# Withdrawal/Redaction Sheet
## Clinton Library

| DOCUMENT NO. AND TYPE | SUBJECT/TITLE | DATE | RESTRICTION |
|---|---|---|---|
| 001. letter | Stephen Groft to James Dowden (partial) (1 page) | 02/09/2001 | b(6) |
| 002. letter | Stephen Groft to Chairperson, American Holistic Dental Association (partial) (1 page) | 02/05/2001 | b(6) |
| 003. letter | Stephen Groft to Suzan Walter (partial) (1 page) | 02/05/2001 | b(6) |
| 004. letter | Stephen Groft to Kathleen Frye (partial) (1 page) | 02/05/2001 | b(6) |
| 005. letter | Stephen Groft to Doris Rager (partial) (1 page) | 02/09/2001 | b(6) |
| 006. letter | Stephen Groft to Margaret Erickson (partial) (1 page) | 02/13/2001 | b(6) |

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

OA/Box Number: 43241

**FOLDER TITLE:**
WHCAM Briefing Book, Discussion Group III, February 22-23, 2001 [1]

2011-0568-S
kc797

**RESTRICTION CODES**

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

**P1** National Security Classified Information [(a)(1) of the PRA]
**P2** Relating to the appointment to Federal office [(a)(2) of the PRA]
**P3** Release would violate a Federal statute [(a)(3) of the PRA]
**P4** Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
**P5** Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
**P6** Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

**C.** Closed in accordance with restrictions contained in donor's deed of gift.
**PRM.** Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
**RR.** Document will be reviewed upon request.

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

**b(1)** National security classified information [(b)(1) of the FOIA]
**b(2)** Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
**b(3)** Release would violate a Federal statute [(b)(3) of the FOIA]
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**b(7)** Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
**b(8)** Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
**b(9)** Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

# Discussion Group III

Breakout Session III
or
Discussion Group III
?

Discussion on
Education
+
CAM

## DISCUSSION GROUP III

TAB

# Tab 1

# 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 9, 2001

James Dowden, Executive Director
American Academy of Medical Acupuncture
American Board of Medical Acupuncture
4929 Wilshire Boulevard, Suite 428
Los Angeles, CA 90010

Dear Mr. Dowden:

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 www.whccamp.hhs.gov.

The Commission will meet on February 22-23 to discuss the topic areas: education and training of health care practitioners, quality of care, and accountability, as they relate to complementary and alternative medicine (CAM). The questions that follow were developed to guide the Commission's deliberations. To accomplish its goal, however, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments by e-mail or fax *as soon as possible* so that the Commissioners have time to review them before the February 22-23 meeting.

Questions Developed for Commission Discussion :

1. Is there currently enough science available on CAM to establish educational programs in integrative health care? (Integrative is defined as combing conventional western medicine with "alternative" therapies.)

2. What should be done to assure that integrative health providers have the appropriate education (knowledge) and training (skills) for their specific scope of practice? Should core competencies be established? If so, how would these "competencies" reflect the various levels of CAM integration – for example, practitioners who use their knowledge to make referrals to CAM providers, practitioners who have this knowledge but also incorporate one or more modified CAM techniques into their patient care, and practitioners who have extensive CAM knowledge and who furnish one or more CAM skills (such as acupuncture) as part of their practice.

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[001]

3. What knowledge and core competencies – and credentialing – should be required for an integrative health care provider to serve in the role of primary care practitioner (PCP)? Should chiropractors, acupuncturists, and other CAM providers be able to serve as PCPs? Should western trained providers have training in CAM to serve as gatekeepers and make referrals to CAM providers?

4. Who and what are needed in developing faculty for integrative health training programs? What are the issues in developing faculty, curricula, resources, etc.?

5. What recommendations or other guidance can be offered regarding funding for integrative health training programs?

6. Should there be continuing education (CE) requirements for all integrative health providers? Should integrative health professionals be required to demonstrate periodically that they maintain core competencies in the modalities they practice?

7. Should there be national CE standards for integrative health care providers? State standards? Professional standards? If so, who should be responsible?

8. What issues, unmet needs and problems currently exist for continuing education? (For example, do certain entities such as state licensure boards accept CAM CEUs?)

9. Should professional credentialing be performed by one, central body or at the state level? If so, who should be responsible? To what degree should the specific profession(s) be involved?

10. Are there medical malpractice issues that you would like to share with the Commission? For example, is there risk to practitioners who do/do not use CAM practices or products?

11. What other measures should be developed to promote quality and accountability amongst conventionally trained providers practicing CAM? Practice guidelines or modality-specific guidelines? Consumer protection programs? What about oversight or regulation of supplements?

Thank you for your invaluable help. Please send your written comments to Maureen Miller, MPH,RN, *fax: (301-480-1691), or email them to whccamp@od.nih.gov.* You may contact her with any questions you have at *cell phone:* (b)(6) *or 301-435-6198.* She will be happy to work with you in any way she can to gain your expert advice

Sincerely,

Stephen C. Groft

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

I am a hospital based physician gynecologist and acupuncturist member of the American Academy of Medical Acupuncture (AAMA) engaged in the practice of medicine at the largest medical center in the middle Tennessee area. I am board certified in Obstetrics & Gynecology and am the Medical Director of the Laparoscopy Center at Baptist Hospital in Nashville Tennessee.

Medical Acupuncture, as distinguished from acupuncture, is the clinical discipline of acupuncture as practiced by physicians trained in both western medicine and acupuncture. By combining the practices of both western and eastern medicine, the Medical Acupuncturist fills a unique role in patient care, which is different from that of their allopathic medical colleagues as well as non-physician acupuncture practitioners.

As regards educational criteria, I would like to point out that AAMA requirements are consistent with the standards of the World Health Organization as well as the World Federation of Acupuncture/Moxibustion Societies, PLUS the requirement of Licensure to practice medicine in the physician's state of residence.

At the completion of acupuncture training and after a requisite period of practice, Medical Acupuncture physicians are eligible to sit for a comprehensive examination for board certification through the American Board of Medical Acupuncture. This examination is the most comprehensive measure of expertise in the many disciplines of acupuncture in the world.

As with any other board specialty in medicine, regulation of physicians practicing acupuncture should come only through their peers represented by the boards; in this case, the American Board of Medical Acupuncture.

The training required by the AAMA is rigorous, time consuming, and expensive, especially when loss of time from one's private practice is considered. Insuring that physician acupuncturists are appropriately compensated for their expertise and time, as are all other board specialists, is only reasonable. Unfortunately, at this juncture, the expense for acupuncture is borne largely by the patient, and very often by the elderly, who most need it and can least afford it. I urge that these circumstances be carefully considered in your decisions and recommendations.

Larry D. Gurley, M.D.

On behalf of the American Academy of Medical Acupuncture (AAMA), a national organization representing more than 2,000 physician acupuncturists in the North America, I thank you for soliciting our input on the important work of the White House Commission on Complementary and Alternative Medicine Policy.

Your questions were thought provoking and critical to the current and future delivery of CAM and its integration into traditional American bio-pharmacologically based medical practices. Our responses, which emphasize our specialty, Medical Acupuncture, follow:

American Academy of Medical Acupuncture (AAMA) Responses to Questions Developed for Commission Discussion :

1. Is there currently enough science available on CAM to establish educational programs in integrative health care? (Integrative is defined as combing conventional western medicine with "alternative" therapies.)

Initially, it is important to note that Medical Acupuncture, that is, acupuncture practiced by a licensed physician (MD, DO) is the ultimate integrative paradigm. Because all AAMA members are physicians, and because they have been taught to evaluate each patient using both Western bio-pharmacological knowledge as well as Eastern acupuncture acumen, the resulting treatment can correctly be said to represent the "best of both worlds" of integrative medicine.

Regarding the AAMA member specialty, i.e., Medical Acupuncture, clearly sufficient scientific evidence exists to validate its inclusion in established educational programs in integrative health care.

More than 25 years ago, the World Health Organization (WHO) and the affiliated World Federation of Acupuncture Societies (WFAS) established educational standards for physician acupuncturists and others which have been followed throughout the world. These standards have been adopted and augmented by the AAMA and now form the basis for Board Certification of physician acupuncturists by the American Board of Medical Acupuncture (ABMA). These standards have formed the basis for most state standards in the US for education for physicians and for non-physician acupuncture licensure.

In addition to conclusions of the WHO and WFAS regarding efficacy of acupuncture, the National Institutes of Health (NIH) issued a Consensus Report in November, 1997, documenting research on the safety and effectiveness of acupuncture in several specific areas.

Research using animals has proven that properly placed acupuncture needles administered by highly skilled practitioners results in definable and distinct changes within the body, regardless of mid-set or pre-disposition. The positive results of veterinary research, on animals with no belief about acupuncture's efficacy, effectively negates the skepticism that acupuncture works solely or partially because of the "placebo effect."

It must also be noted that acupuncture has been taught in European medical schools for decades and that training programs for graduate, licensed physicians now exist in recognized centers of

medical education in the United States and Canada, including the University of California at Los Angeles (UCLA),
New York Medical College, University of Miami, McMaster University (Canada), among others.

Finally, one way to establish the scientific recognition of the validity of a medical paradigm is to examine the scholarly journals that exist on the subject and the recognized researchers actively engaged in investigative projects and reporting on their research findings. Numerous scholarly journals exist on various types of CAM including multiple journals devoted to current research on Medical Acupuncture. Since the NIH Consensus Report in 1997 there have been numerous scholarly research articles published in recognized western medical journals attesting to the efficacy of acupuncture in research projects carried out using traditional western scientific methods. The volume and quality of research in this area is steadily increasing.

2. What should be done to assure that integrative health providers have the appropriate education (knowledge) and training (skills) for their specific scope of practice? Should core competencies be established? If so, how would these "competencies" reflect the various levels of CAM integration – for example, practitioners who use their knowledge to make referrals to CAM providers, practitioners who have this knowledge but also incorporate one or more modified CAM techniques into their patient care, and practitioners who have extensive CAM knowledge and who furnish one or more CAM skills (such as acupuncture) as part of their practice.

It is critical to ensure that all CAM practitioners have the appropriate education (knowledge) and training (skills) for their specific scope of practice. As mentioned above, regarding the practice of Medical Acupuncture:

A. The WHO/WFAS guidelines and standards have been in existence for several decades and have proven effective in other parts of the world and as guidelines in establishing standards in the US for state licensure of acupuncturists.

B. Membership in the AAMA requires fulfillment of specific and rigorous criteria which meets or exceeds the WHO/WFAS guidelines.

C. Board Certification by the ABMA ensures competence and public confidence through extensive examination, practice and continuing educational requirements.

The AAMA strongly believes that core competencies must be established. However, whenever core competencies are discussed, the full extent of competency must be taken into account. Again, we repeat that a distinction must be given to licensed physicians (MD and DO). To that end, the ABMA has undertaken two (2) important projects. The first is to grant recognition to various national and international Medical Acupuncture teaching programs for physicians which meet or exceed the WFAS/WHO acupuncture educational standards. Understanding that all licensed physicians have had the benefit of four (4) years of medical school training (representing approximately 4,000 hours) plus internship and/or residency, the programs which the ABMA recognizes augment the physician's prior medical education with extensive acupuncture education. The programs which gain recognition by the ABMA after intense scrutiny, all meet and exceed the WHO/WFAS standards and should be at the core of US educational standards and recognition for physician acupuncturists. It is important to note that of necessity, the criteria for education of a physician in the arts and science of Medical Acupuncture is different from that of education for a non-physician acupuncturist. The

WHO/WFAS standard of acupuncture education for non licensed physicians is 2,500 hours of training, post secondary school. The WFAS/WHO standard for physician training is 200 hours post medical school. Dissemination of knowledge about these certifying programs for physician acupuncturists and their graduates will protect the public and assure high standards of patient care.

Second, the AAMA has established a Core Curriculum for physician acupuncture education. This Core Curriculum meets and exceeds all international standards for physician-acupuncturist education and should be the standard for physician acupuncture education in the US.

Further, the AAMA has established a status of "Fellow of the American Academy of Medical Acupuncture" as an honor recognizing a discrete number of physician acupuncturists who have evidenced the highest standards of skill, competency, knowledge and patient care. Attaining the honor of Fellow is difficult and rare, and the rigorous requirements include publication, research and teaching credentials, continuing medical acupuncture practice and education. Establishment of Fellowship status emphasizes the AAMA's continuing commitment to excellence, high ideals and achievement.

In addition, the AAMA has an outreach program in place to provide introductory education to medical school students about medical acupuncture. It is our belief that every medical school should initiate an introductory program about CAM and that every licensed physician should be familiar with various CAMs through required CME and CEU courses. The AAMA, which is also a CME granting entity, is at the forefront of these educational programs and is expanding their inclusion as quickly as possible. Every medical school graduate must understand how to incorporate CAM into hi/her patient treatment plan. The knowledge of when and how to use CAM to improve patient outcomes should be a requirement for all medical school curricula.

Similarly, as more and more Americans seek out CAM treatments and integrative medicine becomes the twenty-first century norm (in opposition to the twentieth century oddity), pacticing physicians must become familiar with CAM so that they can make intelligent referrals. While it is not necessary for every physician to actually practice one or more CAM, it is essential that every licensed physician understand the use, application and efficacy of various CAMs in order to

A. protect their patients from unqualified practitioners
B. refer patients for the particular CAM best suited to their particular medical problem.

We also note that many malpractice insurance carriers are now requiring documentation of CAM training and, in some instances, are particular as to which educational programs they will accept. We applaud this incentive as beneficial to the public to insure that only qualified practitioners interact with and treat the public.

3. What knowledge and core competencies – and credentialing -- should be required for an integrative health care provider to serve in the role of primary care practitioner (PCP)? Should chiropractors, acupuncturists, and other CAM providers be able to serve as PCPs? Should western trained providers have training in CAM to serve as gatekeepers and make referrals to CAM providers?

The AAMA strongly believes that the job of primary care provider (PCP) must be limited to western trained, licensed physicians, that is, those with an MD or DO degree. Patients must be able to enjoy the "best of both worlds" in the delivery of medical care. Integrative medicine

means and provides just that. To allow a patient to use any CAM provider as a PCP opens the door to the potential of misdiagnosis and/or inefficacious treatment by a CAM practitioner who is not trained in Western medicine. Every patient should have a choice regarding his/her medical care. But any choice must be made with knowledge. To limit a patient to the knowledge of only one paradigm, that is one particular CAM, without the benefit of western medical knowledge and integrative thought and skill, deprives that patient of the best of both medical worlds.

We believe that non-physician CAM providers can and should play a role in primary patient care, but only under the close and direct supervision of an appropriately trained physician PCP and/or CAM provider. Patient health and safety is paramount. The broadest knowledge is optimum. Integrative medicine, combining the best of bio-pharmacology and CAM is the ideal.

As the AAMA represents only physician acupuncturists, we strongly believe that state medical boards, which license physicians, must be the entity to license physician acupuncturists. It must be noted, regarding non-physician acupuncturists, that licensure and examination processes are in place in most states to assure that otherwise unlicensed (that is, non-physician) individuals are appropriately trained and tested. Current state law regarding the licensing of physicians to practice medicine in most states relies on the state medical boards to enforce provisions that physicians have appropriate training and education for activities undertaken within the scope of their license. A handful of states, notably New York, Pennsylvania, New Jersey, Georgia, Maryland, Virginia, and the District of Columbia currently require physician acupuncturists to document their acupuncture training. Many of these states use the WFAS guidelines as the standard. New York and New Jersey require 100 hours more than the WFAS, while Georgia requires 100 hours less than WFAS. The AAMA requires 20 hours more than the WFAS standards for full membership, and the ABMA requires 100 hours more than WFAS (in addition to other practice and examination requirements).

4. Who and what are needed in developing faculty for integrative health training programs? What are the issues in developing faculty, curricula, resources, etc.?

Regarding Medical Acupuncture, Board Certified physician practitioners who are members of the AAMA are involved at a few medical schools to deliver introductory courses to medical students. The AAMA Core Curriculum forms the basis for their acupuncture overview and gives medical students a basic understanding of the use, practice and efficacy of Medical Acupuncture.

In order fully to understand and appreciate the benefits and application of CAM its integration into daily medical practice, students must experience it first hand in a clinical setting. It is only through clinical observation that a student can understand how and when to suggest CAM to patients. Viewing and participating in the juxtaposition of CAM, osteopathic and bio-pharmacological healing is a powerful learning tool. To that end, some medical schools have integrated clinical opportunities for students to compare and contrast treatments using traditional bio-pharmacology and acupuncture. Grand rounds and case conferencing with physician acupuncturists and western specialists enable medical students to understand the various applications and indications of CAM and bio-pharmacology paradigms.

The AAMA has an outreach program in place to provide introductory education to medical school students about Medical Acupuncture and other CAMs. It is our belief that every medical school should initiate an introductory program about CAM and that every licensed physician should be familiar with various CAMs through required CME and CEU courses. The AAMA is

at the forefront of these educational programs and is committed to expanding their inclusion in medical schools as quickly as possible. Every medical school graduate must understand how to incorporate CAM into his/her patient treatment plan. The knowledge of when and how to use CAM to improve patient outcomes must become a requirement for all medical school curricula.

Regarding acupuncture, the AAMA strongly believes that Board Certification must be the basic criteria for a faculty position. It is interesting to note that changes to the required curriculum for residency training in anesthesiology pain program, for example, now requires that a unit on acupuncture orientation be provided. We applaud the efforts of the anesthesiologists and hope that more medical specialties will add orientation to CAM to their residency programs particularly in the areas of family medicine, internal medicine, pain management and rehabilitation (PM&R) as well as anesthesiology.

Finally, it is as critical that the information taught is scientific and accurate and presented in a manner that medical students and physicians, through CME and CEU, grasp the importance of CAM and its integration into individual medical practices, preventive medicine and health care in general. Regarding acupuncture, the AAMA will establish a uniform medical school educational presentation, based on its Core Curriculum, to familiarize students with the practice of Medical Acupuncture. Utilization of Board Certified physician acupuncturists and the AAMA Core Curriculum will insure the highest level of understanding and education.

5. What recommendations or other guidance can be offered regarding funding for integrative health training programs?
    A. Certified Training Programs funding through grants from CAM product suppliers
    B. Certified Training program funding via self sustaining student supported tuition program
    C. Federal funding

6. Should there be continuing education (CE) requirements for all integrative health providers? Should integrative health professionals be required to demonstrate periodically that they maintain core competencies in the modalities they practice?

Yes and Yes! Just as physicians have continuing medical education (CME) requirements and attorneys have continuing legal education (CLE) requirements, there must be continuing education requirements for all integrative health providers. As an accredited CME provider, the AAMA is at the forefront of providing nearly 100 hours of CME for its members on a yearly basis. Also, regional AAMA chapters regularly provide CME and/or CEU courses for their members.

As part of its leadership position in maintaining excellence in the delivery of acupuncture services as part of integrative health care, the AAMA requires every member to fulfill 50 hours or more of continuing education in medical acupuncture every three years. ABMA Board Certified physicians must complete 150 hours every ten years and AAMA Fellows must earn 75 hours every three years.

Periodic re-testing of CME providers is a good idea. Many medical specialties require periodic re-testing to maintain Board Certification status. Similarly, the ABMA requires re-testing every ten years by every Board Certified physician. This insures continued excellence and a high level of competency.

7. Should there be national CE standards for integrative health care providers? State standards? Professional standards? If so, who should be responsible?

Traditionally, health care licensure and establishment of the standards for health care providers has been the domain of the individual states, not the federal government. Regarding regulation of health care providers, national standards have effectively been established by professional societies over the years. We agree that this should continue and that the AAMA maintain its preeminent role of insuring excellence of physician acupuncturists.

As the AAMA represents only physician acupuncturists, we strongly believe that state medical boards, which license physicians, must be the entity to license physician acupuncturists. It must be noted, regarding non-physician acupuncturists, that licensure and examination processes are in place in most states to assure that otherwise unlicensed (that is, non-physician) individuals are appropriately trained and tested. Current state law regarding the licensing of physicians to practice medicine in most states relies on the state medical boards to enforce provisions that physicians have appropriate training and education for activities undertaken within the scope of their license. A handful of states, notably New York, Pennsylvania, New Jersey, Georgia, Maryland, Virginia, and the District of Columbia currently require physician acupuncturists to document their acupuncture training. Many of these states use the WFAS guidelines as the standard. New York and New Jersey require 100 hours more than the WFAS, while Georgia requires 100 hours less than WFAS. The AAMA requires 25 hours more than the WFAS standards for full membership, and the ABMA requires 100 hours more than WFAS (in addition to other practice and examination requirements).

We strongly urge state medical boards adopt the AAMA criteria and the ABMA Board Certification as the basis of physician CAM licensure and credentialing. It must again be emphasized that physicians, because of their rigorous medical school and post doctoral internship and residency, have an enormous amount of knowledge which non-physicians are not taught. A physician's extensive knowledge is brought with him/her and incorporated into his/her CAM practice. For this reason, the number of hours a physician spends gaining competence in his/her CAM specialty is significantly less than that required by a non-physician to gain competence in a particular CAM specialty. The two educational experiences cannot be compared. Also, for this reason, the regulation, licensing and credentialing of physicians must fall into a category distinct and separate from that of non-physicians. And, for this reason, it is appropriate that state medical boards regulate physicians. And for this reason, it is optimal that state medical boards, which expect the highest standard of patient care also control and supervise CAM practice by non-physicians.

Legislation regarding delivery of CAM services as it may apply to physician practitioners, should be carried out through their state medical/osteopathic boards. Physicians are held to a high standard of practice and patient care that cannot fairly be administered by a board or regulatory body that is not involved in the routine oversight of physician practice. Efforts to regulate or to apply to physicians standards that are intended for non-physicians are inappropriate. As an example, please consider the seeming dichotomy in training requirements between physician and non-physician acupuncturists. Non-physician acupuncturists require more hours of study than physician acupuncturists in order for a non-physician acupuncturist to become certified through their credentialing agency, the NCCAOM and to meet internationally accepted training standards. While physicians (MD, DO) are required to have 300 hours of specific acupuncture training in a multiplicity of acupuncture paradigms before they can become Board Certified, one must remember that these 300 hours are IN ADDITION to their 4 years and approximately 4000

hours of medical school education. To that is added years of internship and/or residency. While the dichotomy between physician and non-physician acupuncture training may be perceived as real because of the difference in the number of hours of study required, the reality is that AAMA members and certainly ABMA Board Certified physician acupuncturists are not only at least equally trained, they better able to deliver truly integrative medicine to their patients because of the multiplicity of paradigms, both western and eastern, in which they are fluent.

Further, it would be ideal if practical questions regarding the use and application of CAM became part of the national medical examinations. This would force every medical school immediately to implement educational requirements about CAM and would expedite integration of CAM into medical practices.

We again want to state that the AAMA and the ABMA have established a Board Certification which represents the only national standard for physicians in US. ABMA Board Certification requirements not only meet, but exceed, all International standards for phsycian education and training in acupuncture.

8. What issues, unmet needs and problems currently exist for continuing education? (For example, do certain entities such as state licensure boards accept CAM CEUs?)

Medical school students have a lot to learn in four years. The perceived lack of medical school time and the need to educate physicians in a multiplicity of important medical specialties presents an impediment to the addition of CAM to the already crowded curriculum. But time must be made, because more and more Americans want to take advantage of CAM.

There is a problem of quality control regarding CEUs. That problem does not exist for CMEs where a nationally recognized governing body , the Accreditation Comission for the Certification of Medical Education oversees the nature and quality of educational programs granting CME credits. Attaining the authority to grant CME credits is a long and arduous task requiring extensive scrutiny into the nature and quality of continuing education programs offered by a requesting entity. The AAMA has satisfied these difficult criteria and has been designated a CME granting body. The existence of the ACCME effectively gives uniformity and substance to CME credits. Unfortunately, there is no comparable body or standard for groups granting CEUs or for programs offering CEUs. Without some system for quality control over CEUs, it is inappropriate and bad public policy to base licensure or retention decisions on them.

9. Should professional credentialing be performed by one, central body or at the state level? If so, who should be responsible? To what degree should the specific profession(s) be involved?

Traditionally, health care licensure and establishment of the standards for health care providers has been the domain of the individual states, not the federal government. Regarding regulation of health care providers, national standards have effectively been established by professional societies over the years. We agree that this should continue and that the AAMA maintain its preeminent role of insuring excellence of physician acupuncturists.

Regarding licensing: states have traditionally licensed all health care workers and we believe that this should continue. States have established minimum licensing requirements. However, both physician (MD, DO) CAM practitioners and non-physician CAM practitioners should be supervised and controlled by state medical/osteopathic boards which have a tradition of insuring the highest standards of professionalism and competence for their citizenry.

Professional credentialing should be performed and supervised by the appropriate professional organizations while licensing for all CAM practitioners, physician and non-physician, should remain within the purview of state medical/osteopathic boards.

Under no circumstances should the credentialing and/or licensing of physician (MD, DO) CAM practitioners fall within the purview of non-physicians. Only physicians, through the state medical/osteopathic boards, can judge the proficiency and competence of other physicians who, by the nature of their position as licensed physicians, are held to a different and higher standard of patient care regardless of the medical modality employed.

We strongly urge state medical boards adopt the WHO/WFAS training standard and the AAMA criteria and the ABMA Board Certification as the basis of physician CAM licensure and credentialing. Also, the regulation, licensing and credentialing of physicians must fall into a category distinct and separate from that of non-physicians. It is appropriate that state medical boards regulate physicians and it is optimal that state medical boards, which expect the highest standard of patient care, also to control and supervise CAM practice by non-physicians.

10. Are there medical malpractice issues that you would like to share with the Commission? For example, is there risk to practitioners who do/do not use CAM practices or products?

Physicians carry medical malpractice insurance as a condition of their state license. A physician is held to a high standard of education and care by the state, by their profession and by the public. This higher standard of care for physicians exists regardless of the medical modality employed. This higher standard of care requirement is reflected in the state requirement that physicians carry considerably more medical malpractice insurance than any other health care practitioner.

An interesting distinction as it relates to malpractice issues must be noted which emphasizes the difference between a physician who practices CAM, for example Medical Acupuncture, and a non-physician CAM practitioner. If a physician is sued on a malpractice claim by a patient he/she treated with acupuncture, the suit would not be based solely on the acupuncture and the harm the acupuncture might have created. On the contrary, the suit would be brought because the treatment was provided by a physician – a person who is held to a higher standard of care than any other licensed practitioner. Physicians are required to carry malpractice insurance--- such requirements should apply to all CAM practitioners.

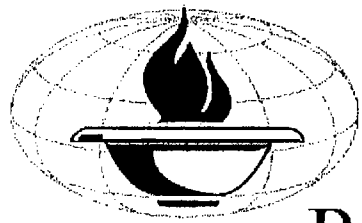
11. What other measures should be developed to promote quality and accountability amongst conventionally trained providers practicing CAM? Practice guidelines or modality-specific guidelines? Consumer protection programs? What about oversight or regulation of supplements?

The AAMA and ABMA have led the way by instituting Board Certification for physicians practicing medical acupuncture. While each individual CAM can establish their own guidelines, it is important to know that each AAMA Board Certified physician is also regulated by his/her state medical board, thus assuring the public a doubled competency standard. General practice guidelines, include moral and practice guidelines, are necessary for non-physician practitioners who do not have the same training and obligation as physicians and are not held to the same standards of patient care. The public is best protected by strong regulation of non-physician CAM practitioners in order to insure competency and public safety.

We thank you for soliciting our ideas and trust that you will not hesitate to contact us with any additional questions, or if we may be of further assistance.

Sincerely,

Marshall Sager, DO, DABMA
President-Elect, American Academy of Medical Acupuncture



AMERICAN BOARD of MEDICAL ACUPUNCTURE

OPTIMA ULTRIUSQUE ARTIS MEDICINAE · FOUNDED IN 2000

# Board Certification Information

## BOARD CERTIFICATION APPLICATION

## BOARD OF TRUSTEES

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**Board of Trustees**

Marshall A. Sager, DO
*Chairman*
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## American Board of Medical Acupuncture
## Board Certification Information

The American Board of Medical Acupuncture (ABMA) was formally established on April 26, 2000. The ABMA has been created as an independent entity within the corporate structure of the American Academy of Medical Acupuncture. The ABMA has a separate, independent

Board of Trustees with full responsibility for the direction and operation of the ABMA.

**Mission of The American Board of Medical Acupuncture**
The mission of The American Board of Medical Acupuncture is to promote safe, ethical, efficacious medical acupuncture to the public by maintaining high standards for the examination and certification of physician acupuncturists as medical specialists.

**Purposes of The American Board of Medical Acupuncture**
The essential purposes of the ABMA are:

1. To establish requirements for the qualifications of applicants who request a certificate of their training and experience in the field of medical acupuncture in its broadest sense.
2. To conduct examinations of approved candidates who seek certification by the Board.
3. To issue certificates to those physicians who meet the Board's requirements and pass the Board's examination.
4. To promote the advancement and betterment of the specialty of medical acupuncture.
5. To assist in improving the quality of post-graduate and continuing education in the specialized medical practice embraced by the field of medical acupuncture.
6. To do and engage in any and all lawful activities that may be incidental or reasonably related to any of the forgoing purposes.

**Purpose of Certification**

The intent of the certification process is to provide assurance to the public that a certified medical specialist has successfully completed an approved educational program and an evaluation, including an examination process, designed to assess the knowledge, experience and skills requisite to the provision of high quality patient care in that specialty. Diplomates of The American Board of Medical Acupuncture possess particular qualifications in this specialty.

Standards of certification are distinct from those of State licensure. Possession of a Board certificate does not indicate total qualification for practice privileges, nor does it imply exclusion of other physicians not so certified. The Board does not purport in any way to interfere with or limit the professional activities of any licensed physician or any of his/ her regular or legitimate activities.

The Board considers Certification to be based upon a process, which includes the education phase, experience phase and examination phase. It holds that the education and training phase are of the utmost importance in preparing the physician in the theory and techniques of medical acupuncture. The most appropriate training is an organized course of study, based on a systematic curriculum that emphasizes an integrated medical acupuncture curriculum from multiple paradigms and acupuncture traditions.

**Definition of Medical Acupuncture**

Medical acupuncture is a medical discipline having a central core of knowledge embracing the integration of acupuncture from various traditions into contemporary biomedical practice.

A Physician Acupuncturist is one who has acquired specialized knowledge and experience related to the integration of acupuncture within a biomedicine practice.

**Education and Training in Medical Acupuncture**

The World Health Organization and the World Federation of Acupuncture and Moxibustion Societies (WFAS) have promulgated acupuncture training and education standards for

Western trained physicians. Those standards were first adopted in Beijing, China in 1987 and reaffirmed at the WFAS conference in Milan, Italy in 1996. These are considered to reflect the minimum level of training necessary for a Western trained physician to enter the practice of medical acupuncture. The WHO standards for physician acupuncture practitioners are as follows:

"4.2.1 For licensed graduates of modern Western medical colleges, who already have had education and training in anatomy, physiology, neurology, and all the other basic and clinical sciences involved in medical diagnosis and treatment, training in acupuncture can be accomplished following a different training pathway for them to master acupuncture as a special medical modality.
The theoretical part and objectives of this acupuncture training are parallel to those described in the complete training section, and the acupuncture core syllabus will be the same. (The entire WHO/WFAS document is available from the ABMA.) The whole course should be devoted to acquiring the knowledge and skill in acupuncture as well as the related basic theory for at least 200 hours of formal training. By the end of the course the participants should be able to integrate acupuncture into their medical practices. The proficiency of training and practice should be evaluated through an official examination by health authorities to ensure safety, competence, and efficacy."

The American Board of Medical Acupuncture has established standards of training and education that exceed those established by WFAS as the entry-level standards. The ABMA will not accept into the process of Certification anyone who has not met the standards for training, education and experience as set forth by the ABMA.

The purpose of postgraduate education in medical acupuncture is to ensure safety, competence, and efficacy in the practice of medical acupuncture, and to understand its proper integration into a biomedical practice. This education can best be achieved through an organized course of study, with a systematic curriculum as described above. Of that program, at least 100 hours are to be clinical in nature, 100 hours didactic.

The educational requirements set forth by the Board are to be considered the minimum requirements of the Board and should not be interpreted to be restrictive in nature. The Board encourages continuing education and training in advanced level courses and in various Microsystems. The Board has adopted a policy requirement that all physicians who have achieved certification from the Board must document minimum levels of continuing education in acupuncture in order to achieve re-certification.

**Acceptable Educational Programs**

The Board has the sole responsibility to evaluate the adequacy and appropriateness of the acupuncture training of those seeking certification from the Board. The Board meets this responsibility in several ways. The Board, from time to time, shall review the curriculum, faculty, teaching methods and other aspects of the programs for formal courses of training physicians in medical acupuncture offered in the United States and Canada. The Board, in its sole judgment, shall determine whether such programs are sufficient to meet its standards.

Formal courses of study and training designed for physicians, as a minimum, should meet the guidelines and standards set forth by WHO/WFAS for such training. Programs must be a minimum of 200 hours of acupuncture specific training, post-medical school, of which 100 hours should be clinical.

Physicians should contact the ABMA for a current listing of those programs that have been reviewed and found to be acceptable by the Board. Providers of such educational programs, which have not already been reviewed by the Board, may contact the Board to obtain

information on how to arrange such review.

Those who are contemplating obtaining training or who have already obtained training through means other than through an approved formal course as discussed above must submit an application to request that the Board review that training program to determine acceptability in lieu of an approved course of study. The application will require that detailed information be submitted regarding the content and curriculum of the course, the faculty, and the teaching methodologies employed. The Board may determine that an oral interview of the applicant is necessary, following the completion of an unapproved course, in order for the Board to determine the adequacy of training. The Board, in its sole judgment, shall determine the acceptability of any such training, on a case-by-case basis.

**Requirements For Certification In Medical Acupuncture**

Candidates for certification in medical acupuncture must meet minimum general requirements, education and training requirements, experience requirements and must successfully pass the Board examination in order to achieve certification.

**General Requirements**

*A. Requirements for graduates of education institutions in the United States or Canada.*

1. Graduation from an accredited allopathic or osteopathic medical school in the United States or Canada.
2. Possession of a current, valid, unrestricted license to practice medicine or osteopathy in a state or jurisdiction of the United States or province of Canada.
3. The ABMA has adopted a policy that explicitly establishes that there is no requirement that applicants be a member of any membership organization or professional society in order to be eligible to apply for or to receive certification.
4. Must have a moral and ethical standing satisfactory to the Board and in conformity with the Statement of Standards of the American Board of Medical Acupuncture. Moral and ethical practices that do not conform to the Statement of Standards may result in rejection of an application or deferral of examination or certification until such matters have been resolved.

*B. Requirements for graduates of schools of medicine from countries other than the United States or Canada.*

1. Must provide evidence of Final Certification by the Educational Commission for Foreign Medical Graduates (ECFMG).
2. Possession of a current, valid, unrestricted license to practice medicine or osteopathy in a state or jurisdiction of the United States or province of Canada.
3. The ABMA has adopted a policy that explicitly establishes that there is no requirement that applicants be a member of any membership organization or professional society in order to be eligible to apply for or to receive certification.
4. Must have a moral and ethical standing satisfactory to the Board and in conformity with the Statement of Standards of the American Board of Medical Acupuncture. Moral and ethical practices that do not conform to the Statement of Standards may result in rejection of an application or deferral of examination or certification until such matters have been resolved.

**Acupuncture Training Requirements**

1. Subsequent to graduation from medical school, the applicant must have satisfactorily completed a minimum of 300 hours of systematic acupuncture training in a program

acceptable to the ABMA. Such training shall include a formal course of study of not less than 200 hours in a program that meets the WFAS standards for such courses as determined by the ABMA.

2. At least 100 hours of the minimum 300 hours of training shall have been clinical training acceptable to the ABMA.
3. All training hours must be acupuncture specific training.
4. Applicants should obtain a current list of ABMA approved training programs by contacting the ABMA office.
5. Applicants who have obtained training through means other than through an ABMA approved training course must submit application to request that the Board review their training to determine acceptability in lieu of an approved course of study. Detailed information regarding the content and curriculum of the course, the faculty, and the teaching methodologies employed must accompany the application. The Board, in its sole judgment, shall determine the acceptability of any such training, on a case-by-case basis.
6. For applicants who obtained training from programs not previously approved by the ABMA, the Board may determine that an oral interview of the applicant is necessary, in order for the Board to determine the adequacy of training.

**Acupuncture Experience Requirement**

1. Applicants for certification must submit an affidavit attesting that the applicant has had a minimum of two years of medical acupuncture clinical experience subsequent to the completion of the basic 200 hour medical acupuncture training and an acupuncture case history of not less than 500 medical acupuncture treatments.
2. Acupuncture practice should involve more than one of the following acupuncture paradigms, including but not limited to energetic acupuncture, neuroanatomic acupuncture, 5 Elements, TCM, Auricular, Scalp, Hand, etc.
3. Applicants for certification must provide confidential letters of references from three physicians pertaining to the applicant's character, professionalism, and standards of clinical practice of acupuncture.
4. No decision regarding the applicant's certification will be made until the physicians from whom references have been requested have replied. All information submitted to the Board by a physician from whom a reference has been requested will remain confidential and will not be disclosed to the applicant without the permission of said physician.

**Examination Requirement**

1. Applicants who have submitted an Application for Certification documenting that the applicant has met the education requirement established by the ABMA will receive notice of eligibility to sit for the written Board examination.
2. The written examination will be conducted in the Spring each year and at such additional times during the year as may be determined by the ABMA.
3. Applicants who have passed the Proficiency Examination offered by the American Academy of Medical Acupuncture prior to May 15, 2000, have met the examination process requirement of the ABMA.

4. All applicants desiring to sit for the examination must meet the educational requirements as set forth above. Applications must be received not less than 75 days prior to the date of any examination offering to allow sufficient time for the Board to review and accept the application if the applicant intends to sit for that examination. All Applicants for Certification who have been accepted by the Board will receive notice of each examination offering.
5. Applicants whose acupuncture training was in a program not pre-approved by the ABMA, may be required to submit to an oral interview to determine the adequacy of training. Organizing, scheduling and completing the interview and evaluation following the interview may require more than 75 days and thus such applicants should plan accordingly in scheduling which examination to sit for.
6. Applicants desiring to withdraw from an examination must submit a written request to withdraw not later than 30 days before the scheduled examination. A refund of $250, ($500 examination fee less a $250 administrative fee), will be provided for those who have provided the appropriate notice. No refund will be provided for withdrawals less than 30 days prior to the scheduled examination or for candidates who fail to appear for the examination.
7. Applicants shall have two years from the time of notification of eligibility to take the examination. Failure to take the examination within the two-year period will result in loss of exam eligibility and forfeiture of all fees paid. Applicants will need to submit an up dated application, with all appropriate fees in effect at that time, to reapply for eligibility to take the examination.
8. Individuals who fail an examination may apply for admissibility for re-examination during any subsequent examination period. Fees for re-examination are $500.

**Application for Board Certification**

1. Application for Board Certification, accompanied by required application and examination fees, may be submitted at any time an applicant feels he or she meets the General and Education Requirements for Board Certification.
2. It is not required that the applicant has met the Clinical Experience Requirements at the time of submission of the Application for Board Certification. However, Board Certification will not be granted until all such requirements have been met to the satisfaction of the Board.
3. Applicants for Certification must submit a Certification Processing fee of $750, which consists of a non-refundable $250 application fee, and a $500 examination fee. The portion of the Processing fee attributable to the examination shall be waived for those applicants who have successfully completed the examination process.
4. The Board will conduct such review and evaluation as necessary to determine whether the applicant meets the requirements for Board Certification including the General Requirements, the Education Requirements, the Clinical Experience Requirements and the Examination Requirements.
5. Applicants whose applications have been approved as to the General Requirements and the Education Requirements only are considered "board eligible". Those applicants who have been determined to be "board eligible" may take the Board Examination. However, Board Certification will not be granted until all requirements have been met, including the Clinical Experience requirements.

**The Certificate**

Upon approval of the application and the candidateÕs successful completion of the examination and completion of the Clinical Experience Requirements, the Board will grant a certificate to the effect that the candidate has met the requirements of the Board. The recipient of a certificate will be known as a Diplomate of the American Board of Medical Acupuncture. (DABMA) and may use such title or initials in his/her professional name.

All certificates issued are time-limited, expiring on June 30th of the tenth year following the date issued. Re-certification procedures are described briefly in the following section and in depth in a separate information booklet available from the office of the Board.

A certificate granted by the ABMA does not of itself confer or purport to confer any degree or legal qualifications, privileges or license to practice medical acupuncture. The ABMA does not limit or interfere with the professional activity of any duly licensed physician who is not certified by this Board. Privileges granted physicians in the practice of medical acupuncture in any hospital or clinic are the prerogatives of that hospital or clinic, not of this Board.
The names of Diplomates of the American Board of Medical Acupuncture appear in the Official Roster of Diplomates of the ABMA available from the Board office.

**Revocation of Certification**

A Certificate issued by the Board is issued with the understanding that it remains the property of the Board. Any certificate issued by the Board shall be subject to revocation at any time if the Board determines, in its sole judgment, that the diplomat holding the certificate was in some respect not properly qualified to receive or retain it.

**Reasons for Revocation**

The ABMA may at is sole discretion revoke a certificate for due cause, including, but not limited to, the following:

1. The Diplomate made any material misstatement or omission to the Board.
2. The Diplomate did not possess the necessary qualifications and requirements to receive the certificate at the time it was issued, whether or not the Board knew of such deficiency.
3. The Diplomate engaged in irregular behavior in connection with an examination of the ABMA, whether or not such practice had an effect on the performance of the candidate on that examination.
4. The Diplomate engaged in conduct that violated the moral or ethical standards of medical practice accepted by organized medicine in the locality where the Diplomate is practicing, resulting in revocation, suspension, qualification or other limitation of his or her license to practice medicine, or the expulsion, suspension, disqualification or other limitation from membership in a local, regional, national or other organization of his or her professional peers.
5. The Diplomate's license to practice medicine has been revoked, suspended, qualified or limited in any jurisdiction.

**Re-Certification Procedures**

Certificates issued by the ABMA expire on June 30th of the tenth year following the date of issuance. To maintain certification beyond the 10-year period, Diplomates must participate in the re-certification program.
To participate in the re-certification program, a Diplomate must:

1. Hold a current, valid, unrestricted license to practice medicine or osteopathy in a

United States licensing jurisdiction or licensure in Canada.
2. Pay an annual $50 fee.
3. Provide evidence of a total of 150 hours of such training over the ten year period.
4. Successfully complete a re-certification examination.

Enrollment in the re-certification program is automatic for all diplomats. Failure to pay the annual fee or failure to report continuing education credits earned for three or more years are considered nonparticipation. Non-participants will be advised when their certificates expire. Delayed participation in the re-certification process may require completion of the requirements for initial certification in order to re-establish certification. Therefore, Diplomates are advised to monitor their participation carefully.

**ADDITIONAL INFORMATION**

For additional information about the American Board of Medical Acupuncture, board certification requirements and procedures, or a Board Certification Application, please contact the ABMA Executive Office at the following location:

**American Board of Medical Acupuncture**
4929 Wilshire Boulevard, Suite 428
Los Angeles, California 90010
323.937.5514 voice
323.937.0959 fax

Click HERE for the ABMA Application form

# Tab 2

# White House Commission on Complementary and Alternative Medicine Policy

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




January 31, 2001

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

Dear Dr. Miller:

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

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
Medicine Policy

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

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

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

# Tab 3

# White House Commission on Complementary and Alternative Medicine Policy

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




February 5, 2001

American Holistic Dental Association
P.O. Box 5007
Durango, CO 81301

Dear Chairperson:

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 **www.whccamp.hhs.gov**.

The Commission will meet on February 22-23 to discuss the topic areas: education and training of health care practitioners, quality of care, and accountability, as they relate to complementary and alternative medicine (CAM). The questions that follow were developed to guide the Commission's deliberations. To accomplish its goal, however, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments by e-mail or fax by February 13th so that the Commissioners have enough time to review them before the February 22-23 meeting.

Questions Developed for Commission Discussion :

1. Is there currently enough science available on CAM to establish educational programs in integrative health care? (Integrative is defined as combing conventional western medicine with "alternative" therapies.)

2. What should be done to assure that integrative health providers have the appropriate education (knowledge) and training (skills) for their specific scope of practice? Should core competencies be established? If so, how would these "competencies" reflect the various levels of CAM integration – for example, practitioners who use their knowledge to make referrals to CAM providers, practitioners who have this knowledge but also incorporate one or more modified CAM techniques into their patient care, and practitioners who have extensive CAM knowledge and who furnish one or more CAM skills (such as acupuncture) as part of their practice.

3. What knowledge and core competencies – and credentialing -- should be required for an integrative health care provider to serve in the role of primary care practitioner (PCP)? Should chiropractors, acupuncturists, and other CAM providers be able to serve as PCPs? Should western trained

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| DOCUMENT NO. AND TYPE | SUBJECT/TITLE | DATE | RESTRICTION |
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| 002. letter | Stephen Groft to Chairperson, American Holistic Dental Association (partial) (1 page) | 02/05/2001 | b(6) |

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

OA/Box Number: 43241

**FOLDER TITLE:**
WHCAM Briefing Book, Discussion Group III, February 22-23, 2001 [1]

2011-0568-S
kc797

**RESTRICTION CODES**

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

**P1 National Security Classified Information [(a)(1) of the PRA]**
**P2 Relating to the appointment to Federal office [(a)(2) of the PRA]**
**P3 Release would violate a Federal statute [(a)(3) of the PRA]**
**P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]**
**P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]**
**P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]**

**C. Closed in accordance with restrictions contained in donor's deed of gift.**
**PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).**
**RR. Document will be reviewed upon request.**

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

**b(1) National security classified information [(b)(1) of the FOIA]**
**b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]**
**b(3) Release would violate a Federal statute [(b)(3) of the FOIA]**
**b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]**
**b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]**
**b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]**
**b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]**
**b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]**

providers have training in CAM to serve as gatekeepers and make referrals to CAM providers?

4. Who and what are needed in developing faculty for integrative health training programs? What are the issues in developing faculty, curricula, resources, etc.?

5. What recommendations or other guidance can be offered regarding funding for integrative health training programs?

6. Should there be continuing education (CE) requirements for all integrative health providers? Should integrative health professionals be required to demonstrate periodically that they maintain core competencies in the modalities they practice?

7. Should there be national CE standards for integrative health care providers? State standards? Professional standards? If so, who should be responsible?

8. What issues, unmet needs and problems currently exist for continuing education? (For example, do certain entities such as state licensure boards accept CAM CEUs?)

9. Should professional credentialing be performed by one, central body or at the state level? If so, who should be responsible? To what degree should the specific profession(s) be involved?

10. Are there medical malpractice issues that you would like to share with the Commission? For example, is there risk to practitioners who do/do not use CAM practices or products?

11. What other measures should be developed to promote quality and accountability amongst conventionally trained providers practicing CAM? Practice guidelines or modality-specific guidelines? Consumer protection programs? What about oversight or regulation of supplements?

Thank you for your invaluable help. Please send your written comments to Maureen Miller, MPH, RN, *fax: (301-480-1691), phone:* (b)(6) *cell or 301-435-6198),* and contact her with any questions you may have. She will be happy to work with you in any way she can to gain your expert advice

Sincerely,

Stephen C Groft

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

Response

To: White House Commission on Complementary and Alternative Medicine Policy
Date: February 10, 2001

I am writing in response to your request to the Holistic Dental Association for input. However, I am writing as an individual officer because all the officers have not had an opportunity to conference and make a group response, but I would guess that the thoughts I have would basically mirror what the group would think is important. You may be getting other individual responses as well.

1. Regarding if there is enough science available, I respond that you should not limit yourselves to considering only that which science can explain. There are many concepts that are based on observation or patient response and not scientifically verified, and/or that are new or experimental. Although too subjective for science, it does offer insight and ideas, which can lead to breakthroughs. Also, you are well aware that some conventional practitioners classify alternative science as pseudo-science if they don't like what the data suggests. So who then decides which scientific research is acceptable to consider or include in CAM? Every perspective offers a piece to the puzzle.

2. When you say "combining" alternative with conventional, it is not quite accurate. It is really integrating into the consciousness of all practitioners that there is more than one way to treat a patient. It is more accurate that treatments, whether conventional or alternative, should often be phased and prioritized and used separately rather than always done concurrently. Or that if an alternative treatment is used, it's progress should if possible be evaluated using conventional testing. And that the different practitioners involved can work collaboratively, and everyone, including the patient, is informed and allowed to give input.

3. Be careful of trying to establish a standard of care. It is more that practitioners must have an adequate understanding of the many concepts that exist, so that the patient and practitioner/s are able to choose among them those that are most appropriate based on benefits vs risk, success rate, time constraints, cost, and patient wishes. There is no one treatment protocol that is usually or always best for a particular situation, i.e. one treatment protocol does not fit all.

4. Think outside the box, don't try to fit CAM into the existing model and thinking of Western healthcare. Define your purpose and intent first, then find ways to fulfill it without limiting yourself to existing "tools".

5. Competence is difficult. You seem to be assuming that continuing education creates competence. This is a myth. Although education is a necessity, it is what the practitioner chooses to do or not to do with that education that counts. That said, there should be a minimal amount of education required for basic certification to allow someone to be called a CAM practitioner that coordinates treatments and makes referrals, and more education required for advanced levels of certification which allow CAM treatments to be administered. And note I said certification, not licensure, two very different concepts.

6. Education is now being done by private practitioners through groups such as the Holistic Dental Association, International Academy of Oral Medicine and Toxicology, and others. This is not an ideal mechanism for core competency because attendance is optional and no tests are given. No mentoring is available either. Independent home study is utilized, but with the same problems. And the various alternative groups simply exist because there is no consensus because of differing philosophies. However, I see differing opinions and philosophies as good if practitioners will agree to disagree, and as a result learn from each other. Recognized institutions such as colleges do not allow CAM subjects to be taught either at undergraduate level or postgraduate level. And then there is the specter of the few highly qualified and experienced practitioners who would be willing to teach being subject to

scrutiny by their licensing boards and likely disciplinary action as a result. There would need to be legal protection from being disciplined for practicing outside the scope of their license as defined by current law. When you say integrated healthcare, you should know that the licensing of dentistry and medicine and chiropractic and pharmacy and nursing and all the others artificially limits the areas of the body a practitioner can treat. . . an impossible situation if you want truly effective CAM. Rather, base allowed treatments by practitioners based on education and demonstrated competence rather than only on the type of license. There is a new college curriculum that grants a CAM degree in Washington, D.C. (let me know if you want more detailed information), but it is too comprehensive for most practitioners if you want to just foster integration and collaboration of existing practitioners rather than full service by one practitioner. Federal funding is often given to healthcare colleges, so require CAM coursework in order to receive funding. Maybe require insurers to help fund education since they are the entities who will benefit financially the most from integrated healthcare.

7. There should not be gatekeepers. However, always require a CAM knowledgeable M.D.'s or D.O.'s input (note I did not say authorization) before any treatment can be rendered. The "gatekeeper" is the patient. Then, require that all practitioners be informed of the progress of treatment and collaborate appropriately.

8. Minnesota passed cutting edge legislation in 2000 that allows some nonlicensed practitioners and some licensed practitioners to practice CAM without interference from licensing boards. Unfortunately, politics prevailed and excluded physicians, dentists, and chiropractors. Having federal approval and urging and help would encourage state's boards to allow CAM practices by its licensees. . . maybe there would need to be strong incentives.

9. Consumer protection is always through education. Buyer Beware is a consistently true adage. The federal government should provide free of charge websites that educate, and written materials at cost that serve to give the patient enough information to make proper decisions. That said, you can't legislate to protect everyone from themselves, i.e. stupid behavior or decisions. What I am saying is facilitating "informed consent" is all you can and should do.

10. There maybe should be federal standards, although I believe in state's rights too. Again, maybe federal guidelines, not requirements or laws. Difficult issue. Standardization is good if it is not arbitrarily restrictive nor implies it is the preferred approach.

Thank you for your efforts. If I can be of further help, don't hesitate to contact me.

Ronald L. King, DDS
Holistic Dental Association - President elect
Minnesota Board of Dentistry - Appointed member
American Dental Association - Member
U of Minnesota School of Dentistry - Former part-time faculty
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# Tab 4

# 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 5, 2001

Suzan Walter
President
American Holistic Health Association
P.O. Box 17400
Anaheim, CA 92817-7400

Dear Ms. Walter:

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 **www.whccamp.hhs.gov**.

The Commission will meet on February 22-23 to discuss the topic areas: education and training of health care practitioners, quality of care, and accountability, as they relate to complementary and alternative medicine (CAM). The questions that follow were developed to guide the Commission's deliberations. To accomplish its goal, however, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments by e-mail or fax by February 13th so that the Commissioners have enough time to review them before the February 22-23 meeting.

Questions Developed for Commission Discussion :

1. Is there currently enough science available on CAM to establish educational programs in integrative health care? (Integrative is defined as combing conventional western medicine with "alternative" therapies.)

2. What should be done to assure that integrative health providers have the appropriate education (knowledge) and training (skills) for their specific scope of practice? Should core competencies be established? If so, how would these "competencies" reflect the various levels of CAM integration – for example, practitioners who use their knowledge to make referrals to CAM providers, practitioners who have this knowledge but also incorporate one or more modified CAM techniques into their patient care, and practitioners who have extensive CAM knowledge and who furnish one or more CAM skills (such as acupuncture) as part of their practice.

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| DOCUMENT NO. AND TYPE | SUBJECT/TITLE | DATE | RESTRICTION |
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| 003. letter | Stephen Groft to Suzan Walter (partial) (1 page) | 02/05/2001 | b(6) |

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

OA/Box Number: 43241

**FOLDER TITLE:**
WHCAM Briefing Book, Discussion Group III, February 22-23, 2001 [1]

2011-0568-S
kc797

**RESTRICTION CODES**

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

P1 National Security Classified Information [(a)(1) of the PRA]
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3. What knowledge and core competencies – and credentialing -- should be required for an integrative health care provider to serve in the role of primary care practitioner (PCP)? Should chiropractors, acupuncturists, and other CAM providers be able to serve as PCPs? Should western trained providers have training in CAM to serve as gatekeepers and make referrals to CAM providers?

4. Who and what are needed in developing faculty for integrative health training programs? What are the issues in developing faculty, curricula, resources, etc.?

5. What recommendations or other guidance can be offered regarding funding for integrative health training programs?

6. Should there be continuing education (CE) requirements for all integrative health providers? Should integrative health professionals be required to demonstrate periodically that they maintain core competencies in the modalities they practice?

7. Should there be national CE standards for integrative health care providers? State standards? Professional standards? If so, who should be responsible?

8. What issues, unmet needs and problems currently exist for continuing education? (For example, do certain entities such as state licensure boards accept CAM CEUs?).

9. Should professional credentialing be performed by one, central body or at the state level? If so, who should be responsible? To what degree should the specific profession(s) be involved?

10. Are there medical malpractice issues that you would like to share with the Commission? For example, is there risk to practitioners who do/do not use CAM practices or products?

11. What other measures should be developed to promote quality and accountability amongst conventionally trained providers practicing CAM? Practice guidelines or modality-specific guidelines? Consumer protection programs? What about oversight or regulation of supplements?

Thank you for your invaluable help. Please send your written comments to Maureen Miller, MPH, RN, *fax: (301-480-1691), phone:* (b)(6) (b)(6) *cell or 301-435-6198),* and contact her with any questions you may have. She will be happy to work with you in any way she can to gain your expert advice

Sincerely,

Stephen C Groft

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

**The following answers to your questions are from the perspective of a consumer organization, not a professional modality association. We have conferred with some healthcare professionals to get their views.**

Questions Developed for Commission Discussion :

1. Is there currently enough science available on CAM to establish educational programs in integrative health care? (Integrative is defined as combing conventional western medicine with "alternative" therapies.)

Your question appears to be addressing the educating of medical doctors so that they can add CAM disciplines to their practice. We would hope that your Commission is also addressing CAM healthcare professionals who are not medical doctors, but rather have become (or are being educated to become) experts in their specific healthcare discipline/modality.

CAM appears to us to have a variety of levels of acceptance and credibility. For the sake of discussion lets group CAM into three levels.

- Those that have a large body of research and are currently licensed (such as chiropractic, acupuncture, naturopathy)
- Those that have a large body of research and are in the process of positioning to be licensed (such as homeopathy)
- Those that do not have an abundance of research and are a long way from being licensed, if ever (such as crystal therapy)

The first two groups have an overabundance of scientific studies available to support educational programs.

2. What should be done to assure that integrative health providers have the appropriate education (knowledge) and training (skills) for their specific scope of practice? Should core competencies be established? If so, how would these "competencies" reflect the various levels of CAM integration – for example, practitioners who use their knowledge to make referrals to CAM providers, practitioners who have this knowledge but also incorporate one or more modified CAM techniques into their patient care, and practitioners who have extensive CAM knowledge and who furnish one or more CAM skills (such as acupuncture) as part of their practice.

From a consumers perspective your goals seem very confusing. Our view is that anyone delivering patient care using any CAM treatment modality must be thoroughly trained in that discipline - whether a medical doctor adding on

another healing modality or a practitioner specializing in that healing modality. Each CAM discipline needs to be in control of what constitutes expertise in that modality – not some outside source.

3. What knowledge and core competencies – and credentialing -- should be required for an integrative health care provider to serve in the role of primary care practitioner (PCP)? Should chiropractors, acupuncturists, and other CAM providers be able to serve as PCPs? Should western trained providers have training in CAM to serve as gatekeepers and make referrals to CAM providers?

From a consumer perspective the patient deserves the right to select what type of healthcare provider he/she has confidence in as the PCP. Some will want a medical doctor, some will want a high level CAM discipline, such as acupuncturist or chiropractor. An individual deserves the right to put together his/her own healthcare team of providers with PCP and others. Having licensing a requirement for serving as a PCP would make sense to use as a yardstick for keeping the level of competence high for being a PCP.

4. Who and what are needed in developing faculty for integrative health training programs? What are the issues in developing faculty, curricula, resources, etc.?

Only those who have the training and experience to reach the level of specialist in their CAM field would be appropriate to serve on the faculty for a CAM training program. For an integrative program it would be very important that the individual teaching each CAM discipline is indeed an expert in that field. In developing curricula, etc. it is again important that only recognized experts in a field make decisions for matters related to that field.

5. What recommendations or other guidance can be offered regarding funding for integrative health training programs?

Are you only addressing integrative health training programs? We were under the impression that you were charged to address CAM matters. In regards to funding we caution you to see that Western medicine and CAM disciplines are treated on an equal basis. If you only address medical doctors adding CAM to their practice, you will lose credibility with the CAM disciplines and the general public.

6. Should there be continuing education (CE) requirements for all integrative health providers? Should integrative health professionals be required to demonstrate periodically that they maintain core competencies in the modalities they practice?

Again, we are concerned that you only ask about integrative health providers, and define these as "combing conventional western medicine with "alternative" therapies". What about CAM practitioners? For the peace of mind of the consumer, the requirements for continuing education need to be addressed by each CAM discipline independently, as each modality would know what is needed and appropriate to maintain a high level of expertise in that specific field. We are assuming that everyone achieving licensing for a CAM discipline is held to the same level of training requirements. We are concerned that currently in some situations a medical doctor is allowed to gain authorization to treat with a CAM discipline after a lesser level of training.

7. Should there be national CE standards for integrative health care providers? State standards? Professional standards? If so, who should be responsible?

This sounds like you are striving to create a new integrative health care category of healthcare specialty. This does not appear to a consumer to be what your Commission is to address. If your question is really about continuing education standards for the various CAM disciplines, as stated before, we believe these are best left up to each modality.

8. What issues, unmet needs and problems currently exist for continuing education? (For example, do certain entities such as state licensure boards accept CAM CEUs?)

The level of CEUs required must be economically appropriate for the income that can be generated by a specific CAM modality.

9. Should professional credentialing be performed by one, central body or at the state level? If so, who should be responsible? To what degree should the specific profession(s) be involved?

Each CAM discipline needs to have a credentialing program that meets their unique situation. As to where the power is positioned - there is always a

problem with a central body as a sole credentialing agency. It gives too much power with too little oversight. Any central body needs to at least have appeal, grievance, etc. options built into the structure, and some sort of oversight accountability factor. State agencies need to find a way to allow reciprocity with other states. Any healthcare professional (medical doctor or CAM practitioner) needs to be held accountable to the same standards for the CAM discipline in question.

10. Are there medical malpractice issues that you would like to share with the Commission? For example, is there risk to practitioners who do/do not use CAM practices or products?

Be sure that malpractice is based on deviations from legal/ethical boundaries that are reasonable and appropriate for the CAM treatment offered. Those outside of the modality should not be in control of setting the standards.

11. What other measures should be developed to promote quality and accountability amongst conventionally trained providers practicing CAM? Practice guidelines or modality-specific guidelines? Consumer protection programs? What about oversight or regulation of supplements?

Here you are only mentioning medical doctors adding CAM disciplines to a practice. We urge you to broaden this to include CAM practitioners. In regard to this question, our position is that any health professional using a CAM treatment needs to be thoroughly trained for that healing modality. The consumer wants to be able to trust that anyone offering say acupuncture is capable of providing safe, effective treatment. Each modality needs to be responsible for establishing the guidelines that protect the healthcare consumer when receiving their specific type of care, including educating the public about what is reasonable to expect. Great care needs to be taken when addressing regulation of the nutritional supplement industry. It would be ideal to protect the consumer's right to access, establish reasonable requirements for research, labeling, and safety, and prevent self-serving disruptive influence from outside entities out for personal gain.

# Tab 5

# 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 5, 2001

Dr. Kathleen Frye
President
American Holistic Medical Association
6728 McLean Village Drive
McLean, VA 22101-8729

Dear Dr. Frye:

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 www.whccamp.hhs.gov.

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[004]

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Thank you for your invaluable help. Please send your written comments to Maureen Miller, MPH,RN, *fax: (301-480-1691), phone:* (b)(6) *cell or 301-435-6198),* and contact her with any questions you may have. She will be happy to work with you in any way she can to gain your expert advice

Sincerely,

Stephen C. Groft

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

From: "Bill Manahan" <bmanahan@mnic.net>
Subject: REPLY

Hi Kathi,

Here are a few of my thoughts about the questions you sent from the White House Commission. I put my answers in capitals after each question. Love and Hugs, Bill

Dr. Kathleen Frye

President

American Holistic Medical Association

6728 McLean Village Drive

McLean, VA 22101-8729

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Questions Developed for Commission Discussion :
Is there currently enough science available on CAM to establish educational programs in integrative health care? (Integrative is defined as combing conventional western medicine with "alternative" therapies.) MORE THAN ENOUGH. THAT QUESTION MAKES ME SAD AS I REALIZE HOW MUCH EVIDENCE THERE IS FOR SO MUCH OF CAM. I ALSO CONTINUE TO REALIZE HOW LITTLE EVIDENCE THERE IS FOR SO MUCH OF WHAT WE DO IN BIOMEDICINE, BUT WE TEND TO DENY THAT REALITY.
What should be done to assure that integrative health providers have the appropriate education (knowledge) and training (skills) for their specific scope of practice? Should core competencies be established? If so, how would these "competencies" reflect the various levels of CAM integration for example, practitioners who use their knowledge to make referrals to CAM providers, practitioners who have this knowledge but also incorporate one or more modified CAM techniques into their patient care, and practitioners who have extensive CAM knowledge and who furnish one or more CAM skills (such as acupuncture) as part

of their practice. THERE IS NOT A NEED FOR CORE COMPETENCIES. WHEN THE RISK OF A TREATMENT IS OF MINIMAL DANGER TO THE RECIPIENT, THERE IS NO NEED FOR LICENSING OR COMPETENCIES. WE ALLOW OUR NEIGHBOR TO PRESCRIBE CHICKEN SOUP, AND CAM PRACTITIONERS NEED TO BE ALLOWED TO PRESCRIBE WHAT THEY BELIEVE HELPFUL AS LONG AS THE RISK OF HARM OR INJURY TO THE PATIENT IS MINIMAL. THE STATE OF MINNESOTA PASSED LEGISLATION ABOUT THIS IN 2000, SO MAYBE THE REST OF THE U.S. NEEDS TO LOOK AT WHAT WE ACCOMPLISHED HERE. IT IS A WONDERFUL PIECE OF LEGISLATION AND VERY SENSIBLE.

What knowledge and core competencies and credentialing -- should be required for an integrative health care provider to serve in the role of primary care practitioner (PCP)? Should chiropractors, acupuncturists, and other CAM providers be able to serve as PCPs? Should western-trained providers have training in CAM to serve as gatekeepers and make referrals to CAM providers? I BELIEVE THERE SHOULD BE A VAST OPENING OF THE SYSTEM SO A LARGE NUMBER OF PRACTITIONERS CAN ACT AS PCPS. PEOPLE SHOULD BE ABLE TO GO TO MOST PRACTITIONERS AS A FIRST CHOICE JUST AS WE NOW GO TO THE DENTIST OR OPTOMETRIST WITHOUT CHECKING WITH OUR PCP. IN OTHER WORDS, PEOPLE ARE SMART ENOUGH AND MUST TAKE RESPONSIBILITY FOR FIGURING OUT WHOM WOULD BE THE BEST PERSON FROM WHOM TO GET HELP FOR THEIR PRESENT PROBLEM. IT COULD BE A PHYSICAL THERAPIST, AN RT, AN OT, A PHARMACIST, AN NP, A PA, A MIDWIFE, AN AUDIOLOGIST, A DENTAL HYGIENIST, OR ABOUT 20 DIFFERENT TYPES OF CAM PROVIDERS SUCH AS A NATUROPATH, A DC, A HOMEOPATH, A TCM PRACTITIONER, ETC. WHEN PRACTITIONERS THEN DO NOT REFER APPROPRIATELY, THEY GET SUED. THERE IS NO AMOUNT OF TRAINING OR COMPETENCIES THAT WILL TEACH ANY PRACTITIONER WHEN TO REFER APPROPRIATELY. LOOK AT THE PRESENT MD SYSTEM. WE PHYSICIANS HAVE SO MUCH TRAINING BUT STILL DO NOT REFER APPROPRIATELY TO CAM PROVIDERS WHEN WE SHOULD BE DOING SO A GREAT DEAL OF THE TIME. THERE IS AN ENTIRE BOOK ABOUT THIS CALLED "Not What the Doctor Ordered" by Jeff Bauer, PhD, a health economist. I wrote the forward!

Who and what are needed in developing faculty for integrative health training programs? What are the issues in developing faculty, curricula, resources, etc.? I BELIEVE I NOW HAVE AN EXCELLENT COURSE FOR TEACHING AN INTEGRATIVE HEALTH PROGRAM AT THE U OF MN MEDICAL SCHOOL. I HAVE 6 TO 8 SENIOR MEDICAL STUDENTS FOR 3 WEEKS TOTAL. THEY SPEND HALF OF THOSE 3 WEEKS WITH CAM PROVIDERS IN THE COMMUNITY AND HALF THE TIME WITH ME. SO, MY FACULTY ARE THE PRACTITIONERS IN THE COMMUNITY WHO ARE ALREADY DOING CAM. MY STUDENTS VISIT THE OFFICES PRACTITIONERS OF HOMEOPATHY, CHIROPRATIC, TCM, CHELATION, MUSIC THERAPY, SHIATSU, MASSAGE, ESOTERIC HEALING, TRANSFORMATIONAL KINESIOLOGY, OSTEOPATHY, NATUROPATHY, AND A FEW OTHERS SUCH AS A TMJ CLINIC. THE STUDENTS USUALLY FIND THE THREE WEEKS ARE A PEAK EXPERIENCE OF THEIR EDUCATION, AND FOR MOST OF THEM, IT INFLUENCES THEIR WORLD-VIEW DRAMATICALLY. THIS KIND OF COURSE WOULD BE AN EXCELLENT ADDITION TO EVERY MD OR DO RESIDENT IN THEIR SECOND OR THIRD YEAR OF TRAINING.

What recommendations or other guidance can be offered regarding funding for integrative health training programs? THERE WILL BE MINIMAL CHANGE IN FUNDING UNLESS WE CHANGE THE WAY WE NOW DELIVER HEALTH CARE. WE MUST WORK TO ELIMINATE THE INCREDIBLE VESTED INTERESTS OF THE INSURANCE, PHARMACEUTICAL, PHYSICIAN, AND HOSPITAL INDUSTRIES THAT NOW DOMINATE OUR MEDICAL SYSTEMS. UNTIL ENOUGH PEOPLE HAVE THE WILL TO CHANGE THINGS, FUNDING WILL NOT CHANGE MUCH.

Should there be continuing education (CE) requirements for all integrative health providers? NO, THERE SHOULD NOT. THERE IS NOT ONE GOOD STUDY SHOWING THAT CE HELPS PRACTITIONERS OF ANY KIND PRACTICE BETTER PATIENT CARE. IT SHOULD CERTAINLY BE OFFERED ON A VOLUNTARY BASIS. Should integrative health professionals be required to demonstrate periodically that they maintain core competencies in the modalities they practice? NO FOR THE SAME REASONS AS ABOVE. IF WHAT PRACTITIONERS DO HAVE A STRONG POSSIBILITY OF CAUSING HARM (i.e. WHAT MDS AND DOS DO), THEN COMPETENCIES SHOULD BE PERIODICALLY DEMONSTRATED. OTHERWISE, NOT.

Should there be national CE standards for integrative health care providers? State standards? Professional standards? If so, who should be responsible? SAME ANSWER AS ABOVE.
What issues, unmet needs and problems currently exist for continuing education? (For example, do certain entities such as state licensure boards accept CAM CEUs?)
Should professional credentialing be performed by one, central body or at the state level? If so, who should be responsible? To what degree should the specific profession(s) be involved?
Are there medical malpractice issues that you would like to share with the Commission? For example, is there risk to practitioners who do/do not use CAM practices or products? I BELIEVE THERE ARE SIGNIFICANT RISKS OF MALPRACTICE FOR PRACTITIONERS WHO DO NOT USE OR REFER PATIENTS FOR APPROPRIATE CAM THERAPIES. IT WILL BE IN THE VERY NEAR FUTURE THAT PHYSICIANS WILL BE SUED FOR NOT BEING MORE COLLABORATIVE WITH CAM PRACTITIONERS AND NOT USING CAM MODALITIES THAT ARE WELL PROVEN. NOT USING CoQ 10 ON A PATIENT WITH CONGESTIVE HEART FAILURE WILL BRING LAWSUITS. NOT USING GLUCOSAMINE ON AN OSTEOARTHRITIS PATIENT WILL BRING LAWSUITS. NOT USING MIND-BODY MODALITIES ON AN ASTHMA PATIENT WILL BRING LAWSUITS. I COULD GO ON WITH HUNDREDS OF OTHER EXAMPLES.
What other measures should be developed to promote quality and accountability amongst conventionally trained providers practicing CAM? Practice guidelines or modality-specific guidelines? Consumer protection programs? What about oversight or regulation of supplements? THE SERIOUS PROBLEMS CAUSED BY SUPPLEMENTS AND HERBS ARE LIKE A MOSQUITO ON AN ELEPHANTS BACK WHEN COMPARED TO THE SERIOUS PROBLEMS OUR PHARMACEUTICALS CAUSE. LET US BEGIN FIRST TO CLEAN UP OUR OWN MESS WITH PHARMACEUTICALS AND WHEN WE HAVE DECREASED THE 200,000 PHARMACEUTICAL DEATHS PER YEAR, THEN WE CAN WORRY ABOUT SUPPLEMENTS.
Bill Manahan, MD
Assistant Professor of Family Practice
University of Minnesota Medical School
Former Director of Minnesota's first Rural F.P. Residency
Presently at the U onf MN's Academic Health Center, the
Center for Spirituality and Healing
Thank you for your invaluable help. Please send your written comments to Maureen Miller, MPH,RN, fax: (301-480-1691), phone: (202-486-4337/cell or 301-435-6198), and contact her with any questions you may have. She will be happy to work with you in any way she can to gain your expert advice

Sincerely,

Stephen C. Groft, Pharm. D.

Executive Director

White House Commission on

Complementary and Alternative

Medicine Policy

Dear Maureen,

Thank you very much for your letter and request for our input to The White House Commission. I have sent your questionaire to several of our key people to get their input. I will collate these and send them back to you by the 13th.

As a bit of background, The American Holistic Medical Association was founded in 1978 to promote holistic medicine and educate physicians in the art and science of holistic medicine. We have about 600 members and have an Annual Scientific Conference every year where physicians receive continuing medical education credits for learning about holistic medicine. Through the American Board of Holistic Medicine, we have just given our first board examination to over 300 physicians which is part of the process leading to certification in Holistic Medicine. In addition to passing this rigorous written examination, physicians must submit a written essay detailing their journey and experience as holistic practitioners. They will also be interviewed by members of the Boards Examining Board. I have asked Dr. Bob Anderson, the Board's founder, to include some information for you about the American Board of Holistic Medicine. As soon as I collate the information I have received from my colleagues, I will email it back to you. Thank you very much for this important work and for allowing us to give our input.

Sincerely,

Kathleen K. Fry, MD
President
American Holistic Medical Association

# Tab 6

White House Commission on Complementary and Alternative Medicine Policy

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



February 9, 2001

Doris Rager, Executive Director
American Holistic Nurses' Association
2733 E. Lakin Drive
Suite #2
Flagstaff, AZ 86004

Dear Ms. Rager:

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 www.whccamp.hhs.gov.

The Commission will meet on February 22-23 to discuss the topic areas: education and training of health care practitioners, quality of care, and accountability, as they relate to complementary and alternative medicine (CAM). The questions that follow were developed to guide the Commission's deliberations. To accomplish its goal, however, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments by e-mail or fax *as soon as possible* so that the Commissioners have time to review them before the February 22-23 meeting.

Questions Developed for Commission Discussion :

1. Is there currently enough science available on CAM to establish educational programs in integrative health care? (Integrative is defined as combing conventional western medicine with "alternative" therapies.)

2. What should be done to assure that integrative health providers have the appropriate education (knowledge) and training (skills) for their specific scope of practice? Should core competencies be established? If so, how would these "competencies" reflect the various levels of CAM integration – for example, practitioners who use their knowledge to make referrals to CAM providers, practitioners who have this knowledge but also incorporate one or more modified CAM techniques into their patient care, and practitioners who have extensive CAM knowledge and who furnish one or more CAM skills (such as acupuncture) as part of their practice.

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| DOCUMENT NO. AND TYPE | SUBJECT/TITLE | DATE | RESTRICTION |
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| 005. letter | Stephen Groft to Doris Rager (partial) (1 page) | 02/09/2001 | b(6) |

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

OA/Box Number: 43241

**FOLDER TITLE:**
WHCAM Briefing Book, Discussion Group III, February 22-23, 2001 [1]

2011-0568-S
kc797

**RESTRICTION CODES**

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

**P1** National Security Classified Information [(a)(1) of the PRA]
**P2** Relating to the appointment to Federal office [(a)(2) of the PRA]
**P3** Release would violate a Federal statute [(a)(3) of the PRA]
**P4** Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
**P5** Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
**P6** Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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**RR.** Document will be reviewed upon request.

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

**b(1)** National security classified information [(b)(1) of the FOIA]
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**b(7)** Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
**b(8)** Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
**b(9)** Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[005]

3. What knowledge and core competencies – and credentialing -- should be required for an integrative health care provider to serve in the role of primary care practitioner (PCP)? Should chiropractors, acupuncturists, and other CAM providers be able to serve as PCPs? Should western trained providers have training in CAM to serve as gatekeepers and make referrals to CAM providers?

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9. Should professional credentialing be performed by one, central body or at the state level? If so, who should be responsible? To what degree should the specific profession(s) be involved?

10. Are there medical malpractice issues that you would like to share with the Commission? For example, is there risk to practitioners who do/do not use CAM practices or products?

11. What other measures should be developed to promote quality and accountability amongst conventionally trained providers practicing CAM? Practice guidelines or modality-specific guidelines? Consumer protection programs? What about oversight or regulation of supplements?

Thank you for your invaluable help. Please send your written comments to Maureen Miller, MPH, RN, *fax: (301-480-1691), or email them to whccamp@od.nih.gov.* You may contact her with any questions you have at *cell phone:* (b)(6) *or 301-435-6198.* She will be happy to work with you in any way she can to gain your expert advice

Sincerely,

Stephen C. Groft

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

# Tab 7

# 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 13. 2001

Margaret Erickson
Executive Director
American Holistic Nurses' Certification Corporation
Austin, Texas

Dear Ms. Erickson:

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 www.whccamp.hhs.gov.

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| 006. letter | Stephen Groft to Margaret Erickson (partial) (1 page) | 02/13/2001 | b(6) |

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OA/Box Number: 43241

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Sincerely,

Stephen C. Groft

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

**Chang, Michele (NCCAM)**

**Subject:** FW: White House Commission request

I have forwarded the questions to a board member of the American Holistic Nurses' Certification Corporation. She is aware of the time constraints and will respond quickly. I will be sending you the information you requested shortly.

Sincerely Yours,
Margaret Erickson PhD, RN, CNS
Executive Director, AHNCC

Thank-you for contacting AHNCC. We are excited about having the opportunity to participate in this important process. We strongly believe in the need for Nursing's movement towards Holistic Health care.

The following criteria are required before an individual may apply for the national HNC examination:

1. Possess a baccalaureatte degree.
2. Possess a current, unrestricted Registered Nurse license in the United States.
3. Be actively involved in the practice of Holistic Nursing for one full year prior to application or part time for a minimum of 2,000 hours of practice in Holistic Nursing within the last 5 years prior to application.
4. Complete a minimum of 48 contact hours of continuing education in areas of Holistic Nursing theory, practice, philosophy and ethics within two years prior to application.

The certification process requires multiple steps. After an individual has met the previous criteria he/she may apply to take the exam. If the individual's application is approved they are then required to complete a qualitative essay. After the applicant's essays have been reviewed and approved they are then eligible to register for the national exam. The exam is offered twice a year at 15 major cities throughout the United States.

Enclosed in the attachment you will find the standards of Holistic Nursing Practice. These standards were used to develop the National Holistic Nurses Certification Examination.

If you have any further questions please feel free to contact me.

Margaret Erickson PhD, RN, CNS
Executive Director, AHNCC

# Summary of Core Values
# American Holistic Nurses' Association

## Core Value 1. Holistic Philosophy and Education

**Holistic Philosophy:** Holistic nurses develop and expand their conceptual framework and overall philosophy in the art and science of holistic nursing to model, practice, teach, and conduct research in the most effective manner possible.

**Holistic Education:** Holistic nurses acquire and maintain current knowledge and competency in holistic nursing practice.

## Core Value 2. Holistic Ethics, Theories, and Research

**Holistic Ethics:** Holistic nurses hold to a professional ethic of caring and healing that seeks to preserve wholeness and dignity of self, students, colleagues and the person who is receiving care in all practice settings, be it in health promotion, birthing centers, acute or chronic health care facilities, end-of-life care centers, or in homes.

**Holistic Nursing Theories:** Holistic nurses recognize that holistic nursing theories provide the framework for all aspects of holistic nursing practice and transformational leadership.

**Holistic Nursing and Related Research:** Holistic nurses provide care and guidance to persons through nursing interventions and holistic therapies consistent with research findings and other sound evidence.

## Core Value 3. Holistic Nurse Self-Care

**Holistic Nurse Self-Care:** Holistic nurses engage in self-care and further develop their own personal awareness as being an instrument of healing to better serve self and others.

## Core Value 4. Holistic Communication, Therapeutic Environment, and Cultural Diversity

**Holistic Communication:** Holistic nurses engage in holistic communication to ensure that each person experiences the presence of the nurse as authentic and sincere; there is an atmosphere of shared humanness that includes a sense of connectedness and attention reflecting the individual's uniqueness.

**Therapeutic Environment:** Holistic nurses recognize that each person's environment includes everything that surrounds the individual, both the external and the internal (physical, mental, emotional, and spiritual) as well as patterns not yet understood.

**Cultural Diversity:** Holistic nurses recognize each person as a whole body-mind-spirit being and mutually create a plan of care consistent with cultural background, health beliefs, sexual orientation, values, and preferences.

## Core Value 5. Holistic Caring Process

**Assessment:** Each person is assessed holistically using appropriate traditional and holisitc methods while the uniqueness of the person is honored.

**Patterns/Problems/Needs:** Actual and potential patterns/problems/needs and life processes related to health, wellness, disease or illness which may or may not facilitate well-being are identified and prioritized.

**Outcomes:** Actual or potential patterns/problems/needs have appropriate outcomes specified.

**Therapeutic Care Plan:** A mutually created plan of care focuses on health promotion, recovery or restoration, or peaceful dying so that the person is as independent as possible.

**Implementation:** The mutual plan of holistic care is prioritized and holistic nursing interventions are implemented accordingly.

**Evaluation:** Responses to holistic care are regularly and systematically evaluated and the continuing holistic nature of the healing process is recognized and honored.

DISCUSSION GROUP III
TAB 7: AHNCC



*Helen Erickson, PhD, RN, HNC, FAAN*
*Chair Elect, AHNCC Board of Directors*
*7306 Anaqua Dr.*
*Austin Texas 78750*

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

February 17, 2001

Dear Dr. Groft,

I am writing on behalf of the American Holistic Nurses' Certification Corporation (AHNCC) and in response to a letter sent to our Executive Director, Margaret Erickson. We are delighted to be able to provide input into the forthcoming White House discussions regarding Complementary and Alternative Medicine (CAM) Policy. I have prepared a preliminary statement that clarifies our general position on CAMs. This is followed by specific responses to each of the eleven articulated questions. If we can be of further assistance, please do not hesitate to contact me directly or our Executive Director, Margaret Erickson, PhD, RN (ahncc@flash.net .

Preliminary Statement. While AHNCC fully recognizes that President Clinton established the White House Commission on CAM Policy and in doing so used traditional language to title the group, we would like to clarify our position on the title. Since health care services are provided by numerous professional groups and each group has a discipline unique to that profession, the AHNCC Board of Directors take the position that the title would be more meaningful if it were the White House Commission on Complementary and Alternative Modalities Policy (rather than Medicine.) The use of the word Medicine suggests two things: 1) only those with a medical degree/license are concerned with these issues, and 2) the emphasis is on the goals of medical care rather than either the specific goals of other professional groups or even interdisciplinary health care.

Preferably we would discuss the use of Complementary and Alternative Modalities as they apply to the general care of individuals with various types of health care needs, delivered by various disciplines. The title, Complementary and Alternative Medicine is inconsistent with the fact that each professional group has it's own legal practice acts which define the parameters and limits of the profession and the professional members' scope of practice[1]

More specifically, Complementary and Alternative Modalities, can be used in providing professional medical care, nursing care, occupational therapy, physical therapy, etc. When all disciplines are combined under the rubric of medicine, the unique orientation of the various professional groups, their disciplines, and professional goals are negated.

All of this said, we assume that the intent of the President was to seek information regarding interdisciplinary health care rather than medical care. Thus, my comments below were written within this context. Nevertheless, consistent with our view, when the acronym CAM is used, I am referring to Complementary and Alternative Modalities (CAM) rather than Complimentary and Alternative Medicine.

Finally, it is necessary to state that while I have responded on behalf of the

[1] For example, most medical practice acts refer to the practice of medicine as the diagnoses and treatment of conditions, ailments and/or disease.

- holistic nursing is an interactive, dynamic process that occurs between client and nurse;
- holistic nurses facilitate clients to gain and maintain quality of life (sometimes even as they are taking their last breathe);
- the client-nurse relationship is an energy field that can be negotiated to facilitate healing;
- the mind, body, and spirit are dynamically interconnected so that the whole is greater than the sum of the parts; and
- can be used to reduce stress, promote healing and facilitate improved quality of life.

Holistic nurses do not talk about cardiac patients, diabetic patients, etc. Instead they talk about the individual who has a cardiac condition, diabetes, etc. That is, the person is not reduced to a disease, but the disease or condition becomes a part of the dynamic interactions of the whole. All factors that affect the person's well-being are considered, including the disease, the disease process and the disease's impact on one's well-being. The work of Linda Boss, PhD, RN at the University of Cincinnati is a good example of this distinction. While Dr. Boss is concerned with ejection fractions, blood gases, and so forth, she has repeatedly noted that these are not always a good predictor for functional status. Instead, the individual's ability to mobilize multiple types of internal and external resources is a better predictor of functional status.

Holistic nurses use their knowledge of basic and behavioral sciences (including normal growth and developmental processes)[2], factors that interfere with normal, healthy processes; and resultant dynamics[3]. We work in many types of settings including intensive care units, the community, church, etc. We use CAMs to help us in our work, but CAMs are not required for holistic nursing. Therefore, the holistic nurse's scope of practice is the promotion of health and healing processes (including transitions and transitional periods in life). Our goals are to facilitate healing and to assist clients' attainment and maintenance of quality of life. We develop interactive, dynamic relationships between nurse and client to facilitate goal attainment. CAM's can be used to enhance this relationship, but do not constitute the relationship. CAMS can also be used to facilitate client healing

So, to speak to the question: *What should be done to assure that integrative health providers have the appropriate education and training for their specific scope of practice?* It is assumed that this question addresses the Modalities, not the specific discipline. If this is the case, knowledge and skills unique to a modality, minimal core competencies and advanced sets of competencies should be established by recognized interdisciplinary organizations made up of experts in the modality. Certified members of these organizations should train providers.

Concurrently, each professional group should be responsible for how and where their members acquire knowledge and skills unique to the profession and each should determine appropriate application of such knowledge and skills within the context of the professional's philosophy and goals. IF CAMs are applicable to a given professional group, that group should determine how the CAM science relates to the discipline of the profession. A.C. McKennell's work addresses this issue and provides guidelines for knowledge development[4].

For example, persons who use hypnosis should have a minimum number of CEUs taught by specialists certified or endorsed by The American Society of Clinical Hypnosis or The Erickson Foundation. These hypnotherapeutic techniques should be required (by the licensing boards of each of the professional groups) of all persons who use hypnosis.

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[2] These processes include normal bio-physiological processes and psychosocial system dynamics.
[3], Such as pathophysiology . pathopsychology, and pathopsychophsiology.
[4] . McKennell, A.C. (1974) Surveying Attitude Structures: Elsevier Scientific Publishing

scope of practice. AND, yes, all health professionals should be required to demonstrate periodically that they maintain core competencies in their selected modalities.

7. I've already answered this question above, but will add this: There should be professional standards with the possibility of an interdisciplinary model unique to the care of a specific population identified by age and setting (e.g. the elderly in the community) with additional standards related to this population.

8. I believe that this depends on the discipline and the state.

9. The professional group should do Professional credentialing. Modality endorsement or certification should be done by the specific organizations developed to oversee knowledge and skills related to the modality. Each professional group should decide which skills and what knowledge is necessary for credentialing.

10. There are some modality "specialists" who don't know the limits of their knowledge base. They believe that their care can cure all things. Since they lack a broad base of knowledge, they sometimes fail to recognize health problem symptoms that warrant referral. For example, a self-referred client came to me complaining of having difficulty sleeping. She had been to a MD who had ordered sleeping pills that she rejected because of their side affects. Next she went to a chiropractor because someone told her she might need an "adjustment'. That didn't seem to help either. Next she went to a "yoga expert", hoping that this would help her. Finally, after continued decompensation, she presented herself to me. When I assessed her situation, it became clear that her sleep difficulty might be due to frequent urination day and night. Further discussion disclosed symptoms that suggested that she might have diabetes. When the onset of the symptoms was explored, she reported initial onset about 6 months after a major life loss. A referral to a MD helped her stabilize her endocrine system; work with me helped her resolve her loss. Approximately 6 months later she reported sleeping nights, a return to work, new social activities and a much happier, healthier life in general.

11. I think there should be national organizations unique to the modality that set minimum and advanced standards, and promote quality and accountability. At the same time, each professional group should be responsible for its members' application of knowledge and skills (this is not different than what currently exists in respect to basic sciences). Each of the professional groups decides which basic and behavioral sciences are needed for their members' education. Each also decides how that knowledge is applied.

If you have questions or need clarification, please do not hesitate to contact me at helenerickson@mail.utexas.edu or ahncc@flash.net.

Sincerely,

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# Tab 8