a serious health problem do not tell their physicians that they are using CAM therapies. Hence, physicians need to know enough about CAM to provide information about possible interactions with pharmaceutical prescriptions and to provide reliable information to help patients sort through all the multilevel marketing of CAM products.

Providing information about CAM is not straightforward, in part because the general area of CAM refers to a variety of methods that may be either more or less effective for specific medical conditions and individuals. Outcome studies are needed so that physicians can make decisions about the use of CAM based on scientific evidence of efficacy rather than on regional economics and cultural norms.

The impact of physicians incorporating CAM therapies into their practice (or referring patients to CAM providers; see Question #5) has the potential to change the delivery of health care, but the trend toward managed care, standardization of care, and shorter office visits is in conflict with patients' and physicians' interest in more individualized treatments.

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

The major reasons listed by physicians for their practice of, referral for, or interest in CAM are (in order of frequency): 1) lack of response to conventional treatment; 2) patients' request or preference; 3) physician belief in efficacy; and 4) possibility of fewer adverse effects.

Physicians should develop sufficient knowledge of the commonly employed alternative remedies to counsel patients about those that are harmful, those that might interact adversely with prescribed medicines, those that are harmless and can be used with impunity, and those that have been shown to be beneficial. Communications with CAM practitioners by physicians assumes that the patient wishes this communication to take place. Referrals must also respect patient confidentiality and consent. Transmitted information should be limited to the issue at hand, and should include all pertinent history/physical/lab findings, just as with any referral to a conventional physician.

Physicians must realize that one or more of the major CAM disciplines may not be licensed in a particular state—theoretically, this could increase malpractice exposure (see Question #8). Licensure requirements can be state or even municipality-specific when it comes to certain CAM modalities. If referral is made to an unlicensed practitioner and a lawsuit arises, the plaintiff's attorney may capitalize on the licensing issue. Yet major health care organizations contract with CAM practitioners who are not licensed in their states. The National Committee for Quality Assurance (NCQA) does not restrict health plans to licensed CAM providers, but NCQA does require plans to follow a process to evaluate the quality of CAM providers they work with.

Some questions that the physician needs to evaluate when considering referral to a CAM practitioner are: 1) The CAM provider's willingness for give-and-take in the referral process; 2) Which conditions or types of patients is the CAM practitioner particularly helpful with? 3) How can physicians begin to feel comfortable with knowing when to refer? 4) How many visits does a typical treatment regimen last? 5) Does the CAM practitioner receive referrals from any (other) conventional providers? 6) If so, from whom, and for what types of conditions? 7) Does the CAM practitioner refer regularly to any conventional providers? Again, if so, to whom?

Physicians also should become aware of any CAM networks that are active in his or her area and whether any major payers have credentialed internal networks.

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

Yes. The National Guidelines Clearinghouse™ (NGC) uses four inclusion criteria to determine whether or not a clinical guideline meets its requirements.

- The clinical practice guideline contains systematically developed statements that include recommendations, strategies, or information that assists physicians and/or other health care practitioners and patients who make decisions about appropriate health care for specific clinical circumstances.

- The clinical practice guideline was produced under the auspices of medical specialty associations; relevant professional societies, public or private organizations, government agencies at the Federal, State, or local level; or health care organizations or plans. A clinical practice guideline developed and issued by an individual not officially sponsored or supported by one of the above types of organizations does not meet the inclusion criteria for NGC.

- Corroborating documentation can be produced and verified that a systematic literature search and review of existing scientific evidence published in peer reviewed journals was performed during the guideline development. A guideline is not excluded from NGC if corroborating documentation can be produced and verified detailing specific gaps in scientific evidence for some of the guideline's recommendations.

- The guideline is in the English language, current, and is the most recent version produced. Documented evidence can be produced or verified that the guideline was developed, reviewed, or revised within the last five years.

Although few guidelines have been submitted to the NGC, the third criterion could be difficult for CMA investigators to meet. With an expanding evidence base, including studies emanating from NCCAM's Centers of Excellence, as well as the Cochrane Library, this should no longer be an impediment.

7. Should there be condition-specific or modality-specific practice guidelines, and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

   Clinical practice guidelines are systematically developed statements to assist practitioners' and patients' decisions about appropriate health care for specific clinical circumstances. Continuing steps to make CAM more evidence-based must include codifying these treatments and defining their exact therapeutic indications.

   The NGC categorizes guidelines by "disease/condition" and by "treatment/intervention." Guidelines are searchable by guideline developers' organization names. For two examples see *Acupuncture* and *Music therapy programming for individuals with Alzheimer's disease.*

8. In terms of malpractice, what are the malpractice implications of not discussing, offering, or referring a patient to CAM practices and products; what is the liability of referring a patient to a CAM practitioner who then has an adverse outcome; and what policy changes should be made to reduce malpractice liability associated with referral to CAM practices and products?

   As a general rule, a physician's mere referral of a patient to a CAM practitioner, without additional interaction or oversight, should not expose the referring physician to liability, unless:

   - The referral was negligent (e.g., a CAM referral was made rather than a referral to another appropriate practitioner and the CAM referral eliminates or delays treatment which causes injury/damages to the patient).

   - The referring physician is determined to be vicariously liable (e.g., the negligence of the CAM practitioner is imputed to the referring physician). This is more likely to occur in situations where the CAM practitioner is supervised by, employed by, works collaboratively with, or is "integrated" with the referring physician. This more often occurs in institutional settings like hospitals, clinics or MCO's.

   - The physician makes a CAM referral to a practitioner who is known to be incompetent or a referral is made that is known to have no benefit to the patient.

   Proof of negligence for failure to make a CAM referral typically would require expert testimony that the failure to refer violated the recognized standard of care and caused injury to the patient. To mitigate liability for referral or non-referral for CAM, the physician should discuss the available alternative therapies, noting whether it is experimental or scientifically based. The physician also should explain potential adverse effects if known, as well as other established risks and benefits. The conversation should be documented in the medical record in detail indicating that the patient had an opportunity to ask questions. Also, if the physician has no knowledge or information on the efficacy of CAM treatment, it should be shared with the patient and noted in the medical record.

   It is important for physicians to ensure that any alternative practitioner to whom a referral is made is licensed. Courts generally assess malpractice claims against licensed alternative

medicine practitioners according to standards set by the particular "school" itself. CAM practitioners should be encouraged to have their own malpractice insurance.

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

   Please see the answer to question five.

10. In terms of quality of CAM practices and products: a. How and by whom should "quality" be defined? b. How and by whom should quality be measured? c. What should consumers be told about costs, safety, effectiveness?

    Measures of quality emanating from CAM practices should be evidence-based. It is our understanding that the Evidence-Based Practice Centers of the Agency for Healthcare Research and Quality have undertaken to study some CAM practices as part of their examination of other evidence-based activities. The experience and activities of the American Cancer Society are also instructive (Committee on Complementary and Alternative Practices). Finally, the activities of NCCAM's Centers for Excellence should be looked to for leadership. In general, the physician members of the AMA are concerned about the quality, safety and efficacy of dietary supplement products, especially herbal remedies (see Question 11).

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

    In order to minimize these types of interactions, physicians, as well as CAM practitioners, need a database of information. In other words, the dietary supplement industry should be held to the same standards as pharmaceutical companies regarding proactive investigation of potential safety issues with their products. Manufacturers of dietary supplements should be required to obtain quality data on the potential interactions of their products with other dietary supplements, prescription and OTC drugs, and the effects of adding dietary supplements to foods. Such information should be clearly identified on the product labeling. The FDA should continue to educate physicians and the public about FDA's MedWatch program and strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.

    In general, the physician members of the AMA are concerned about the quality, safety, and efficacy of dietary supplement products, especially herbal remedies. The AMA believes that the primary problem is the Dietary Supplement Health and Education Act of 1994 (DSHEA), which fails to provide for adequate regulatory oversight of these dietary supplement products by the FDA prior to marketing. The AMA believes that dietary supplements should undergo FDA approval for evidence of safety and efficacy.

    Recently companies have begun to mix dietary supplements and herbal remedies, and have attempted to mix dietary supplements with traditional over-the-counter drugs. In particular, these products should be held accountable to good manufacturing practices and meet

standards established by the United States Pharmacopeia (USP) for identity, strength, quality, purity, packaging, and labeling. They should also meet FDA postmarketing requirements to report adverse events, including drug interactions.

To facilitate education of physicians and CAM practitioners, a web-based compilation of interaction dietary supplement-based interactions should be considered. In the absence of modifications to current federal law, the AMA believes the FDA must actively regulate dietary supplements to the fullest extent permitted by law, in order to fulfill its obligation to protect the health of the American public.

I hope that these comments are helpful.

E. Ratcliffe Anderson, Jr., MD
Executive Vice-President, AMA

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National President
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Reston, VA 20191

Dear Ms. Srinivas:

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, 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. 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?

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

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

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

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

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

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.

Sincerely,

Stephen C. Groft

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

AMERICAN MEDICAL STUDENTS ASSOCIATION

Thank you for including AMSA in your information gathering. There are many medical students and physicians currently working diligently at their own schools and in their own practices to bring much of this theory into reality. We have very high hopes.
Sincerely,
Mara Merritt
Humanistic Coordinator of AMSA

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?

Miriam S. Wetzel, PhD, David M. Eisenberg, MD, and Ted J. Kaptchuk, OMD address this in "Courses Involving Complementary and Alternative Medicine at US Medical Schools" (JAMA. Vol. 280 No. 9, September 2, 1998). In response to the a survey in which 94% of the 125 U.S. medical schools answered, 65% of the medical schools either include topics in complementary and alternative medicine in required courses or offer elective courses. Some of the educational formats reported included lectures, demonstrations by practitioners, and patient presentations. Common topics included chiropractics, acupuncture, homeopathy, herbal therapies, and mind-body techniques.

Although this study reports coverage of CAM in most of the U.S. medical schools, the sense among students (especially those with interest in and/or awareness of the existence of the spectrum of CAM therapies) is that CAM is negligible to nonexistent in our medical school curricula. The quality of the elective courses varies from school to school. In order to answer this question thoroughly, a much greater time span would be needed to talk to the students at different schools and assess their experiences.

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?
Barriers:
1) Lack of genuine interest within the faculty of the medical education establishment; it seems that the students are more interested in learning about CAM than the administration is willing to teach it, or even acknowledge its importance.
2) The abundance of useless facts that medical students are expected to memorize. Any additional matter tends to get low priority in med school because there is so much material to cover in the first two years. Material that is covered on the boards is prioritized over anything not on the boards.
3) A "closed-mind, know-it-all" attitude by medical school faculty and a complete lack of clinical experience using CAM.

4) Many allopaths and osteopaths are ignorant of CAM modalities and view them with disdain.
5) Difficulty in changing something already established—it would take time and effort to incorporate CAM into the curricula of medical schools.

Incentives:
1) Making obvious the importance of CAM—having bodies such as the White House Commission on CAM make a public statement regarding the need for change in the current system is a starting place.
2) CAM is the medicine of the future; it is where the patient population is spending millions of dollars out of pocket. Training in CAM makes better physicians who are able to offer more complete care.
3) Inclusion of questions about CAM therapies on the national board exams.
4)To increase awareness and respect for alternative ways to heal. To broaden the scope in which physicians think about healing, since most patients are already doing this.

3. What policy recommendations can you make to facilitate the inclusion or expansion of CAM in medical school curricula and/or graduate medical education?
Every medical school needs a department of CAM staffed by *experienced* CAM practitioners! CAM should be present in every medical school curriculum across the country, allopathic and osteopathic. Ideally, CAM therapies would be integrated in (herbs would be covered in pharmacology, the ideas behind acupuncture would be covered in neuroscience, etc.) but perhaps also introduced in a survey-type class during the first year (1-2 lectures a week for the first semester). This survey class would focus on those areas and aspects of CAM that are most frequently encountered in the US, and each lecture would be taught by an expert in that field.

4. What should every medical student know about CAM? How should that level of knowledge be determined?
Medical students should at least know the scope of CAM usage in the U.S. They should know about what people are using - herbs, nutritional supplements, homeopathy, acupuncture, traditional Chinese medicine, etc. They should know the basic precepts of each modality, specific areas when adjunctive therapies can be used, and how to locate credible practitioners of these modalities. They should know enough to realize that these therapies are serious sciences and respect the efficacy of them. While they don't need to know the details of every CAM therapy, medical students need a general knowledge of when to use what CAM therapy. They should also be given a chance while in med school to do further training in areas of interest.

5. 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?
YES! We most definitely need to develop integrative residency programs. Most importantly because there are many students who are looking for them. Demand should create supply! Many, many students are struggling with the fact that the training

currently available to them will not prepare them to practice how they want, or even to be the kind of physician they want. Implementation of such program including finding people who are already integrative practitioners (there are many) and eager to work with physicians in training and providing the program with funding. The teachers should be experts in their field. These programs could be most effective by having residents work in teams with acupuncturists, naturopaths, midwives, herbalists, homeopaths, massage therapists, etc. as well as osteopathic and allopathic physicians who have incorporated pieces of these other modalities into their practice.

6. How and by whom should the inclusion or expansion of CAM in medical education be funded?
Training grants. Federal and state funding. Private foundations. The NIH. Allowing big vitamin, herb and acupuncture companies to fund chairs of CAM at medical schools. A shifting of existing funds. Since CAM therapies will ultimately produce more effective results cases and have less side effects than some conventional therapies, it is economically sound to have CAM integrated into medical school curricula and residency programs.

7. What should every practicing physician-irrespective of specialty-know about CAM? How and by whom should that level of knowledge be determined?
Physicians need to know what modalities of CAM exist and when they are used. CAM needs to be integrated into the medical curriculum and knowledge determined just like any other therapy. This could include questions on the board and licensing exams. A certain number of CME credits in CAM therapies could be required for licensing and relicensing.

8. What should physicians know when referring patients to CAM practitioners? How and by whom should that level of knowledge be determined?
At the least, if standard medical work up is negative and there is no reasonable recourse then CAM should be considered. If we do a good job with 7, this issue will naturally occur. Ideally, CAM therapies will come to be used before some of the more invasive Western pharmaceutical interventions and procedures. Each physician should strive to find out about reputable practitioners in their local area by looking at their credentials, their licensing information, perhaps their record, and personal interaction with them (similar to whatever information is available when patients are referred to standard practitioners in the current system). There are already Medical Boards in Holistic Medicine and Medical Acupuncture. Some states have M.D. (H) designation to physicians who have obtained and passed the Homeopathic boards. There are other degrees such as ND, LAC, DC, etc.

9. Should there be national standards or certification to provide CAM practices and products, and why or why not? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they

be implemented?
There is already such certifications for M.D.'s as mentioned above. ND, LAC, DC have their own board. Independence of each healing tradition should be respected. They should apply to those that are professionally trained in their respective fields, rather than just to any M.D. (or D.O.) that decides that they want to be a "holistic" doctor with no training in anything other than pharmaceutical therapy. Standards should be set ONLY by established CAM organizations who have been doing CAM for many years. This includes The American Holistic Medical Association, The American College for the Advancement in Medicine, The American Association of Medical Acupuncture, The American Academy of Environmental Medicine, etc.

10. What information should conventional physicians communicate to a CAM practitioner? What information should a conventional physician expect to receive from a CAM practitioner?
When referring patients to CAM practitioner, the physician should expect to communicate with them verbally and in writing to assess if the practitioner has experience with a certain disorder and if they feel comfortable taking the case as well as providing them with as much initial information about the patient as possible. CAM training programs should encourage their students to communicate with physicians. Medical records and treatment plans should be shared between conventional physicians and CAM practitioners; ideally, everyone would be able to work together as a team to give the patient the maximum benefit of each person's individual expertise. The flow of information should work both ways, so that each practitioners' charts recognize and include appropriate details about the care prescribed by the other practitioner.

Tab 19

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

John B. Crosby, JD
Executive Director
American Osteopathic Association
142 East Ontario Street
Chicago, IL 60611-2864

Dear Mr. Crosby:

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 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 (science, resources, expertise, qualified faculty, interest) to inclusion of CAM in CME curricula? Conversely, what are the incentives for inclusion of CAM in CME curricula?

3. What policy recommendations would 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. Should there be national standards or certification to provide CAM practices and products, and why or why not? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?

7. Should there be condition-specific or modality-specific practice guidelines, and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

8. In terms of malpractice, what are the malpractice implications of **not** discussing, offering, or referring a patient to CAM practices and products; what is the liability of referring a patient to a CAM practitioner who then has an adverse outcome; and what policy changes should be made to reduce malpractice liability associated with referral to CAM practices and products?

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

10. In terms of quality of CAM practices and products:

a. How and by whom should "quality" be defined?
b. How and by whom should quality be measured?
c. What should consumers be told about costs, safety, effectiveness?

11. 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>), 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

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

AMERICAN OSTEOPATHIC ASSOCIATION
142 EAST ONTARIO STREET, CHICAGO, ILLINOIS 60611-2864 • 800-621-1773 • 312-202-8000 • FAX 312-202-8200

February 13, 2001

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative Medicine Policy
1090 Vermont Avenue, NW
Suite 510
Washington, DC 20005

Dear Dr. Groft:

On behalf of the American Osteopathic Association (AOA), representing 44,000 osteopathic physicians and the 19 colleges of osteopathic medicine, thank you for requesting our comments on complementary and alternative medicine in continuing medical education (CME). The AOA's Council on CME accredits the 169 organizations that are Category 1-A osteopathic CME providers.

Osteopathic medicine is one of two distinct branches of traditional medical practice in the United States. They represent about 5% of the total number of physicians practicing in the United States. Osteopathic physicians are licensed and practice in all 50 states. They practice in more than 23 specialties and subspecialties, and in hospitals and clinics around the country and in several foreign nations.

In addition to learning conventional medicine, osteopathic physicians are schooled in the healing art of manual medicine. Manual medicine, such as osteopathic manipulative treatment for low back pain[1], is part of the standard care provided by osteopathic physicians.

Below are the questions you asked and our responses.

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?**

We believe that osteopathic physicians should be informed about other therapies that their patients may be utilizing. AOA policy supports the education of physicians regarding the philosophy, efficacy, safety and scientific basis of CAM that patients may be using.

However, AOA policy prohibits its AOA-accredited Category 1-A sponsors from promoting or teaching CAM. In addition, when providing information on CAM, it is the responsibility of CME

[1] Andersson, GBJ; Lucente, T; et al: A Comparison of Osteopathic Spinal Manipulation with Standard Care for Patients with Low Back Pain. *N Engl J Med* 1999;341:1426-31.

sponsors to describe the evidence-based, efficacy or outcome studies published in traditional, peer-reviewed medical journals that address the CAM approach to be discussed.

The AOA supports the teaching of CAM at colleges of osteopathic medicine. Colleges have a rigorous process of review and the highest standards education. It is the responsibility of CME sponsors to inform CME participants of colleges of osteopathic medicine that offer the CAM approach to be discussed.

2. **What are the barriers (science, resources, expertise, qualified faculty, interest) to inclusion of CAM in CME curricula? Conversely, what are the incentives for inclusion of CAM in CME curricula?**
3. **What policy recommendations would you make to facilitate the inclusion or expansion of CAM in CME curricula?**

(Combined Response) In order to properly evaluate CAM, the AOA strongly believes in the development of controlled, peer-reviewed studies on the efficacy of CAM practices. Healthcare professionals would use such information to assess and analyze CAM treatments before they are accepted into mainstream medical practice. Such studies should be conducted before the funding of CAM services by Medicare and Medicaid.

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?**

(Combined Response) The amount of information a physician has on CAM services should depend on that physician's specialty and the needs of his or her patients. The AOA does not mandate uniform guidelines on what an osteopathic physician must know regarding CAM. The amount of knowledge on CAM should be left to the individual physician to evaluate his or her own needs.

6. **Should there be national standards or certification to provide CAM practices and products, and why or why not? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?**
7. **Should there be condition-specific or modality-specific practice guidelines, and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?**

(Combined Response) The AOA would be opposed to national standards or guidelines on CAM at this time until the scientific research has been completed.

8. **In terms of malpractice, what are the malpractice implications of not discussing, offering, or referring a patient to CAM practices and products; what is the liability of referring a patient to a CAM practitioner who then has an adverse outcome; and what policy changes should be made to reduce malpractice liability associated with referral to CAM practices and products?**

Malpractice varies by state law, case law, and the individual circumstances of each case.

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

Depends on the situation.

10. **In terms of quality of CAM practices and products:**
    a. **How and by whom should "quality" be defined?**
    b. **How and by whom should quality be measured?**
    c. **What should consumers be told about costs, safety, effectiveness?**

Answers to these questions should be driven by research.

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

Physicians should educate their patients about dietary supplements. Physicians should inform patients of the hazards of using supplements. Dietary supplements do not undergo the rigorous testing and quality controls required by the pharmaceuticals.

I hope this information is of use to you. Please feel free to call me at 312-202-8001 if I can be of further assistance.

Sincerely,

John B. Crosby, JD
Executive Director

cc: Donald J. Krpan, DO, AOA President
Morton J. Morris, DO, JD, Chair, Council on CME

Tab 20

White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

February 1, 2001

cc from ACOG to APGO

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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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?

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: (pollenq2@mail.nih.gov <mailto:pollenq2@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,

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

February 1, 2001

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on CAM Policy

Dear Dr. Groft,

We received a copy of the e mail sent to Ralph Hale, M.D., Executive Vice President of ACOG. APGO (The American Professors of Gynecology and Obstetrics) represents the educators focused on undergraduate medical education in women's health for the United States Colleges and Schools of Medicine. While we cannot give you specific answers because the exceptionally short time frame, we can share general answers. We do have mechanisms for polling our members, however the time line is more than 6 months and this would not meet your time frame.

Re questions:

1. Variable. Both the AAMC and the ACGME may have better answers for you. It is not a mandated part of the undergraduate curriculum. Of particular import is who and when this should be covered. It is particularly of concern to women's health because the majority of users of CAM are women.
2. Barriers are similar to other emerging medical areas: what will be deleted to include this? Expertise varies. Some colleges (PSU for example) have faculty who have devoted their entire professional careers to this, many have none. Published research, as you are well aware, is sparse. Inclusion in pharmacology is often the only place it receives attention due to the significant drug/drug interactions and side effects of some of the herbal remedies.
3. Policy: Facilitation through pharmacology, women's health groups and development of curricula that can stand alone (eg. CD based, web based) will make it more likely to be adopted rapidly. Educators have much less time than ever, so providing literally turn-key curricula is exceptionally helpful in adoption of new areas.
4. Every student should know the drug/drug interactions, significant side effects, and how to ask a patient about their use of CAM's (as we know, patients don't offer this because of the traditional cynical view of many medical professionals). Determining that level of knowledge should take the form of the majority of medical education: inclusion on Step 1/11 of the NBME.
5. Similar.
6. Similar.

7. What is meant by integrative residency program? Integrative of what? CAM + women's health/ ob/gyn? CAM + Family Medicine. CAM + Internal Medicine? What would the added value of such a "discipline" be? Would ACGME accreditation be likely? (NO).
8. Funding. This is always the problem. A mandate without funding is bankrupt from the beginning.
9. CME: alive and well. As an example: included at PSU CME virtually on a yearly basis in WH and primary care CME. Included in Grand Rounds. Lots of interest. Unfortunately, much interest has been generated by the possibility of this as an additional source of income for physician and the ethics of physicians selling the CAM is a very vexing one with conflicts of interest and a subtle form of coercion as key issues.
10. Funding helps. Development of scholars in CAM out of many disciplines will help all of the above. The development of "scholarships" for focused study in CAM, different from research, would provide a pool of talent. One of the particular issues is that this pool doesn't exist, and merely funding research does not produce "educators" in this area.
11. See above.
12. Most common herbal remedies used in their area and by their population of patients (differs widely). Drug/drug interactions (these are not dietary additives, these are drugs). Common side effects. Efficacy (double blind controlled trials...rare). Alternatives.
13. Physicians need to know the competence of the practitioner. Often the person is the clerk at a natural food store, and the level of competence is minimal. It would require developing a standardized curricula for pharmacists/ or for trainees that could be tested that meets rigorous scientific standards for any competence to be evaluable.
14. A national board would be preferable.

Sincerely,

Joanna M. Cain, M.D.
University Professor and Chair, Dept of O/G/WH
Penn State University
President, the American Professors of Gynecology and Obstetrics.

Tab 21

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

Steven Mirin, M.D., Medical Director
American Psychiatric Association
Office of the Medical Director
1400 K Street NW
Washington, DC 20005

Dear Dr. Mirin:

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?

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?

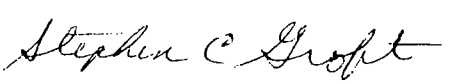
13. What should physicians know when referring patients to CAM practitioners? How and by whom should that level of knowledge be determined? What information should conventional physicians communicate to a CAM practitioner? What information should a conventional physician expect to receive from a CAM 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

Receipt Acknowledged

Response Promised

Tab 22

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 26, 2001

Mohammad Akhter, M.D., M.P.H.
Executive Director
American Public Health Association
800 I Street, NW
Washington, D.C. 20001-3710

Dear Dr. Akhter:

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 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. Do you provide any training in complementary and alternative medicine (CAM) in your undergraduate, graduate, or continuing education curricula? If no, please explain why not. If yes, please answer the following:

- What CAM modalities or therapies are offered in your curricula?
- Approximately how much time is devoted to CAM?
- Is there any discussion of CAM as a different approach to healing?
- What are the barriers/incentives to inclusion of CAM in your curricula?

2) What policy recommendations can you make to facilitate the inclusion or expansion of CAM in your curricula?

3) Should questions regarding CAM be included in national board exams?

4) What should members of your profession know about CAM or about making referrals to CAM practitioners? How should that level of knowledge be determined?

5) Is malpractice a concern in terms of offering or not offering referrals for patients for CAM practices and products?

6) Are there any risks associated with CAM that may be of concern to your practitioners? If so, can you suggest any ways that they can be minimized?

7) Do you have any other thoughts or suggestions that may assist the Commission in formulating their recommendations?

Thank you for your invaluable assistance. Please send your written comments to Ms. Corinne Axelrod *(e-mail: axelrodc@mail.nih.gov, fax: 301-480-1691, phone:301-435- 7592)*, and contact her with any questions you may have.

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 23

White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-169
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

January 30, 2001

Jordan J. Cohen, M.D., President
Association of American Medical Colleges
2450 N Street NW
Washington, DC 20037

Dear Dr. Cohen:

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?

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: (pollenq2@mail.nih.gov <mailto:pollenq2@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

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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2450 N STREET, NW WASHINGTON, DC 20037-1127
PHONE 202-828-0400 FAX 202-828-1125
HTTP://WWW.AAMC.ORG

Jordan J. Cohen, M.D., President

February 21, 2001

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

Dear Dr. Groft,

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

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

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

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

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

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

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

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

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

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

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

Graduate Medical Education Core Curriculum

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours sincerely,

Jordan J. Cohen, M.D.

Tab 24

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 2, 2001

Neil H. Sampson, MPH, MGA
Deputy Associate Administrator
Bureau of Health Professionals
Health Resources and Services Administration
5600 Fishers Lane, Room 8-05
Rockville, MD 20857

Dear Mr. Sampson:

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>.

Thank you for agreeing to testify during the plenary session on February 22 at the Commission's meeting on "Training, Education, Credentialing, and Licensing of CAM Practice." The issues the Commission would appreciate your addressing are described below. Each presenter is asked to speak no more than 10 minutes, focusing on issue highlights.

The Commission would also appreciate receiving a more extensive written response to these issues by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before their working sessions on February 23.

The following issues have been identified by the Commission:

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

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

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

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

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), as well as your response to our request regarding the draft Executive Summary. She will be pleased to answer 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

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

Health Resources and Services Administration
Bureau of Health Professions
Response to Questions from the White House Commission on Complementary and Alternative Medicine Policy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chiropractic Demonstration Projects

Purpose

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

Program Description

Each project must include the following:

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

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

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

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

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

Previous Funding Experience

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

Eligibility

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

Application Procedures

No competitive cycle is planned for FY 2001.

Applicants should address inquiries regarding grants management to:

Grants Management Officer (R18)
3HPr, HRSA
Parklawn Building, Room 8C-26
5600 Fishers Lane
Rockville, Maryland 20857
Telephone Number: (301) 443-6960

Programmatic inquires should be addressed to:

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

Chiropractic Program Web Page

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

Tab 25

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

Darin Haug
Chair, Council of Osteopathic
Student Government Presidents
C/O Michael Dyer, AACOM
5550 Friendship Boulevard, Suite 310
Chevy Chase, MD 20814

Dear Mr. Haug:

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?

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

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

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

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

Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: (pollenq2@mail.nih.gov <mailto:pollenq2@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.

Sincerely,

Stephen C. Groft

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

Tab 26

White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

cc from ACOG to CREOG
No response

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>.

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?

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

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

Tab 27

White House Commission on Complementary and Alternative Medicine Policy

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February 2, 2001

James R. Winn, M.D.
Executive Vice President
Federation of State Medical Boards
of the United States, Inc.
400 Fuller Wizer Road, Suite 300
Euless, TX 76039-3855

Dear Dr. Winn:

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>.

Thank you for agreeing to testify during the plenary session on February 22 at the Commission's meeting on "Training, Education, Credentialing, and Licensing of CAM Practice." The issues the Commission would appreciate your addressing are described below. Each presenter is asked to speak no more than 10 minutes, focusing on issue highlights.

The Commission would also appreciate receiving more extensive written response to these issues by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before their working sessions on February 23.

The following issues, as related to CAM, have been identified by the Commission:

1. Should there be condition-specific or modality-specific practice guidelines for CAM, and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

2. What is the impact of integrating CAM with conventional medicine with regard to standard of care?

3. How is the investigative process applied to allegations of professional misconduct?

5. What should a practitioner do to protect his or her license when integrating CAM with conventional medicine?

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), as well as your response to our request regarding the draft Executive Summary. She will be pleased to answer 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,

Steve Groft

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

Tab 28

White House Commission on Complementary and Alternative Medicine Policy

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February 2, 2001

Kenneth I Shine, M.D., President
Institute of Medicine, Nat'l Academy of Sciences
2101 Constitution Ave. NW
Washington, DC 20418

Dear Dr. Shine:

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. To what extent is CAM included in medical school curricula? 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, for example, science, resources, expertise, qualified faculty, interest? Conversely, what are the incentives for inclusion of CAM in medical school curricula?

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

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

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

6. 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?

7. 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?

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

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

From: Kenneth Shine [KShine@nas.edu]
Sent: Monday, February 05, 2001 9:27 AM
To: Pollen, Geraldine (NCCAM)
Subject: Re: White House Commission

I am sorry that I can not help with the answers to your inquiries. The IOM bases its advice on studies carried out in the relevant areas. We have not conducted studies which would allow us to address these questions with authority. Most of the questions regarding education are best addressed to the AAMC. KIS

Tab 29

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 2, 2001

Russell Massaro, M.D.
Execu. Vice Pres. of Accreditation Operations
Joint Commission on Accreditation
of Healthcare Organizations
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

Dear Dr. Massaro:

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 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 Commission would appreciate your particular attention to the following issues:

1. 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?

2. In terms of quality of CAM practices and products:

   a. How and by whom should "quality" be defined?
   b. How and by whom should quality be measured?
   c. What should consumers be told about costs, safety, and effectiveness?
   d. How can quality assurance for CAM be established through systems design and the training of people within those systems?

Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: (pollcng2@mail.nih.gov <mailto:polleng2@mail.nih.gov>), fax: (301-480-1691), phone: (301-435-6233 or 7592), as well as your response to our request regarding the draft Executive Summary. She will be pleased to answer 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

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

Tab 30

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

June E. Osborne, M.D, President
Josiah Macy Jr. Foundation
44 East 64 Street
New York, NY 10021

Dear Dr. Osborne:

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 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 following questions were developed to guide the Commission's deliberations:

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

2. What were the findings of the November 2-5, 2000 conference on "Education of Health Professionals in Complementary/Alternative Medicine," sponsored by the Josiah Macy Jr. Foundation?

With regard to the second question, would it be possible for the Foundation to share a draft copy of the Executive Summary for review by the White House Commission staff, or by the staff and selected members of the Commission's working group, who are examining the issue of education of health professionals in CAM. In neither case would the draft be regarded as a public document. The opportunity to have preliminary input on the conference findings in preparation for the February meeting would be greatly appreciated.

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), as well as your response to our request regarding the draft Executive Summary. She will be pleased to answer 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

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

I am responding to your e-mail of 1/30 concerning the conference on Complementary and Alternative Medicine that was sponsored by the Macy Foundation in November 2000. That conference was chaired by Dr. Al Fishman, Senior Associate Dean of the University of Pennsylvania Medical School. It is our custom to identify a chairman for a given Macy conference based on his/her extraordinary leadership and expertise in a given area, and Dr. Fishman is a fine example of that. As President of the Macy Foundation I work with the chairman in developing the program, but the expertise is his. Thus it would be most appropriate if you would contact Dr. Fishman with your request.

I have called him in advance to let him know of your queries and interest, and he will be looking for your call -- his phone number is 215-662-3194. In addition I forwarded your request so that he could be aware of your specific points of interest in advance of your conversation. His e-mail addresss is : fishmana@mail.upenn.edu.

As he will tell you, our executive summary of the November conference is in draft format at present, but we both feel that it is far enough along to share with your Commission if it would be helpful. In addition, while the monograph that will ultimately arise from the conference is not yet available, Dr. Fishman could be quite helpful in letting you know who gave particularly important papers that will ultimately be represented in the monograph.

I wish you success with this important topic and the Commission's work.

Sincerely yours,
June E. Osborn, M. D.
President, Josiah Macy, Jr.
Foundation.

EDUCATION OF HEALTH PROFESSIONALS IN COMPLEMENTARY/ALTERNATIVE MEDICINE

Alfred P. Fishman, M.D.
Senior Associate Dean and William Maul Measey
Professor Emeritus of Medicine
University of Pennsylvania School of Medicine

Preface

The following is a draft of the Executive Summary of a conference sponsored by the Josiah Macy Jr. Foundation. For the University of Pennsylvania School of Medicine, the conference represented the cap on a three-year study, commissioned by the CEO-Dean, on the role of Complementary/Alternative Medicine in the academic medical center. Previous meetings over the years, attended by June E. Osborn, M.D., President of the Josiah Macy Jr. Foundation, as consultant and critic, had reached consensus that Complementary/Alternative therapies should be integrated into the educational, research and clinical programs of the Medical Center. En route to reaching this consensus, testimony by experts was taken, the literature reviewed and procedures were developed for quality control, licensing, credentialing and for dealing with legal issues. The Macy Conference (agenda appended) dealt with continuing relevant issues, such as cultural diversity, the physician-patient relationship, the placebo effect and the conduct of research on Complementary/Alternative medicine.

The Draft Report

Recent surveys show that at least half of the population uses one of the diverse array of complementary and alternative medicine practices now known collectively by the acronym CAM. That use has grown dramatically over the past decades despite the fact that few insurance plans provide coverage for any of the many CAM procedures. Users pay an estimated $21 billion a year out of pocket for these services, and make more visits to CAM providers than to primary care physicians.

As further indications of how firmly entrenched in the health care system CAM has become, the National Center for Complementary/Alternative Medicine at the National Institutes of Health invests more than $50 million a year to investigate the safety and efficacy of some of these approaches. Such well-known institutions as Memorial Sloan Kettering Cancer Center and a small, but growing, number of health maintenance organizations and insurance plans now offer some CAM procedures. Nor has big business ignored the growing appeal of CAM, for herbal remedies, alone, have become a $10 billion a year industry that is growing at a projected annual rate of 20-30 percent.

No single definition adequately captures the range of practices that fall under the CAM rubric. Even those that simply define CAM as practices that are not part of mainstream medicine, or as practices used by patients in their health care management or as therapies that are not widely taught in western medical schools or available in most hospitals, fail to capture the complexity of the field. CAM includes health care practices that range from vitamins, herbal remedies and massage therapies to the ancient traditions of Ayurveda and Chinese medicine, along with chiropractic, naturopathy, homeopathic medicine, meditation, hypnosis, acupuncture and a host of other lesser known approaches to health and health care.

Though their use is common and standard practice in much of the world, most CAM procedures have never been tested according to the rigorous, scientific standards of western, evidence-based medicine. Because of this, the response of medical practitioners to the growing CAM phenomenon has ranged from an outright dismissal of practices not proven safe and effective to a gradual recognition that such extensive use can no longer be ignored. Several surveys suggest that at least half of practicing physicians want to know more about CAM so they can advise and guide their patients.

Other studies show that most CAM users are not abandoning western medicine but want the best of both words—an alternative caregiver with strong ties to the medical establishment and a physician who both understands and will make appropriate referrals for CAM therapies. But this poses yet another problem for physicians, for studies also show that many CAM users do not tell their physicians what they are doing and that most practicing physicians know almost nothing about the potential benefits or risks of CAM because their training has focused almost exclusively on western scientific medicine.

Academic health centers have started to respond to the challenge of CAM, both by introducing content into medical curricula and by considering research on some of these approaches, perhaps because they

recognize that by ignoring CAM, they will fail future physicians and their patients. Yet questions abound, for it is far from clear how teaching institutions should address what has, in effect, become a parallel system of health care. What should they teach and who should do the teaching? What research needs to be done, and for which CAM approaches? And how should teaching institutions insert this admittedly controversial material into already crowded curricula?

Macy Conference addresses questions

With its long-standing commitment to the education of health professionals, the Josiah Macy, Jr. Foundation convened a conference in November of 2000 to examine such questions. The conference, "Education of Health Professionals in Complementary/Alternative Medicine," brought together consumers, CAM and mainstream practitioners, medical school deans, and physicians and other health care professionals who have experience with CAM and have looked for ways to integrate these approaches into a mainstream medical education program. Alfred P. Fishman, M.D., Senior Associate Dean for Program Development at the University of Pennsylvania Health System, served as chair.

Presentations and discussions at the two- and a half-day conference explored the challenges to medical education posed by CAM from many directions, including a brief look at the history and ancient roots of traditional practices, the research that has been done to establish the safety and efficacy of some of these approaches, and the role of multiculturalism in the use of these therapies. At the end of the conference, participants agreed on the brief consensus statement and set of recommendations found at the end of this summary.

From the beginning of the conference it was clear that no single definition or description adequately covers the array of practices that fall under the CAM rubric. CAM a government-inspired acronym has become accepted shorthand in the U.S. for what is known as integrative medicine in much of Europe and much of which is considered mainstream medicine in many parts of the world.

The appeal of CAM

What was clear, though, was that many CAM therapies are widely used by the public, even though they fail to meet the standards of evidence-based medicine. Still, to many at the conference, the reasons for CAM's popularity was clear. CAM practitioners spend time with patients, an average of 30 minutes per session, whereas under managed care, physicians today spend an average of seven minutes. As one participant observed, the real issue is not whether the appeal of CAM relies on anecdote or science but that western medicine, bowing to financial pressures and the ease of handing out pills, increasingly ignores both the patient and the patient's context.

Another appeal comes from the fact that most CAM approaches are holistic, rooted in the belief that health is not determined by a given medical system or tradition but involves the interaction of mind and body. Practices tend to focus on healing and therapy maintenance of health, not illness and disease. Touch, caring and healing are essential ingredients and many CAM practices stress the importance of self-care and the beliefs and attitudes that influence healing. CAM systems tend to

emphasize the individual and work with natural processes. They are therapeutically conservative and value knowledge and wisdom gained through experience. Participants were reminded of the sharp philosophical differences between CAM and mainstream medicine. Unlike many CAM approaches, medicine today deals with illness and disease, focusing on isolated body systems, not on the whole body or mind-body interactions. Treatments are based on therapeutic activism and an effort to dominate natural processes, with high value placed on technological knowledge and skills, and standardized approaches.

The broad usage of CAM

While its growth has coincided with both the rise of multiculturalism and greater affluence, the appeal of CAM seems far broader, for the use of CAM therapies is not confined to any one segment of the population. According to recent surveys, use is slightly higher among women than men, slightly lower among African Americans, and slightly higher on the west coast. Use is also slightly higher among those with more education and in the higher income brackets. These surveys also show that use cuts across age and economic barriers. "Baby boomers" are frequent users, more for prevention and lifestyle than therapeutic intervention; those under 30 in "generation X" are even more frequent users, again for lifestyle. At the same time, nearly one third of those over 65 have used at least one CAM to treat a serious illness and about 20 percent have visited a CAM provider. And, though few CAM therapies are covered by any form of insurance, some 43 percent of people making less than $20,000 a year spend at least $250 annually for this kind of help. Little information exists about use of CAM approaches among minority populations. What data does exist suggests use patterns are very different, and that use is increasing. One study of Latino, black, white and Chinese women with breast cancer showed at least half had used one alternative approach and one third had used two. Yet use differed along racial and ethnic lines. Blacks turned more to spiritual healing, Chinese to herbal remedies, the Latino women to dietary and spiritual approaches and the whites to dietary and physical therapies like massage and acupuncture. Such differences, though, cloud the fact of heterogeneity within cultural and ethnic groups and ignore differences in use patterns in different parts of the country.

Because so many people are reluctant to admit to CAM use, existing studies underestimate the extent of CAM use, participants were reminded. These studies show that half of the estimated 600 million annual visits to CAM practitioners are for massage and chiropractic procedures and that at least 10 percent of the population admits to using chiropractic, massage, herbal remedies, relaxation and meditation techniques.

And they are willing to pay for perceived benefits. People spend an estimated $27 to 34 billion every year for techniques that include chiropractic, acupuncture and massage, biofeedback, megavitamins, homeopathy, relaxation and meditation, spiritual healing, folk remedies, lifestyle diets, herbal remedies and energy healing. Some CAM practices are no longer considered unorthodox having been accepted by mainstream medicine. An NIH consensus conference approved the use of acupuncture for certain types of pain, while federal guidelines recommend chiropractic techniques for low back pain. Psychosocial support for cancer patients is well established in many institutions. Even health maintenance organizations are starting to offer some CAM therapies for their patients though greater coverage has been slowed by worries about the broader implications of establishing a precedent for paying for unproven, experimental therapies.

Patients reluctant to discuss CAM use

As lines between mainstream medicine and CAM have blurred, though, surveys show patients are still reluctant to discuss their use of alternative approaches with their physicians. Even though 97 percent of CAM users also have a regular physician, more than 60 percent don't tell their physicians – either because physicians don't ask and or because the medical profession doesn't help patients to feel comfortable about telling that they use other therapies.

Participants explored reasons behind this communication failure, wondering about the role shame and humiliation may play. Physicians are shame-prone; humiliation is part of their training and they are particularly humiliated by HMOs and even the threat of malpractice. Patients, in turn, are ashamed to tell doctors why they seek alternatives, when they go to other physicians, even what kinds of medicine they are taking.

This communication failure has a negative impact on health and patient care, though. It erodes trust, which is fundamental to a good doctor-patient relationship. But it can also lead to serious complications if, for instance, use of high doses of ginseng induce bleeding that can interfere with surgery or other supplements either enhance or diminish the effectiveness of prescribed medications. Also, certain readily available supplements -comfrey, for instance, which is hepatotoxic—can have serious side effects.

Such potential problems underpin the demands of many in mainstream medicine that CAM therapies be tested for safety and efficacy through the same type of clinical trials required for mainstream therapies- even though, as one participant reminded, at least 85 percent of what western medicine does has never been subjected to this kind of scrutiny and a recent Institute of Medicine study documented an alarming number of deaths due to mistakes and inappropriate use of approved medications.

These demands would ignore anecdotal evidence and personal experience, which guide much use of CAM therapies, in favor of controlled scientific studies with results published in peer-reviewed journals and replicated by other researchers. They also insist that vitamins, herbs and other CAM remedies be subjected to the same federal approval mechanisms required for pharmaceutical agents, if only to ensure that dosages are standardized and products meet some kind of quality guidelines. Under current law, such remedies are considered food supplements which require no advance approval by the Food and Drug Administration.

More research needed

While CAM supporters at the meeting supported the call for more research, they also pointed out that many procedures can never meet the "gold-standard" of a double-blind, controlled clinical trial which seeks to isolate a single, effective agent. Many CAM approaches, they pointed out, are integral to an entire system of care. Even the trials that have documented the effectiveness of acupuncture for certain problems by isolating single points ignored the "whole-system approach" and the results

achieved by experienced practitioners. Further, they observed, manufacturers of vitamin and herbal supplements

that are already widely available have no incentive to spend the millions of dollars required for clinical trials.

Many CAM practices also defy conventional scientific testing because they deal with chronic, subjective and individualized complaints difficult to measure precisely. Some participants noted, rigid scientific studies ignore such vital, but often untestable contributions to therapeutic effectiveness as the "bedside manner" of the practitioner, the natural healing forces of nature, the expectations of the patient, and the therapeutic response that comes from any therapy, elements often grouped as a "placebo effect." For some patients, it was pointed out, even the decision to seek help seems to provide relief.

From their discussions, participants seemed to agree that science-based medicine and CAM can learn from each other. For instance, medical practitioners could help patients by learning when to use effective CAM therapies for such chronic conditions as low back pain while CAM providers need to recognize when to refer for medical care patients with conditions for whom orthodox therapy might be curative or life-saving: meningitis was offered as an example. Medical practitioners might benefit by learning to make better use of the placebo effect and natural forces of healing, and by returning to a time when patient therapy was provided with caring, several participants commented.

At the same time, participants agreed that more research was needed to assess the safety and effectiveness of various CAM therapies. Both CAM and orthodox providers need to help the public overcome the belief that "natural equals safe" or that a preparation is safe simply because it has been used for thousands of years, especially since it is not clear precisely what ingredients some of these remedies contain. Lack of standardization has made it difficult, if not impossible, to test some of these remedies. Analysis in one prospective study, for instance, showed that the preparation to be tested contained none of the reported active ingredient.

Because CAM covers such a wide and diverse group of approaches to health and health care, many participants supported an approach to further research which would group therapies into those which demanded further testing for safety and efficacy, those which were probably safe, and those with a higher risk in which any use should be dissuaded. CAM providers could provide a useful service by giving a straightforward account of what condition was treated and keeping track of outcomes, they suggested. Such information would help physicians guide their patients and even recommend use of CAM to be safe and may be beneficial, and to dissuade use of those with a higher risk of being unsafe.

<u>The teaching dilemma</u>

The question of what and how to teach medical students proved difficult to answer. While the explosion of interest in CAM therapies requires that physicians need to know what patients are using and the potential problem areas, and also where to find reliable information to guide their patients, participants agreed physicians do not need to become competent in CAM therapies. They do,

however, need to know when, where and how to refer their patients. Because of financial pressures and already crowded curricula, participants agreed any effort to introduce formal courses addressing CAM would be unworkable. They also agreed teaching physicians to be CAM practitioners would be

both unworkable and unnecessary, and acknowledged that each institution would have to design its own strategies for teaching CAM.

Based on their own experiences integrating CAM approaches into a medical curriculum, several participants emphasized the need to teach students the art of communication and listening to patients. Having medical students actually experience some of these approaches has proven effective. In one program, for instance, students were hooked to a biofeedback device to experience how they could change physiological parameters by changing their thinking, or were taught yoga and meditation. The experience effectively changed the way the students viewed alternative approaches and also improved the way they interacted with patients. Other programs have emphasized self-care for students.

In terms of who should do the teaching, those with experience in the field suggested that CAM practitioners be involved in the process, since so few physicians have any knowledge of their fields. Also, as participants were reminded, definitions of health, illness and appropriate care are culturally derived, and complicated by different religious and philosophical beliefs, so students need to be exposed to and taught about these differences and definitions.

Summary and Recommendations

At the conclusion of their deliberations, participants agreed upon the following statement and recommendations:

Summary Statement

More Americans visit CAM practitioners in a given week than consult primary care practitioners. Most of these CAM clients also see their physicians but only a minority share that information with their physicians, unaware of the risks of untoward interactions between the two systems of care or of any benefits that may come from CAM approaches.

Most physicians are unfamiliar with the theories and practice of CAM and the extent of their patients' adherence to those approaches. Therefore, the education of medical students, as well as resident and practicing physicians, must include sufficient information about the theories and practices of CAM approaches to permit them to provide more comprehensive care for their patients. Therefore, the education of all health professionals should include familiarity with the uses of CAM practices, what is known about the efficacy of various CAM practices, as well as the potential risks and benefits from the use of these practices. The education of health professionals should promote an awareness of CAM to influence patient care and to facilitate communication between doctors and patients.

Recommendations

1. Schools of medicine, nursing and pharmacy and academic health centers should integrate an awareness and knowledge of the most commonly used CAM theories and practices, with their potential for benefit and harm, as part of their curricula.

2. Academic health centers should engage in rigorous collaborative, scientific research on the safety, efficacy and mechanisms of CAM, involving those with expertise in CAM practices in these research efforts.

3. Academic health centers should also initiate the collection of data about the use of CAM therapies and approaches in diverse cultural and ethnic settings.

4. Professional and educational health care associations should make high quality, evidence-based CAM information widely available, include it in continuing education programs and encourage the provision of this high-quality information on the internet and to the public.

5. Professional licensing and credentialing bodies should include information pertinent to safety and efficacy of CAM procedures among all of their requirements.

Josiah Macy, Jr. Foundation Conference
Education of Health Professionals in Complementary/Alternative Medicine

Arizona Biltmore Resort & Spa
Phoenix, Arizona

Thursday, November 2, 2000 - Sunday, November 5, 2000

Agenda

Thursday, November 2, 2000

Evening

7:00 - 9:00	Welcome Reception Paradise Garden Business Casual

Friday, November 3, 2000

Casual attire is recommended for all daytime events.

Morning

7:30 - 8:30	Breakfast Sedona Room

All sessions of the conference will be held in the Grand Canyon Room.

SESSION 1.	BACKGROUND
8:30 - 8:45	Opening Remarks June E. Osborn, M.D. Josiah Macy Jr., Foundation
8:45 - 9:05	Introduction and Orientation Alfred P. Fishman, M.D., Chair University of Pennsylvania Health System
9:05 - 9:35	A Taxonomy of Complementary/Alternative Healing Traditions Marc S. Micozzi, M.D., Ph.D. College of Physicians of Philadelphia
9:35 - 9:55	Discussion

9:55 - 10:25	Usage Patterns - What's Happening Now David M. Eisenberg, M.D. Beth Israel - Deaconess Medical Center
10:25 - 10:45	Discussion
10:45 - 11:05	Break West Foyer
SESSION 2.	COMPLEMENTARY MEDICINE IN THE ACADEMIC HEALTH CENTER
11:05 - 11:20	Session Orientation Chair: Roger J. Bulger, M.D. Association of Academic Health Centers
11:20 - 11:50	Learning Pathos and Pathology - Medical Education in Complementary and Alternative Medicine Wayne B. Jonas, M.D. Uniformed Services University of the Health Sciences Brian M. Berman, M.D. University of Maryland School of Medicine
11:50 - 12:10	Discussion
Afternoon	
12:15 - 1:15	Lunch Sedona Room
1:15 - 1:45	What Was Found at Penn - Lessons Learned? Brian L. Strom, M.D., M.P.H. University of Pennsylvania Health System
1:45 - 2:05	Discussion
2:05 - 2:35	What is the 'Culture' of Western Medicine? Leon Eisenberg, M.D. Harvard Medical School
2:35 - 2:55	Discussion
2:55 - 3:15	Break West Foyer

3:15 - 3:30	Survey of Medical Education (Discussion Paper) Miriam Wetzel, Ph.D. Harvard Medical School
3:30 - 3:45	Who is Practicing? (Discussion Paper) Richard A. Cooper, M.D. Medical College of Wisconsin
3:45 - 4:30	Wrap Up

Evening

7:00 - 10:00	Cocktails and Dinner Aztec Room Business Casual

Saturday, November 4, 2000

Casual attire is recommended for all daytime events.

Morning

7:30 - 8:30	Breakfast Sedona Room

All sessions of the conference will be held in the Grand Canyon Room.

SESSION 3. ISSUES OF CULTURAL DIVERSITY IN A MULTI-CULTURAL SOCIETY

8:30 - 8:45	Session Orientation Chair: Leon Eisenberg, M.D. Harvard Medical School
8:45 - 9:05	Cultural Diversity Charles K. Francis, M.D. Charles R. Drew University of Medicine and Science
9:05 - 9:15	Discussion
9:15 - 9:35	Cultural Competency Dyanne D. Affonso, Ph.D., RN University of Nebraska Medical School - College of Nursing
9:35 - 9:45	Discussion

9:45 - 10:05	The Intersection of Culture and Complementary Medicine Bonnie O'Connor, Ph.D. Hasbro Children's Hospital
10:05 - 10:15	Discussion
10:15 - 10:35	Break West Foyer
10:35 - 10:55	Issues of Access: Who is Paying? Wade Aubry, M.D. The Lewin Group
10:55 - 11:05	Discussion
11:05 - 11:25	The Placebo Effect (Discussion Paper) Alvan R. Feinstein, M.D. Yale University School of Medicine
11:25 - 11:35	Discussion
Afternoon	
12:00 - 1:00	Lunch Sedona Room
SESSION 4.	ISSUES THAT MAKE IT CRUCIAL THAT PROVIDERS OF STANDARD CARE KNOW ABOUT COMPLEMENTARY / ALTERNATIVE MEDICINE
1:00 - 1:15	Session Orientation Chair: Brian L. Strom, M.D., M.P.H. University of Pennsylvania Health System
1:15 - 1:35	The Significance of Shame and Humiliation in the Doctor/Patient Relationship Aaron Lazare, M.D. University of Massachusetts Medical School
1:35 - 1:45	Discussion
1:45 - 2:05	"What Matters" From the Patient Point of View Alice Trillin Consultant
2:05 - 2:15	Discussion

2:15 - 2:35	Safety Issues in Mixed Therapies Lisa Corbin Winslow, M.D. University of Colorado Health Sciences Center
2:35 - 2:45	Discussion
2:45 - 3:05	Break West Foyer
3:05 - 3:20	Evidence, Ethics and the Evaluation of Global Medicine (Discussion Paper) Wayne B. Jonas, M.D. Uniformed Services University of the Health Sciences
3:20 - 3:35	Herbalism (Discussion Paper) Lenore Arab, Ph.D. University of North Carolina at Chapel Hill
3:35 - 4:05	Wrap Up

Evening

6:30 - 7:00	Transportation to the Heard Museum In front of the hotel
7:00 - 10:00	Dinner Heard Museum Business Casual

Sunday, November 5, 2000

Casual attire is recommended for all daytime events.

Morning

7:30 - 8:30	Breakfast Sedona Room

All sessions of the conference will be held in the Grand Canyon Room.

SESSION 5. PROFESSIONAL AND RESEARCH ISSUES/CONSENSUS AND RECOMMENDATIONS

8:30 - 8:40	Session Orientation Conference and Session Chair: Alfred P. Fishman, M.D. University of Pennsylvania Health System
8:40 - 8:55	Complementary/Alternative Medicine in the Making of a Physician and Other Health Care Professionals Michael Whitcomb, M.D. Association of American Medical Colleges
8:55 - 9:05	Discussion
9:05 - 9:20	Research as a Basis for Complementary/Alternative Medicine Kim A. Jobst, M.A., D.M., M.R.C.P., M.F.Hom. Oxford Brookes University
9:20 - 9:30	Discussion
9:30 - 9:45	Break West Foyer
9:45 - 10:00	Conference Reactor June E. Osborn, M.D. Josiah Macy, Jr. Foundation
10:00 - 12:00	Discussion of Recommendations and Conclusions
Afternoon	
12:00 - 4:00	Transfers to the Airport

Tab 31

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

Donald E. Melnick, M.D., President
National Board of Medical Examiners
3750 Market Street
Philadelphia PA 19104

Dear Dr. Melnick:

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 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 National Board examinations?

2. What are the barriers to and incentives for inclusion of CAM in National Board examinations?

3. What policy recommendations can you make about the inclusion of CAM on National Board examinations?

Thank you for your invaluable assistance. Please send your written comments to Ms. Gerry Pollen (e-mail: (pollenq2@mail.nih.gov <mailto:pollenq2@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

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

Stephen C. Groft, PharmD
Executive Director
White House Commission on
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6701 Rockledge Drive
Suite 1010, MS-7707
Bethesda, MD 20817-7707

Dear Dr. Groft:

Dr. Donald Melnick has forwarded your recent e-mail inquiry to me. As you know, the National Board of Medical Examiners (NBME) is involved with the development of examinations which include the United States Medical Licensing Examination (USMLE), medical school subject exams, and numerous specialty board certification and self-assessment examinations. I am responsible for management and oversight of examination programs at the National Board, including the USMLE.

Background

The USMLE is the single pathway to licensure for allopathic physicians who are graduates of LCME accredited schools in the United States and Canada, and for all international medical graduates seeking licensure in the United States. The USMLE is jointly owned by the National Board of Medical Examiners and the Federation of State Medical Boards (FSMB), and is governed by a Composite Committee consisting of representatives from the NBME, the FSMB, the Educational Commission for Foreign Medical Graduates (ECFMG) and public representatives.

The purpose of the USMLE is to assess a physician's ability to integrate basic science and clinical medicine to provide safe and effective patient care. USMLE consists of three complementary steps. Step 1 and Step 2 are constructed from integrated content outlines organizing basic science and clinical science material respectively. The Step 3 examination is constructed around a data-based model of generalist medical practice in the United States. Step 1 and Step 2 are usually taken during undergraduate medical school. Step 3 is usually taken during post-graduate training. The Composite Committee delegates authority for standard setting and matters of content to three Step Committees. Standards are reviewed every three years, and the content of the three Steps is reviewed annually. More detailed information can be found on the USMLE web site (www.usmle.org), or on the National Board web site (www.nbme.org).

Although the USMLE is primarily intended to assess competency to practice medicine, it has a powerful effect on undergraduate and graduate medical curriculum design. For this reason, it is essential that the NBME avoid the perception of endorsing unproven, ineffective, or unethical methods of treatment.

Complementary and Alternative Medicine in the USMLE

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

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

The Step committees reviewed USMLE content in CAM at the Step Committee Retreat in August 2000. Dr. Wayne Jonas was invited to address the issue of CAM on USMLE. Dr. Jonas acknowledged that current courses on CAM have no consistency and little quality; he emphasized the physician's need to integrate information in the context of patient care. Dr. Jonas also noted the financial incentives associated with CAM; there is a danger that economic pressures may drive some health care institutions and providers to offer alternative therapies to patients.

Dr. Jonas suggested that areas in which CAM could be included in the USMLE include (1) evaluation of communication skills with patients utilizing CAM, and with CAM practitioners; (2) the side effects and adverse drug interactions associated with herbal or alternative medications; and (3) evaluation of literature related to CAM. Dr. Jonas concluded by emphasizing that alternative therapies should be held to the same standard of evidence as traditional therapies.

A summary of the Step Committee deliberations at the Retreat follows:

Step 1 Summary

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

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

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

Conclusion

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

I hope this information is helpful to you. If you have additional questions or need further elaboration on any of the above information, please do not hesitate to contact me directly at pscoles@mail.nbme.org or by phone at 215-590-9666.

I will plan on attending the February 22 session in Washington; please provide me with further details if possible.

Sincerely,

Peter V. Scoles, MD
Vice President
Assessment Programs

Tab A