

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Stephen Groft to Larry Malerba (partial) (1 page)	02/06/2001	b(6)
002. letter	Stephen Groft to Brian Berman (partial) (1 page)	02/06/2001	b(6)
003. email	Brian Berman re responses to questions (partial) (1 page)	02/13/2001	b(6)
004. letter	Stephen Groft to Roberta Lee (partial) (1 page)	02/05/2001	b(6)
005. letter	Stephen Groft to Marty Sullivan (partial) (1 page)	02/06/2011	b(6)
006. letter	Stephen Groft to Andrew Weil (partial) (1 page)	02/05/2011	b(6)
007. paper	Victoria Maizes and Andrew Weil, responses to inquiry (partial) (1 page)	02/13/2001	b(6)

COLLECTION:

Federal Records

White House Commission on Complementary and Alternative Medicine Policy [WHCCAMP]

OA/Box Number: 43231

FOLDER TITLE:

WHCCAM Briefing Book, Discussion Group III, February 22-23, 2001 [2]

2011-0568-S

kc798

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

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White House Commission on Complementary and Alternative Medicine Policy

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

February 6, 2001

Larry Malerba, DO, MPH
Jennifer Jacobs, MD
American Institute of Homeopathy
801 N. Fairfax - Suite 306
Alexandria, VA 22314

Dear Drs. Malerba and Jacobs:

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 combining 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 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.?

Chair

James Gordon, MD

Commissioners

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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?

In addition, we would appreciate the following information on your program:

- What is your program's educational philosophy and mission? How and why did you arrive at these?
- Provide a brief description of your program and the educational approach for preparing students/providers for an integrative health care practice.
- What are the strengths of your program? Are there any weaknesses that may need to be addressed? What resistance, issues, problems have you encountered?
- Can you provide us with the names and phone numbers of 3 graduates who would be willing to share their experiences and observations with the Commission staff.

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

To: Maureen Miller, MPH, RN
Stephen C Groft, PharmD, Executive Director, WHCCAMP

Dear WHCCAMP Representatives,

Thank you for this opportunity to give our input to the WHCCAMP on educational issues regarding homeopathic medicine. We believe that the American Institute of Homeopathy is the organization that best represents the potential to bridge the gap between the conventional medical and the homeopathic communities. In order for our perspective to be best understood, we will first describe the AIH and give you some background information about its role in US homeopathy.

BACKGROUND

The American Institute of Homeopathy is a 501(C) 6 trade Association, whose membership comprises medical and osteopathic physicians, dentists, advanced practice nurses and physician assistants. Its purpose is the promotion and improvement of homeopathic medicine and the dissemination of medical knowledge pertaining to homeopathy. Established April 10, 1844, the AIH is the oldest national medical professional organization in the United States, predating the establishment of the AMA by three years.

Historically homeopathy has been the form of holistic medicine in the U.S. that has had the most medical practitioners, with an enormous body of literature, and extensive clinical documentation. Since the mid-1800's thousands of MD's and DO's have practiced homeopathy. At the end of the 19th century, there were 22 homeopathic medical schools, numerous journals published, thousands of clinical texts in print, and over 100 homeopathic hospitals. There stands a 100 year old monument to its founder, Samuel Hahnemann, MD just a few blocks from the White House.

In spite of these circumstances, homeopathy has nevertheless remained off the radar screen, surviving in the 20th century in relative obscurity. There are various reasons that homeopathy has not been embraced by the conventional medical world. First, homeopathic theory is very different from conventional medical thinking, in that it is based upon the principle of similars. The prescription of a diluted substance that can cause symptoms similar to the illness in question, can act as a bioenergetic catalyst that promotes healing. This tends to be dismissed outright by many physicians simply because it makes no sense to them, not because they have had any actual experience that has guided them to their opinions. Second, because of its therapeutic success, it has been perceived as a threat to conventional medical territory. It is because of its very value as a widely applicable therapy that it has been so reluctantly received.

This unfortunate resistance to homeopathy has long prevented a very valuable therapy from being offered to the American public. Homeopathy can be utilized in a very practical, predictable, and effective way, to treat conditions that run the entire range of medical specialties. The homeopathic medicines that are documented in the United States Homeopathic Pharmacopeia, established by Congress in 1938 as part of the Food, Drug, and Cosmetics Act, have been regulated as such by the FDA since that time. They can be used in the appropriate

circumstances for ailments such as ear infections, urinary tract infections, pharyngitis, bronchitis, croup, asthma, allergies, viral illnesses, influenza, migraines, constipation, diarrhea, irritable bowel syndrome, eczema, hives, warts, back pain, sciatica, injuries, sprains, arthritis, myalgias, dysmenorrhea, anxiety, depression, post traumatic stress disorder, ADHD, and many other conditions.

Unfortunately, as a result of the relative vacuum created by the conventional medical world's lack of receptivity to homeopathy, there has been a strong proliferation of non-medically trained, and sometimes lay practitioners of homeopathy. This is of great concern to the AIH which represents primarily homeopathic physicians, and it should be of concern to conventional physicians too. The AIH has always stood ready to cooperate with conventional medical institutions to provide guidance as to how homeopathy should be integrated into the medical school curriculum and into actual clinical practice.

EDUCATION, STANDARDS, AND CERTIFICATION

A fundamental starting point should be that the AIH be recognized by medical and governmental institutions as the authority on the standards and practice of homeopathy in the U.S. If the AIH were recognized as such, there would be no need to reinvent the wheel because the entire structure for education, standards of practice, and Board Certification for homeopathy are already in place. The following programs and organizations already exist in the homeopathic community.

1. The American Institute of Homeopathy (AIH) is the oldest medical institution in the U.S. and continues today to represent the interests of homeopathic physicians. The AIH sponsors a Primary Care Homeopathy Program (PCHP) modeled after a similar program being taught around the world. Its purpose is to educate physicians and licensed medical professionals about the entry-level use of homeopathy in simple acute care situations. Completion of this 30-hour program and an exam leads to Certification in Primary Care Homeopathy. This program could easily be integrated, preferably at an early stage, into medical school curriculums or later as a post-graduate option.
2. The Council on Homeopathic Education (CHE) accredits many of the more extensive educational programs around the country which are pursued by physicians looking for a more in depth understanding of homeopathy in chronic care situations. It is unfortunate that these programs remain outside of the medical mainstream and as such become influenced too often by non-medically trained practitioners.
3. The American Board of Homeotherapeutics (ABHt) was incorporated in New York State in 1960 as the organization that sets the standards for professional competence for homeopathic physicians in the U.S. It grants the above mentioned Primary Care Certification, and more importantly, it has created and oversees the process of Board Certification for homeopathic physicians. This is a rigorous process that includes educational credit hour requirements, written documentation of long term case management, a written exam, and an oral exam that leads to the designation Doctor of Homeotherapeutics (DHT). Diplomates are required to complete continuing education credits. It has been the hope that this Board will allow homeopathy to someday be

recognized as a legitimate medical specialty by the American Board of Medical Specialties. Of course, this would become a more realistic goal if actual residency programs in homeopathy were established in affiliation with conventional medical institutions.

4. As mentioned before, The Homeopathic Pharmacopeia of the United States (HPUS) is published under the direction of the Pharmacopeia Convention of the American Institute of Homeopathy. The Convention is entrusted with setting the standards for the preparation of homeopathic medicines of the highest quality, and strictly adheres to the regulations set forth by the FDA. Homeopathic medicines have an unparalleled safety profile, and are rarely associated with side effects of any consequence.

USE OF HOMEOPATHY IN THE US

There is a logical hierarchy of homeopathic usage that exists, and should be recognized as such. This includes:

1. The very popular usage of homeopathic medicines for families at home for self-care of simple, self limited, acute conditions such as colds, flus, sprains, and bruises.

2. The use of very simple yet potentially powerful homeopathic interventions by medical practitioners in selected settings. For example: the prescription of Arnica post surgically by a local plastic surgeon that I know, significantly reducing the healing time and potential morbidity. The similar use of Arnica and other first aid homeopathic remedies in the primary care clinic or ER setting for example, could dramatically reduce the need for stronger drugs such as pain killers and anti-inflammatory drugs.

3. The use of a limited range of homeopathic medications in the primary care setting as is taught in the Primary Care Homeopathy Program. This could provide an effective alternative to the growing problem of the overuse of antibiotics for such illnesses as acute otitis media, sinusitis, and other minor infections.

4. The various medical specialties could make use of a limited range of homeopathic medicines that would be applicable to very specific problems that present to each given specialty. For example, neurologists could use Hypericum after lumbar puncture to prevent pain and potential complications. Orthopedic surgeons could use Symphytum to assist union of fractures after they have been set. A psychiatrist could prescribe Aconite for the onset of a patient's first experience of acute panic attack.

5. There are many extensively educated homeopathic physicians that practice homeopathy as their primary specialty. Some treat the entire range of conditions seen in a typical general practice, and some restrict their practices to specific circumstances. These homeopaths could serve as primary care providers, or they could choose to practice homeopathy exclusively.

6. It is very reasonable that affiliated professions such as PA's, NP's, and RN's should be educated and allowed to be involved with homeopathic medicines in accordance with the scope of their practices.

RECOMMENDATIONS

The following recommendations would allow homeopathy to find its place within a fully integrated medical system that offers patients the best of all medical worlds:

1. Government and medical institutions should recognize the AIH as the national authority on issues pertaining to physicians and the practice of homeopathy. The AIH would gladly provide speakers for various events and settings to educate physicians and government institutions about the AIH and about homeopathy.
2. Medical schools should introduce the fundamentals of homeopathy to its students early on. The perfect model for this introduction exists in the AIH sponsored Primary Care Homeopathy Program. The AIH is more than willing to help medical schools set up a basic curriculum, and to provide instructors if desired.
3. Similarly the AIH is willing to recommend instructors to teach more advanced topics within the medical school setting.
4. The American Board of Medical Specialties should be encouraged to recognize homeopathy as a legitimate medical specialty for those homeopathic physicians who have achieved board certification (DHT) through the American Board of Homeotherapeutics.
5. It would be of prime importance to have a variety of institutions grant CME credit for homeopathic educational events and programs. Currently, such credits are very difficult to receive.
6. Pharmacy students should be thoroughly educated about the HPUS and FDA regulation of homeopathic medicines and be knowledgeable to advise consumers about these products.
7. Research into the clinical outcomes of homeopathic treatment in a variety of medical conditions, both acute and chronic, should be strongly promoted and supported. The U.S. lags way behind many other countries in terms of resources committed to homeopathic research.
8. Homeopathic residency programs should be set up in medical institutions.
9. Hospital formularies should introduce commonly used homeopathic medicines for commonly encountered in-patient medical conditions. Once again, the AIH would gladly provide guidance to any interested party.
10. Medical institution libraries should be encouraged to subscribe to the Journal of the AIH and possibly other homeopathic journals.

In closing, it must be emphasized that a long-standing concern of the homeopathic community of physicians is that homeopathy not be relegated to merely an adjunct or watered down in an attempt to integrate it into the conventional system of medicine. Homeopathy must be accepted in its undiluted form in order for it to remain a viable therapy. Just as any experienced homeopathic physician recognizes the

value of conventional medical diagnostics and treatment, and realizes the limitations of homeopathy, so too it is reasonable to expect that a conventional physician educated in the art and science of homeopathy should be able to recognize when homeopathy is indicated. He or she should be willing to recommend such a therapy to a patient without hesitation or prejudice, in the name of doing what is best for the well being of the patient.

We at the AIH thank you sincerely for the opportunity to express our views on these very important issues. We believe that we are the organization that best represents the potential to bridge the gap between the medical and the homeopathic communities. We are at your service and encourage you to contact us with any questions or requests that you may have.

Respectfully,

Larry Malerba, DO, DHt
2nd Vice President, AIH
Phone (518) 357-4210
Fax (518) 357-4216
< zog@albany.net >
PO Box 588, Altamont, NY 12009

Jennifer Jacobs, MD, MPH
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23200 Edmonds Way, SuiteA, Edmonds, WA 98026

Tab 9



White House Commission on Complementary and Alternative Medicine Policy

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

February 6, 2001

Dr. Brian Berman, Director
Complementary Medicine Program
University of Maryland
Kernan Hospital Mansion
2200 Kernan Drive
Baltimore, MD 21207-6697

Dear Dr. Berman:

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James Gordon, MD

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William Fair, MD
Joseph Fins, MD, FACP
Veronica Gutierrez, DC
Wayne Jonas, MD
Linnea Larson, LCSW, LMFT
Taraona Low Dog, MD, AHG
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Doris Kingsbury
Geraldine Pollen, MA

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Kenneth Fisher, PhD
Maurice Miller, MPH
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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?

In addition, we would appreciate the following information on your program:

- What is your program's educational philosophy and mission? How and why did you arrive at these?
- Provide a brief description of your program and the educational approach for preparing students/providers for an integrative health care practice.
- What are the strengths of your program? Are there any weaknesses that may need to be addressed? What resistance, issues, problems have you encountered?
- Can you provide us with the names and phone numbers of 3 graduates who would be willing to share their experiences and observations with the Commission staff.

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

If you have any thoughts or suggestions we can use them. Hope things are going well
Steve

From: Brian Berman [mailto:BBerman@compmed.ummc.umaryland.edu]

Sent: Tuesday, February 13, 2001 9:03 AM

Below are the responses to your questions for the commission discussion. Answers are brief, there wasn't enough time to prepare.

Q1. Yes most definitely. Of course, this will vary depending on types of educational programs - content; depth; level of providers.

Q3. Chiropractors already serve in role as Primary Care providers. Western trained providers need to have some level of CAM knowledge in order to act as gatekeepers and refer appropriately

At this level, survey courses (familiarization) would suffice.

Q4. Faculty in medical schools are on the whole unfamiliar about CAM issues. The need to be familiarized as to the safety, efficacy of CAM; when to refer; clinical uses, etc.

Q5. Do it! Without funding, the levels of training and competences will never be developed. With funding, it will be very possible to develop what should be taught at what levels. Also, CAM providers will need to learn something about clinical research methods in order to raise the standard and relevance of research being produced.

Q6. Yes

Q7. It would let each professor be responsible for it's own people.

Q10. There is a risk for M.D.'s who practice CAM depending partly on which state they're practicing in CAM is not the standard care and so if an issue arises, the physician is out on a limb.

What is your program's educational philosophy and mission?

Our program's mission is to provide quality research-based education in CAM to medical students, residents, faculty, and other healthcare providers within the University of Maryland Medical System. To do this, we draw upon a thorough investigation of the literature as well as our own research and clinical programs. Provide a brief description of your program and the educational approach for preparing students/providers for an integrative health practice.

Our CAM education program spans the 4 years of medical school. We have incorporated CAM lectures and case-based learning in the core curriculum of years 1

through 3. We offer a month-long elective in the 4th year.

Year I: One hour lecture during the Introduction to Clinical Practice course on basic guidelines for discussing CAM with patients.

Year II: One- hour overview lecture on CAM covering the main systems and therapies that are in wide scale use.

Two- hour small group session on pain and analgesia, in which they discuss cases centered on chiropractic and acupuncture treatment of pain. Four two-hour sessions over a month in which they research and discuss a CAM centered problem based learning case.

Year III: Two hours of lecture and cases during the Family Medicine clerkship. Lectures and cases focus on herbals and supplements, alternative diets, acupuncture, and myofascial trigger point therapy.

Year IV: A one-month elective survey course in CAM. It provides a comprehensive exposure to CAM with a focus on exposure to clinical practice, experiencing different therapies, and completing a research project on a CAM topic.

Family Medicine Residency Program: Two hours of lecture on CAM in the core curriculum and a three-part lecture series to the 2nd and 3rd year residents on self-care. In addition, 2nd year residents spend two afternoons in the CMP's Center for Healing during their Behavioral Medicine rotation.

We co-sponsor with the Complementary Medicine Club (1st and 2nd year medical students) a seminar series on CAM open to the medical school community.

Three times per year we sponsor a Distinguished Speaker Lecture in CAM for which CME credit is available. Our approach to preparing students and residents for an integrative health care practice has been to expose them to different paradigms for understanding health and healing. Providing the evidence base for the different models has been key. We also emphasize teaching them how and where to find the best evidence based information on CAM in order to adequately address their own as well as their patient's questions.

What are the strengths of your program? Are there any weaknesses that may need to be addressed? What resistance, issues, problems have you encountered?

Our program is very strong in the areas of CAM research and data collection. In addition, we have a rapidly growing integrative clinical service. Our clinicians and

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003. email	Brian Berman re responses to questions (partial) (1 page)	02/13/2001	b(6)

COLLECTION:

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White House Commission on Complementary and Alternative Medicine Policy [WHCCAMP]

OA/Box Number: 43231

FOLDER TITLE:

WHCCAM Briefing Book, Discussion Group III, February 22-23, 2001 [2]

2011-0568-S

kc798

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]
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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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researchers provide outstanding teaching to the students and residents and we utilize a number of community CAM practitioners to teach and provide site visits for the students to see and experience how CAM is actually practiced. Our weaknesses include not being seamlessly integrated into the medical school's curriculum. We would like to include CAM information throughout their lectures where there is sufficient evidence to support the integration of particular CAM treatments or therapies. We would also like to build a more substantial CME program.

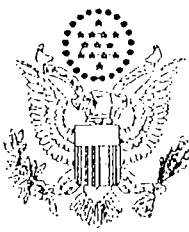
The biggest resistance overall has been acquiring more time in the core curriculum for CAM.

The following are the names and phone #'s of 2 students who graduated medical school in 2000 and completed the 4h year CAM elective:

Stacy Garrett, M.D. (b)(6)

Esther Elizabeth Elliott, M.D. (b)(6)

Tab 10



White House Commission on Complementary and Alternative Medicine Policy

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

February 5, 2001

Roberta Lee, MD
The Continuum Center for Health and Healing
Beth Israel Medical Center
245 Fifth Avenue at 28th Street
New York, New York 10016

Dear Dr. Lee:

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 combining 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.

Chair

James Gordon, MD

Commissioners

George Bernier, Jr., MD

David Bresler, PhD, LAc, OME

Thomas Chappell

Elle Cho, PhD, RN, DHA

George DeVries, III

William Fan, MD

Joseph Fins, MD, FACP

Veronica Gutierrez, DC

Wayne Jonas, MD

Linnea Larson, LCSW, LMFT

Tieraona Low Dog, MD, AHG

Charlotte Kerr, RSM

Dean Ornish, MD

Conchita Paz, MD

Joseph E. Pizzorno, Jr., ND

Buford Rolin

Julia Scott

Xiaomin Shen, MD, EA

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Margen Miller, MPH

James Swyer, MA

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?

In addition, we would appreciate the following information on your program:

- What is your program's educational philosophy and mission? How and why did you arrive at these?
- Provide a brief description of your program and the educational approach for preparing students/providers for an integrative health care practice.
- What are the strengths of your program? Are there any weaknesses that may need to be addressed? What resistance, issues, problems have you encountered?

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004. letter	Stephen Groft to Roberta Lee (partial) (1 page)	02/05/2001	b(6)

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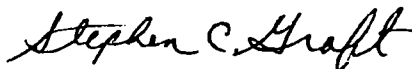
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[004]

- Can you provide us with the names and phone numbers of 3 graduates who would be willing to share their experiences and observations with the Commission staff.

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

Center For Health and Healing
245 5th Ave, 2nd Floor
New York, New York 10016
Tel: 646-935-2220
Fax: 646-935-2273

February 13, 2001

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

Thank you, for inquiring and enclosed are my replies to your kind inquiry on the correspondence dated February 5, 2001:

1. I feel that there is sufficient data to indicate that conventional therapeutic measures do not always work for specific medical problems. Additionally in selected instances there is data indicating that some forms of CAM are successful for tough medical problems – for instance pain control and the use of acupuncture in chronic non-surgical back pain. Sadly, much of what is known in CAM is not known by many conventional doctors. Patients are losing out as these choices for care are ignored by their conventional health care physicians.

There certainly are articles emerging which are beginning to address integrative care though few. There needs to be so much more.

The public has demanded physician's have some knowledge as patient advocates in CAM, thus whether the science is complete the public mandate places enormous pressure on physicians to be knowledgeable in this area.

2. I think that academic centers should come together and form an educational consortium to define the core competencies of an integrative curriculum. This should be a tiered competency. At the heart of general integration the practitioner should be able to discuss the philosophy and

lifestyle and mechanism(s) of healing that distinguishes this integrative management. Graduates should be able to vouch for having experienced a significant number of the CAM modalities from the patient perspective. Additionally certain core material such as botanical medicine, nutritional medicine, exercise and mind/body medicine, energy medicine, Traditional medicine systems etc should be known (by graduates) to such a degree as to be able to explain in simple English the philosophy and mechanism of healing in each core subject. There should be some methodology learned for referral choices in CAM which can be articulated by the integrative practitioner. Of course the consensus of these choices would need to be agreed upon by a certain body of experts.

For those who choose to practice a modality within their medical practice a second level of competency should be reached which conveys that a knowledge base has been attained that sufficiently demonstrates clinical proficiency much as we see with the Helms /UCLA acupuncture course for example.

3. I do not believe that primary care is the sole domain of MDs especially if the public is willing to pay out of pocket- access should remain open to the public to choose CAM.

However, if other CAM providers serve as primary care providers there should be core competencies developed which stipulate best medical practices for them concerning good primary care standards. I have observed a wide range of understanding in each CAM specialty concerning good medical practice and scope of care which has not served in the patient's best medical interest.

4. Fellowships should be made for integrative care modeled for instance after the Program in Integrative Medicine at the University of Arizona and the upcoming Beth Israel Postdoctoral fellowship in Integrative Medicine. These programs contain a mixture of didactic and experiential core material that is evidence based. Faculty in different areas of primary care OB/GYN, Internal medicine, Family practice are needed as integrative faculty to address issues in education pertinent to their specialty. Issues for potential focus could include identification of material resources which are reliable. Funding is an issue Integrative educational programs until recently there lacked federal and state funding sources.

5. More state and federal dollars should be made for programs under integrative development to increase educational access. Currently programs developed in this field rely heavily on private donations to get things initiated- limiting the availability of these programs to medical students and residents.
6. It would be good to have educational requirements demonstrating competency over time as evidence for and against use of supplements, botanicals and other CAM modalities is ever changing.
7. Each professional body e.g. medical versus herbalist versus acupuncturist versus chiropractic etc should govern and define itself defining what constitutes acceptable standards of care. (To some degree this is emerging). I am reluctant to endorse state and national intervention unless it has strong input from the CAM practitioners themselves. In the past 100 years there has been a history of tight allopathic control on alternative medical practices often to restrict access to practice – we need to guard against this tendency.
8. Mandated funding for ongoing education among medical providers and a paucity of academic grade programs that provide this service is a problem. Additionally, not all boards accept CAM CEU's.
9. Credentialing should be developed but each CAM profession should set its own criteria for licensure. It would be nice to have a centralized body if it was efficient.
10. There are many gray areas in integration. One example being evaluation of patient grievances in CAM - who evaluates these cases and from what knowledge base are the reviewers? This can vary greatly from state to state. Additionally, legal clarification of the level of responsibility of the practitioner in a case with a poor outcome if a CAM choice is knowingly chosen by the patient is ill defined.

On the subject of risk for those who do not use CAM-- there is indirect risk to the patient in that those unfamiliar with CAM have not shared potentially valuable medical options with their patients in this area of medicine. Furthermore, those without adequate knowledge of CAM may have great difficulty in preventing needless out of pocket expenses to patients whom they may render advice.

11. I would like to see a CAM consumer protection program for all modalities to help the public. I would like to see oversight implemented in supplement and botanical dispensing by pharmacists (currently it is health clerks). I would like to see federally mandated programs to educate pharmacists in nutritional supplementation and botanical medicine making them the primary vehicle for dispensation of medical advice in this area to practitioners and patients. I would like to see practice guidelines developed for medical training in CAM along with modality specific guidelines.

12.

13. Our program:

Our educational philosophy involves the concept that health requires attention to maximizing the human experience of not only the body but also the mind, spirit and community. Therefore, the mission of the program is to optimize medical education to address education in areas that have been overlooked in conventional medical training. Examples of such subjects are courses that address mind/body medicine, botanical medicine, traditional medical systems, manipulative medicine, energy medicine, lifestyle management and self care. Furthermore, it is the objective of this program to provide more doctors who will become teachers in academic programs thus facilitating integrative education into mainstream medical training programs. However, we feel that it is important that though out – the evaluation of scientific evidence is critical in guiding the curriculum. Lastly, the incorporation of self care will also be emphasized in the curriculum as it is the hope that by example graduates will inspire their patients and other colleagues to consider this as a more sustainable and fulfilling medical model.

This philosophy was developed by those who have observed the clinical effects of conventional training in primary care. While many medical triumphs have occurred difficulty with particular medical areas such as chronic pain and other chronic disease processes have been frustrating. Yet many who have ventured to go beyond their usual medical training to implement botanical medicine, Chinese medicine, hypnosis or other CAM modalities have extended their clinical successes. Thus was born the need to provide another training program which could share this knowledge with others and provide teachers in this integration.

The Continuum Center's Post Doctoral Fellowship is a one year fellowship open to MD's and DO's who have completed specialty training in a primary care field who wish to learn integrative medical management. It is the expectation of this program that all who graduate will enter a teaching institution to become faculty as Integrative instructors. It will begin on January 2002. The directors of the program are Roberta Lee, MD and Benjamin Kligler, MD

Thank you for your time and interest. If I can be of further help please do not hesitate to contact me.

Sincerely,



Roberta Lee, MD

Director of Medical Education

Co-director of the Integrative Fellowship at CCHH

Tab 11

MULTI-LEVEL INTEGRATED CURRICULUM IN COMPLEMENTARY/ALTERNATIVE MEDICINE

BETH ISRAEL MEDICAL CENTER/ALBERT EINSTEIN COLLEGE OF MEDICINE

PROGRAM GOALS

1. **To develop a vertically and horizontally integrated CAM educational program for healthcare providers that can serve as a template for implementation at most schools of medicine, dentistry, nursing and health related professions.**

This process will be implemented by:

- Building on and expanding on our existing program for development of an undergraduate medical curriculum in CAM.
 - *Vertically* integrating the educational program so that it is available at all levels of medical and healthcare education: undergraduate; residency; continuing education (CME, CE).
 - *Horizontally* integrating the educational program so that it can be used across the various healthcare professions: medical, dental, nursing, health-related professions, and, when appropriate, across specialties within a profession (i.e., oncology, neurology, family practice, etc.).
2. **To complete the development of an undergraduate CAM curriculum to be integrated into all 4 years of medical school.** This process is already under way in the Division of Education at AECOM.
 3. **To support and expand the ongoing efforts to make education in CAM a required part of the Beth Israel Residency Program in Urban Family Medicine** in order to further develop a national model for integration of CAM education into a primary care residency program. This program will be an integral part of the overarching educational program described in Goal 1, and will serve as a platform to develop and implement a curriculum which can be reproduced in other primary care training programs, first within Beth Israel and the other teaching hospitals of AECOM, and then at other medical schools around the nation.
 4. **To develop a multi-module, two-year, continuing education certification program in CAM for practicing healthcare providers**, beginning with physicians, and expanding to courses for nursing, dentistry, and other healthcare professions. This program will combine didactic and experiential teaching strategies to provide a strong basis in at least six CAM modalities in the context of a coherent educational framework. This integrative program will provide a "next step" for the large group of practicing physicians and other healthcare providers who have been participating in a variety of introductory Continuing Education courses in CAM over the past five years and have been unable to find a program which can give them a coherent overview of the field as a whole on a more substantial educational level. It will also serve as an essential mechanism for bringing current medical school faculty "up to speed" on CAM, at a time when their students will be receiving formal CAM education under this program.
 5. **Develop and implement a one year full-time fellowship training program for physicians in integrative medicine with a strong emphasis on clinical practice.**

6. **Develop a prototype for a state-of-the-art Web-based curriculum in CAM using current technology (Interactive Internet)** that can be directly accessed and modified by medical schools at minimal cost without the need for repetitive and redundant development processes at each and every medical, dental, and nursing school. This is a long term goal, to be addressed in years 4 and 5 of this grant.

In January 2000, with the support of Dean Dominick Purpura, the AECOM Division of Education made a major commitment to the development of CAM education at the undergraduate level. With the support and assistance of Dr. Woodson Merrell, executive director of the Center for Health and Healing, and Dr. Benjamin Kligler, Medical Director of the CHH, the development of an undergraduate integrative medicine curriculum is now well under way at AECOM. This curriculum is being developed under the leadership of Dr. Albert Kuperman, Associate Dean for Educational Affairs at AECOM; Dean Kuperman has been the driving force in the complete remodeling of the preclinical program at AECOM over the past five years and is a leading innovator on a national level in the area of medical education.

When the program is completely developed, we expect to provide an outstanding, vertically integrated system of training which provides all conventional medical practitioners with a useful, working knowledge of CAM and its relationship to mainstream medicine. This knowledge will enable these practitioners to deal effectively and compassionately with patients on these issues, and to critically evaluate scientific evidence for or against any particular alternative therapy. Health care providers thus trained will be better able to assist patients in making safe and sensible decisions regarding the use of CAM, as well as to move the field forward in the areas of research and education.

Medical School Initiative

Over the past five years, a core group of faculty in the Beth Israel/AECOM system have been laying a substantial groundwork for a system-wide curriculum development initiative in CAM. The following is a summary of work done at AECOM in this curriculum area to date, and of future plans for medical school curriculum development.

First/second year (preclinical) curriculum.

Until 1999, the integrative medicine curriculum at AECOM consisted of one elective course and one afternoon workshop in the Introduction to Clinical Medicine course. In an effort to expand this offering and to integrate it into the existing undergraduate curriculum, the Associate Dean for Educational Affairs at AECOM, Dr. Albert Kuperman, has convened a standing committee of faculty members (which includes Drs. Kligler and Merrell) which is currently planning this expanded curriculum. This committee is currently contacting the course directors of the first/second year curriculum to define the appropriate settings for the integration of teaching on this area into the curriculum. Based on our work to date, it is clear that the most significant and easily-accessed openings for the integration of teaching on CAM into the existing preclinical curriculum will come at first in the area of the problem-based learning (PBL) and case-based learning curricula already in place at the medical school. Faculty in these courses have been relatively receptive to the idea of incorporating elements of CAM into their cases and this innovation does not require any change in the way curriculum hours are currently allocated between departments. Furthermore, incorporating the CAM teaching into the PBL setting allows for a small-group

teaching approach, which is generally much more effective when dealing with an area of some controversy. It will also allow for the rigorous critique of research methods and in-depth discussion of the concepts of evidence-based medicine as they relate to CAM which are critical to developing a useful curriculum in this area. A number of cases which include elements of CAM are under development at AECOM. We anticipate that by next academic year at least one of the cases in each major course will incorporate some aspect of CAM into the case. Faculty development to provide the discussion group leaders with adequate education on CAM to lead intelligent discussion is planned and will be initiated during the coming year. In addition, the course directors of the Introduction to Clinical Medicine Course have agreed to add required elements (workshop on ethics of CAM in the first year, workshop on clinical techniques in the second year, incorporation into standardized patient interviews in the interviewing course) in CAM throughout this course.

The second step in developing the preclinical curriculum in CAM will be to work with the course directors of the longitudinal multi-disciplinary courses to include in the didactic portion of each course the CAM perspective on treatment of the disease or condition under discussion. This is a longer term goal, because didactic time devoted to CAM in these courses inevitably means less time devoted to the material deemed indispensable by the other departments responsible for the course material. Based on the experience of CAM educators at other medical schools, we anticipate that this process, though it will inevitably occur, will be slow and should be looked at as a five to ten year goal. We will develop a step-by-step plan for the gradual integration of this program into conventional medical curricula, including an evaluation process with benchmarks, so that the process can continue to be implemented and monitored even after the current project is completed.

Third/Fourth year (clinical) curriculum

Currently there are fourth year electives offered by the clinical faculty in the Montefiore Hospital and Beth Israel Family Practice programs. These electives provide the opportunity for students to observe the clinical practice of a variety of CAM modalities including chiropractic, herbal medicine, mind/body approaches, osteopathic manipulation, and acupuncture. In addition, students do extensive reading on a range of CAM topics and prepare a research paper applying an evidence-based approach to one discipline or to CAM treatment options for one particular disease entity. Students meet weekly during this elective with the course leader for interactive discussion of their clinical experiences and of the reading materials. At present, these electives can, unfortunately, each accommodate only one student per month, and demand for spots in these electives far exceeds availability.

Alongside the development of the preclinical curriculum will be an expansion of the availability of electives in CAM for third and fourth year students. The BI CHH will provide a clinical site to serve as the focus for a larger, more comprehensive clinical experience than is currently available. This experience would reinforce the teaching being incorporated into the basic science curriculum. Ultimately this elective will also be expanded to include advanced practice nursing students and nurse practitioners, physician assistants in training, and other allied health professionals. As the Center for Health and Healing becomes firmly established on a par with other medical school-affiliated clinical departments over the next few years, a long term goal will be to turn this elective into a required rotation for third and fourth year students. This is certainly a long term goal which may not be achieved within the period of this grant, but it is stated as one of our ultimate objectives with this project.

An interesting challenge exists in trying to implement this new topic into existing curricula: the current faculty often are not aware of, and/or are not sympathetic to the new information, thus creating a potentially awkward situation where the students would know more than the teachers. For this reason, the CME element of this project, outlined below in section d.1.iii, is critical to the

progress of the undergraduate element, as the availability of high quality CME programs—which will be offered at discounted rates to AECOM faculty--will enable the AECOM faculty to more rapidly become comfortable with CAM as an important element in the undergraduate curriculum. Many medical school faculty are currently struggling with the question of how they can teach effectively in this area when they themselves have never been taught about it. The presence of an extensive and well-conceived CME program for faculty existing side-by-side with a strong undergraduate curriculum initiative will make this a model with great potential to answer this important question.

Residency Level Initiative

Over the past five years, faculty in the Beth Israel Residency Program in Urban Family Practice (BIRUFP) have worked to develop the foundation for a required three-year longitudinal curriculum in CAM for the family practice residency. The centerpiece of this three year curriculum is a one-month required block rotation in CAM in the second year of the residency program. This one month experience brings all the second year family medicine residents together for a four week block. During this time, participants receive 20 hours per week of didactic/ experiential education in herbal medicine, hypnotherapy/ mind-body medicine, nutritional medicine and osteopathic manipulation. The faculty for the month is interdisciplinary and includes nursing professionals as well as a number of CAM practitioners in addition to the physician faculty. The overall goal for the month is to have residents develop a basic understanding of each of the four modalities above, at a level sufficient to allow them to intelligently consider integrating these modalities into their discussions with their primary care continuity patients.

The initial two days of the course are focused on issues of cultural diversity and sensitivity, on assessment of patients' health beliefs, and on research issues in the area of CAM. This introduction is followed by 4-5 mornings on each of the four major modalities covered. The course as a whole revolves around a systems approach, using the cardiovascular and respiratory systems as a model. Thus the clinical examples and the bulk of the teaching material in each modality are focused on treatment of hypertension, coronary artery disease, hyperlipidemia, asthma and other chronic respiratory conditions. This systems approach allows for a more coherent overview of the modalities. The goal was not to suggest that these were the only areas where the modalities could be used, but rather to provide continuity throughout the course to prevent participants from being overwhelmed by the diversity of approaches being presented. Because we feel that direct experience is the most effective teacher for physicians attempting to learn about CAM, the teaching in this course was largely experiential, involving extensive practice periods in which residents implemented their new skills with each other in role plays and sample cases. Our goal for future years is to incorporate patient volunteers into the teaching program. This required CAM month is the first program of its kind in a residency in this country, and was extremely well received in its first year. Many programs from around the nation have contacted us to request copies of our syllabus and our course schedule. Our experience with the first year was presented in May 2000 at the National Meeting of the Society of Teachers of Family Medicine

A primary motivation for developing a strategy to produce primary care physicians with skills in CAM has been to increase access to CAM services for underserved population. The BIRUFP has as its primary mission the training of primary care providers to work in underserved urban areas. The program specifically recruits for residents who are interested in this mission, with a special emphasis on women and members of minority groups. Thus the hope is that training a cadre of primary care physicians with skills in CAM will ultimately increase access to CAM for underserved urban populations.

There has been a movement within family medicine education over the past five years to develop models for the incorporation of CAM teaching into residency training. There has been general agreement that basic skills and knowledge on CAM have become an integral part of being a well-rounded primary care practitioner. Furthermore, there is general agreement within the discipline that many elements from CAM are quite coherent with the biopsychosocial model of health and illness which forms the philosophical basis for family medicine as a discipline. This fall, the Board of Directors of the Society of Teachers of Family Medicine (STFM) approved a set of suggested curriculum guidelines in this area for residency programs. The guidelines were developed by the Group on Alternative Medicine of STFM, representing the consensus work of approximately thirty family medicine educators from around the nation. This document, published in January 2000, represents the first formal endorsement of teaching guidelines in this area by an academic medicine organization in this country.

Despite the consensus regarding its importance, though, so far efforts to incorporate substantial teaching on CAM into the residency curriculum on a national level have consisted mostly of a few didactic presentations and elective rotations for those who are interested. What distinguishes the Beth Israel program is that it is a required component of the residency training with a substantial expectation in terms of skill development and implementation in the continuity practice.

The long-term plan for the residency initiative is to develop a three year longitudinal curriculum designed to make basic skills and knowledge in the area of CAM an integral part of family medicine training. The first year curriculum, which is securely in place at this point, consists of three three-hour sessions during the orientation month offering basic information on each of the four modalities to be covered in the block month. In addition there are bi-monthly Grand Rounds on a variety of CAM topics for the entire program. The second year curriculum so far is as described above; however there is a great deal of further work to be done on the month intensive to make it a long-term sustainable part of the residency program. The third year curriculum has not been fully developed to date. Our plan for the third year experience is to develop opportunities for ongoing clinical precepting on applications of the modalities, as well as an option to do more in-depth study of one of the modalities through an elective experience. The "clinical apprenticeship program" described below is an important element in our planning for our third year residents..

We plan to continue with the "systems" approach to teaching, focusing on the cardiovascular and respiratory systems for most of our cases, as we found this to be a very effective strategy in our first year. Residents would return to their continuity practice in the afternoon after a morning of CAM education and find themselves presented with exactly the problem—asthma, hypertension, hyperlipidemia—which had been discussed that morning. This immediate interface with their clinical practice is a great strength of the course design. We plan to capitalize on this strength further by having residents bring in case examples from their practice on a regular basis during the month to serve as the focus for the teaching points.

Other curriculum changes planned for the block month experience include a greater focus on the applications of the principles of evidence-based medicine to each of the four modalities discussed. In addition, through the involvement of Marisol Culshaw, a nurse-educator who has been involved in the development of curriculum for several other BMC residency programs, we plan to add a stronger nursing perspective to the block month and to more specifically address the question of how we educate our residents to collaborate effectively with practitioners from other disciplines.

After this coming year, we plan to develop the block experience further by expanding its audience to include participants from other medical specialties as well as from nursing and the other allied health professions. To date this CAM month experience has only been available to family practice residents from Beth Israel, but we plan in future years to have participants from other medical specialties as well as from allied health professions. Within the next two years we

plan to open the course to family practice residents from other programs, and to residents from other primary care disciplines. Within the two years following we will open it to advance practice nurses and nurse practitioners and to physicians' assistants. We have already had numerous inquiries from physicians' assistants, from nurse practitioners, and from other nursing professionals who would like to participate in the course. We also anticipate that some of the participants in the two year certification CME program described below may be interested in the month block as a way to "jump-start" their experience if their practice schedules allow for this type of time commitment.

As with the development of the undergraduate program the greatest challenge of the residency initiative relates to the faculty development needs of the family medicine residency faculty. Since we are providing extensive education for residents and expecting them to implement this education in the family practice clinic, we must rapidly provide significant education for the precepting faculty in the area of CAM. We hope to spend six two-hour sessions per year with the family medicine faculty over the course of the next two years. We believe this will provide an adequate basis for integrating the CAM material covered in the month-intensive fully into our ongoing work with the residents.

After participating in this faculty development program, our core faculty will be able to easily integrate information on and applications of CAM into their day-to-day clinical precepting with residents in the family practice center. We plan also to invite faculty from other residency programs in the area to participate in this faculty development program, which will help underwrite the cost of this element of the project. The faculty development component is critical to the success of the residency curriculum initiative. The third element of the residency curriculum initiative is in the development of the clinical apprenticeship program as part of the third year experience.

Continuing Education Initiative

In keeping with our plan to develop curricula at all three levels of medical education, we propose to develop a multi-module CME certification program, to be offered to practicing physicians over a two year period. At present, we envision this program as consisting of 10 modules over the course of two years. The program will offer education in the field of CAM as a whole and in each of at least six specific CAM modalities, in the context of the underlying philosophy of an integrative, whole-person approach described previously and further elaborated in the following section. This certification program will fill a vacuum which currently exists in CME education in this area for a coherent, systematic overview of the field of CAM from the perspective of the "conventional" health care provider.

The CME element of this project is critical to the progress of the undergraduate and residency element, as the availability of high quality CME programs will enable the AECOM and residency faculty to more rapidly become comfortable with CAM as an important element in the undergraduate curriculum. **This concept, training the current conventional educators through CME certification programs, addresses a critical problem in organizing the introduction of a new content area into medical and healthcare education, by using a "top-down" approach as much as possible. That is, if current faculty are unaware of, or are resistant to the new content, the process will fail or move slowly and grudgingly. Once developed, the CME modules will be offered to AECOM faculty, with the strong encouragement of the Dean, and with discounted or supplemented fees. This process will help to eliminate the gaps in knowledge among the various levels of providers. Consequently, we believe that the development of what we are calling "CME modules" is in many ways the most important aspect of this entire program, since its content and purpose support all of the other educational activities of the program.**

The CME certification program will be offered as a series of four-day intensives, each covering an important aspect of CAM education. Participants may complete either the entire certification program or only the selected modules of their choice. Each module will be coordinated by one of the key personnel in the CHH Division of Education. Some of the modules will be co-led by a nationally-recognized leader in the particular dimension of CAM being covered in this module, while others will be taught solely by the CHH faculty. This combination of strategies and the linking of prominent nationally-known faculty with in-house faculty will ensure that the underlying philosophy of integrative approach we are committed to disseminating will inform the teaching on each of the modalities offered over the course of the program.

The expectation for course participants will not be that they will emerge from each module able to actually practice the modality discussed. However, for each area covered they will be expected to be knowledgeable regarding the following:

- a. basic theory/principles of the modality
- b. evidence for and against efficacy for specific conditions (where such exists)
- c. safety issues
- d. licensing/credentialing issues

Each of the core curriculum areas will have a coordinator designated from the faculty who will work in conjunction with the CHH faculty to develop and implement that segment of the teaching program. Some of the content, reflecting the underlying principals, will be taught longitudinally, integrated into each module. For example, after an initial segment on evidence-based medicine in the introductory module, a segment of each content-based module will cover research evidence and issues for that content. Similarly, how that CAM can be used in a collaborative approach will be covered in each module. Subject to planning and guidance from the Advisory Committee, the tentative set of core areas and their coordinators are as follows:

Principles of Integrative Medicine	Core Faculty
Research Issues	Samuel Shiflett, Ph.D.
Nutrition	Darwin Deen , M.D.
Manipulative Medicine	James Dillard M.D., D.C.
Strategies of Behavior Change	Barbara Glickstein, R.N./Benjamin Kligler, M.D.
Indigenous Systems	Lewis Mehl-Madrona, M.D.
Mind/Body Approaches	Dorothy Larkin, R.N., Ph.D./Benjamin Kligler, M.D.
Herbal Medicine	Roberta Lee, M.D.
Homeopathy	Edward Shalts M.D.
Collaborative Approach to Care	Marisol Culshaw, R.N./Barbara Glickstein, R.N.

In general the program will emphasize experiential and case-based learning wherever possible. Participants will practice skills on each other, and small group discussion will be the preferred teaching mode. Lecture time will constitute only a small percentage of the didactic curriculum.

A tentative list of the areas covered in each of the four-day intensives and the faculty who will provide the instruction is included below. Several of the intensives are presented only by the in-house faculty; others will be presented by these faculty working in conjunction with a nationally-known expert in the particular modality. Please note that in cases where visiting faculty are listed the curriculum will be developed in collaboration with the CHH faculty to ensure that there is consistency in philosophical approach and presentation strategy . We will require that visiting faculty and in-house faculty confer extensively with Dr. Grossman, our

curriculum development and evaluation specialist, on content and teaching strategies during the months preceding the intensive. Furthermore, each intensive will include a module organized by Samuel Shiflett, Ph.D., on the issues of research methodology pertinent to this particular discipline. Marisol Culshaw, R.N., will also be involved in the planning of each of the intensives to ensure that issues pertaining to collaboration and effective communication across disciplines are addressed. The integration of these critical curriculum elements in a longitudinal fashion through the certification program will ensure that participants leave each module both with a good sense of how to properly critique the research literature in that particular area and with a sense of what challenging issues may arise in collaborating with practitioners of that modality.

1. Introduction to CAM: Issues and Methods	Core/CME Faculty
2. Western Herbal Medicine	Roberta Lee M.D./Tieraona Low Dog, M.D.*
3. Nutritional /Functional Medicine	Darwin Deen, M.D./Jeffrey Bland, Ph.D.*
4. Nutritional Medicine II(Supplements)	Woodson Merrell M.D./Alan Gaby, M.D.*
5. Homeopathy	Edward Shalit, M.D.
6. Hypnotherapy	Benjamin Kligler, M.D./Dorothy Larkin, Ph.D.
7. Visualization/Imagery	Marisol Culshaw, R.N./Jeanne Achtenberg, Ph.D.*
8. Manipulative Medicine	James Dillard, M.D.,D.C.
9. Indigenous Systems	Lewis Mehl-Madrona, M.D.
10. Case Studies in Integrative Medicine	Core/CME Faculty

*denotes visiting faculty

The certification program described above will meet the current need for an in-depth education program in CAM for practicing professionals who are unable to make a time commitment at the fellowship level. The five-times-per-year intensive format would allow for this program to be offered to physicians from around the country as a certification which they could complete over the course of the two years. If more than 10 modules are developed, a model could be developed in which with 5 or 6 core modules are required, with the remaining modules being electives. Given the quality of the faculty who have indicated an interest in participating in this program, this program could serve as a prototype for a CAM certification program for physicians. Offering this program as a CME program to practicing physicians will also generate significant revenue to help support the residency initiative after the NCCAM grant expires.

We plan to open this certification program to allied health professionals as well, including physicians assistants, nurse practitioners, nurse midwives, and other advanced-level nursing professionals. This will provide the opportunity for inter-disciplinary training experience which is currently so lacking in both undergraduate and CE level training programs.

Fellowship Initiative

Beginning in January 2002, we will be offering at the Center for Health and Healing a one year, full-time clinical fellowship in integrative medicine. Fellows will full-time at CHH for one year, with four four-day intensive course to supplement ongoing training. These intensives will allow for in-depth didactic and clinical teaching of skills in the various modalities.

The fellowship curriculum will include education in the basic philosophy of integrative medicine, as well as in a number of specific modalities, including hypnotherapy, osteopathic manipulation, herbal and nutritional medicine, and possibly acupuncture. The fellows will spend three days per week in clinical care at the CHH under the supervision of a faculty supervisor, and will have roughly two days per week of didactic/experiential learning, focused on the development of specific skills in the above modalities. These didactics will be taught by a group of faculty in the New York area with extensive clinical and teaching experience in the relevant modalities.

The clinical days will be spent at CHH seeing patients under faculty supervision. One of the core fellowship faculty will serve as preceptor for the fellows, discussing each patient they see in depth and assisting them in planning and carrying out the treatment plan. The clinical days also will allow opportunity for demonstrating and teaching a set of critical CAM skills in actual practice. For example, a fellow who sees a patient who is looking for help with smoking cessation might have the opportunity to work with the faculty preceptor to develop and implement a smoking cessation plan using a combination of hypnotherapy and acupuncture. Fellows also will attend the weekly interdisciplinary integrative health care rounds at the Center, where practitioners of medicine, acupuncture, chiropractic, homeopathy, nutrition, psychology and manual therapy discuss the most challenging cases currently being seen in the Center.

There will be a strong emphasis in the fellowship on development of skills necessary not only to practice integrative medicine but to teach about it. Fellows will participate in the part-time Faculty Development fellowship currently offered in our area through the Institute for Urban Family Health. Our hope is that after graduation our fellows will take positions as teachers in academic settings, thus meeting some of the need described above for medical school and residency faculty knowledgeable and skilled enough to teach on CAM both at the undergraduate and residency levels.

Tab 11



White House Commission on Complementary and Alternative Medicine Policy

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

February 6, 2001

Dr. Marty Sullivan, Director
Duke Center for Integrative Medicine
DUMC 3022
Durham, NC 27710

Dear Dr. Sullivan:

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 combining 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 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.?

Chair

James Gordon, MD

Commissioners

George Bernier, Jr, MD

David Bresler, PhD, LAc, OME

Thomas Chappell

Effic Chow, PhD, RN, DiplAc

George DeVries, III

William Fair, MD

Joseph Fins, MD, FACP

Veronica Gutierrez, DC

Wayne Jonas, MD

Linnea Larson, LCSW, LMFT

Nerajna Low Dog, MD, AHG

Charlotte Kerr, RSM

Dean Ornish, MD

Conchita Paz, MD

Joseph E. Pizzorno, Jr, ND

Buford Rolin

Julia Scott

Xiaoming Tian, MD, LAc

Donald Warren, DDS

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- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
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- 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]

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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?

In addition, we would appreciate the following information on your program:

- What is your program's educational philosophy and mission? How and why did you arrive at these?
- Provide a brief description of your program and the educational approach for preparing students/providers for an integrative health care practice.
- What are the strengths of your program? Are there any weaknesses that may need to be addressed? What resistance, issues, problems have you encountered?
- Can you provide us with the names and phone numbers of 3 graduates who would be willing to share their experiences and observations with the Commission staff.

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



Duke Center for Integrative Medicine
A SERVICE OF DUKE UNIVERSITY HEALTH SYSTEM

February 13, 2001

Maureen Miller, MPH, RN
WHCCAMP
6701 Rockledge Drive
Suite 1010
MSC 7707
Bethesda MD 20817

Dear Ms. Miller:

Thank you for contacting us on behalf of the White House Commission on Complementary Alternative Medicine Policy. We look forward to a productive interaction with this group, which we hope will help to shape a better health care future for the United States. Enclosed are answers to your specific eleven queries, along with information about our educational perspectives and an outline of the programmatic aims of the Duke Center for Integrative Medicine. If you have any questions, please feel free to contact me. We look forward to working with you in the future.

Best Wishes,

A handwritten signature in black ink, appearing to read 'Marty Sullivan', with a stylized, flowing script.

Marty Sullivan, MD
Director, Duke Center for Integrative Medicine
Associate Professor of Medicine
Duke University Medical Center

MS/kg

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

There is enough science to provide a basis for an evidence-based discussion on numerous CAM topics. It is also important for students to be aware of the status of the evidence for those topics, which do not have a significant research base.

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.

Core competencies for the lowest level of knowledge would be useful at the medical school and residency level to assist in preparing providers for making appropriate CAM referrals and for counseling patients in making informed choices. Higher levels of competency should be coordinated with state and national certification/licensing programs.

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?

Naturopaths from accredited training programs might be appropriate for the role of PCP if they are licensed by the state as in the State of Washington. Chiropractors are licensed in all states, but it is not clear that they have appropriate training to act as PCP's. Acupuncturists would not be appropriate for PCP's since they have no training in conventional medicine.

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

Faculty development is important both for acquiring a broad perspective of the CAM modalities, and also in acquiring some personal knowledge of techniques that can be useful for self-care such as meditation, yoga, stress reduction, massage and self-hypnosis. More in-depth training in other patient care modalities such as acupuncture, homeopathy, manipulative therapies and herbal medicine will require a much more significant commitment on the part of the faculty in terms of sabbatical time, etc.

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

Funding should be targeted toward efficient dissemination and integration of the evidence-based information that is currently available and the development of required stress management/self-care programs that are an integral part of the curriculum.

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

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

Yes, state and national professional organizations

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?)

CME offices should seek collaborations with CAM professional organizations to provide valid credit for introductory and advanced training in CAM modalities for physicians.

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?

Professional credentialing is currently done at the state level for most health care providers. It would be good to have national standards, but I don't see reversing the trend towards this state control over credentialing issues.

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?

We have made an extensive review of malpractice issues concerning integrative medicine. The primary risks for physicians seem to revolve around neglect of standard therapies which have proven value in favor of some alternative therapies which may not have value. Our review of case law does not reveal litigation concerning the addition of complementary and alternative medicine modalities to standard therapy. Our review also reveals that malpractice litigation for CAM practitioners (massage, acupuncture, naturopathy) appears to occur at a relatively much lower rate than standard medical 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?

Integrative medicine, which is the combination of conventional medicine with conventionally-trained health care providers who also incorporate complementary and alternative medicine and mind-body-spirit approaches, is certainly a new field in medicine. Over time, it will improve this field of medicine to develop practice guidelines and, potentially, credentialing/sub-specialty boards in this area. Clearly, regulation of supplements and herbal products in the United States is a significant problem. To my knowledge, we are the only first-world country that does not regulate herbal medicinals in a way, which treats them as if they were medical therapies. Clearly, consumer protection is needed to provide medicinal supplements and botanicals, which contain pharmacologically active ingredients which are bio-available and which are free of contamination. Clearly, education of undergraduate medical students, health care practitioners, graduate medical education, CME, and education of the public in the realm of integrative medicine is a vital mission of the Duke Center for Integrative Medicine. Our program's educational philosophy is that health care providers must understand both the mind-body-spirit approach and evidence-based use of complementary and alternative medicine in order for health care to undergo significant changes which will benefit patients, providers, and insurance carriers over the next ten years. We feel strongly that just inserting CAM techniques into the current system will not lead to the kind of health care reform that will achieve lasting benefits.

Enclosed is an outline of the Duke Center for Integrative Medicine Clinical Research and Educational Programs, along with biographical sketches on our faculty and current program information.



Pg 1-2 / pressed up
DUKE UNIVERSITY HEALTH SYSTEM

**DUKE CENTER
FOR
INTEGRATIVE MEDICINE**

===== *Brilliant Medicine. Thoughtful Care.* =====

CAM PRO

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A. EXECUTIVE SUMMARY

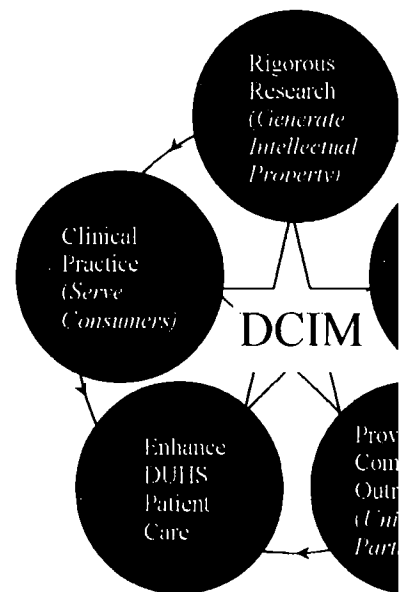
Integrative medicine is a rapidly emerging field that seeks to improve health care by combining technology based medicine with both self care approaches aimed at the whole patient (mind-body-spirit) and Complementary and Alternative Medicine (CAM) techniques derived from traditional medical systems, such as acupuncture and herbal medicine. Above all, integrative medicine emphasizes the caring bond between the patient and the caregiver and the responsibility of the latter to ensure the patient to be empowered to benefit from the full array of modalities, which can be shown to improve health. Recognizing the vital importance of this new area, the Duke University Health System has established the Duke Center for Integrative Medicine. Through academic leadership, research, and education, we carry out the following mission:

To improve health care by combining traditional, mind-body-spirit, and complementary medicine approaches to medicine through academic leadership, rigorous research, and innovative education.

The full scope of activities of the DCIM is depicted in **Figure 1** and includes:

1. Establishment and growth of rigorous top-notch programs in basic and clinical research in mind-body medicine, spirituality, naturopathy, nutrition, acupuncture, and Chinese medicine.
2. Developing an outpatient clinic, which will combine evidence-based CAM, mind-body-spirit-centered care, and traditional medicine. Combine this with residential retreat programming to attract a national referral base.
3. Improve care throughout DUHS through provider education and direct program implementation (including Mindfulness training)
4. Develop community outreach programs to provide education and direct support to those in need, and
5. Play a major role in transforming health care to incorporate the practice of integrative medicine as the standard care over time.

Figure 1: Scope of DCIM



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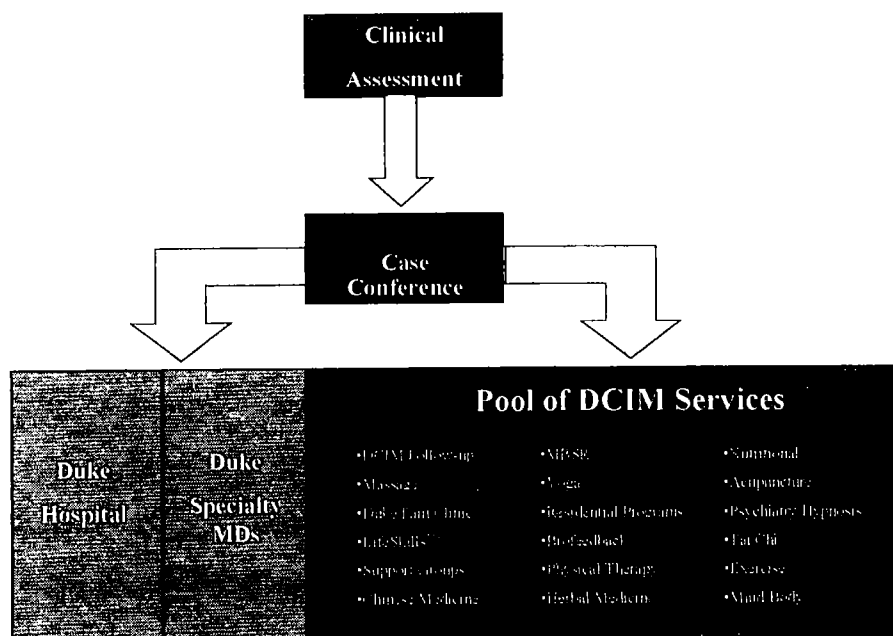
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PROGRAM OUTLINE

The core elements of the proposed Duke Center for Integrative Medicine include Clinical Practice, Research, Education programs as follows:

1. Patients will first meet with a staff physician (MD/PA) for a consultation lasting one hour. This initial medical evaluation is essential to ensure that the patients receive appropriate care for any disease processes that need traditional medical treatment. The physician will also complete a thorough history and physical examination relevant to an “integrative” evaluation. Lifestyle management, mind-body-spirit approaches, herbal and nutritional therapy approaches will often be addressed and initial recommendations made to the patient.
2. A weekly case conference will convene the panel of MD clinicians and DUMC accredited IM consultants to discuss new patients and give progress reports on patients in treatment. Evidence supporting or challenging various treatment options will be discussed, and transcripts of proceedings will be kept. A final **Personalized Health Plan** will be devised for the patient and appropriate recommendations regarding follow-up will be offered at that time.
3. Appropriate follow-up care will be delivered from the pool of DCIM sponsored services. (See **Figure 4.**)

Figure 4: DCIM Clinic



MINDFULNESS-BASED STRESS REDUCTION: : STRUCTURE AND MANAGEMENT

DCIM is currently offering its fourth eight-week MBSR cycle to patients and hospital staff. The program begins with a one-hour intake interview between the customer and the course instructor, during which time they discuss the customer's relevant personal and medical history as well as program goals. The class is held once per week, three hours per session, for eight weeks. The content of the course includes meditation, patient education and discussion, and periodic yoga training. At the end of the eight-week program, the patient/customer meets with the instructor for a one-hour out-take interview. Since the program's inception in September 1998, some 200 individuals have participated in MBSR. Patient satisfaction ratings have been consistently high, and outcome data shows significantly improved symptoms and quality of life.

RESIDENTIAL PROGRAM: STRUCTURE AND MANAGEMENT

DCIM's Residential Program will begin on the DCL campus in late 2000, and will be fully operational in 2002 with the anticipated completion of the planned hotel facility and a separate DCIM programming facility. The Residential Program will serve clients during stays ranging from three days to several weeks. The retreat environment will facilitate intensive training in Integrative medicine modalities for patients interested in wellness/integrative lifestyles or those with chronic disease. Patients will begin the retreat with a thorough medical assessment, a clinical case conference, and a Personalized Health Plan as described above. Individualized therapeutic interventions involving the full range of DCIM services will be supplemented by group educational programs including nutrition, Mindfulness-Based Stress Reduction, and other life-skill approaches. It is anticipated that specialized programs could be evolved for patients with cancer, heart disease, depression, and chronic fatigue/fibromyalgia.

D. RESEARCH PROGRAM

STRATEGY

DCIM's Research Program will position Duke as the leading academic institution in the fast growing area of integrative medicine research. The program will be designed to foster and coordinate exemplary scientific investigations in the area of integrative medicine throughout the many departments doing integrative medicine -related research at DUMC. To achieve this goal, the program will offer a core infrastructure based on personnel, information systems, and laboratories. This infrastructure will be capable of enhancing the research projects of other Departments doing integrative medicine-related research as well as launching its own research initiatives in the long-term. Figure 5 outlines the operations summary for research.

The research program will provide core informatics and statistical support for the collection and analysis of clinical outcome data from DCIM clinical and community based educational operations. The results will guide the development of cutting edge clinical programs by providing evidence to support or reject the value of a clinical intervention.

The research division will initiate a funding program for pilot research projects in integrative medicine. These will initially be available to faculty who participate in Center planning. The purpose will be to generate preliminary data necessary for research grant applications to the NIH and to other agencies and foundations. Two new NIH proposals are currently under review at NIH, and several research projects are under development. As the Center matures, we will aim to establish the DCIM as a major NIH-funded institution in this field.

Figure 5: Operations Summary

Phase 1	• Faculty network • Grant opportunities • Build market awareness
Phase 2	• Amass clinical informatics database • Analyze outcomes data
Phase 3	• Pilot research projects • Support and collaborate with PIs with similar research interests using DCIM services and infrastructure • DCIM research faculty development

DCIM fellows who plan to pursue research careers in one of the fields of integrative medicine will be teamed up with a PI working with DCIM. For example, the Department of Behavioral Medicine may be able to make available one of its training program slots for a DCIM fellow.

As DCIM's annual budget rises, additional new research faculty will be recruited to expand DCIM activities into developing fields that are not represented by current faculty. New faculty will be responsible for developing research and clinical activities that can support their salaries and expenses.

Current research efforts in the DCIM include acupuncture anesthesia, Contemplative Care of the Dying, acupuncture and hypertension, Mindfulness-Based Stress Reduction and Irritable Bowel Syndrome, and meditation in patients with hypertension.

E. EDUCATIONAL PROGRAM

STRATEGY

The Educational Program will provide comprehensive integrative medicine education to medical students, residents, health care professionals, and to the lay community. This program will serve to improve the scientific understanding of CAM principles in DUHS and to enhance compassionate care by improving provider – patient interactions. We have provided education for over 1500 health care providers in this area, and anticipate significant continued interest in this area in the near future.

The Educational Program focuses in five primary areas of activity:

1. Duke student education (graduate and undergraduate).
2. Durham/North Carolina community outreach.
3. Educational materials/informational web site.
4. Fellowship training program.
5. CME conferences.

OPERATIONAL PLAN

CORE PROGRAMMING

Medical student education in Integrative medicine will be a leading national program.

- CFM 251, *Complementary Medicine -- Academic and Community Perspectives* will be even stronger as internal clinical expertise and the scientific literature on integrative medicine grow.
- An MS3 study track will allow students to conduct integrative medicine research with Principal Investigators focused in the field. CFM 251 and a second elective in research methodology will be required of MS3's in the study track.
- An intensive one-month elective for MS4's at DCIM's Clinic. The experience will focus on the clinical practice of integrative medicine, on personal healing and self-exploration. Enrollment will be limited to one student who will immerse him/herself in DCIM's clinical activities.
- An integrative medicine collection will be developed at Medical Center library.

The integrated medical vision between the University and Medical Center will gain strength.

- A curriculum for an East Campus Freshman FOCUS Program with a wellness theme will be developed for Fall Semester 2000.
- Medical faculty will act as consultants to facilitate evening wellness programming for the new West Campus non-smoking dormitory during the Fall Semester 1999.

CME programming: Current activities include an "Integrating Mind, Body, and Spirit in Medical Practice" Conference, a "Mindfulness Meditation Workshop," and Integrative Medicine Study Group lectures and journal club. This year's program will expand beyond Mind-Body-Spirit offerings to include

other areas of complementary medicine. As demand grows, DCIM will host up to 3 annual CME conferences, targeting health care professionals throughout the Southeast who come for the state-of-the-art curriculum offerings.

Web site development is an essential component of DCIMs strategy of expanding awareness about integrative medicine on a national level. This effort will seek to provide balanced and authoritative information in this area, consistent with Duke's academic leadership strategy.

EXTERNALLY SPONSORED PROGRAMMING

Community outreach in the form of population-based pilot programs will allow DCIM to examine the measurable contribution of different integrative medicine interventions to community health. For example, Dr. Kabat-Zinn has contracted to train Massachusetts prisoners and guards in MBSR and plans to measure the impact of this program on prison violence, recidivism, and early parole.

DCIM will explore providing statewide educational programming to community hospitals through the AHEC system. DCIM will provide lectures and training for health care professionals with a focus on "what a practitioner needs to know about integrative medicine". *This represents an opportunity to make significant contributions to the practice standards of health care in our region.* Programming will be facilitated by an educational administrative coordinator and teleconferencing.

Fellowship program: central to DCIM's mission of expanding the horizons of medical practice. Training physicians to practice evidence-based integrative medicine and to design rigorous research protocols will ensure DCIM's reputation as the leader in the field of integrative medicine. Two fellowship positions will be offered every year, and the program will last two years. One fellow will focus 75% of his/her energy on research, 25% on clinical practice; the other fellow will have the opposite emphasis. To support this program DCIM will pursue an NIH-NCCAM training grant.

Hospital staff education: workshops in Mindfulness-Based Stress Reduction, Anodyne Imagery, Healing touch, Compassionate Care, and Healing the Healer. Will advance Duke's model for compassionate care, decreased employee stress and improved job satisfaction.

F. HISTORIC IMPLICATIONS

Medicine today stands at a critical juncture with regards to its historic lineage and mission. The integrative medicine approach offers a critical balance that will significantly improve patient outcomes and improve both health care provider and patient satisfaction in the future. The DCIM represents an important agent in bringing this more balanced vision into reality. In addition to its commitment to improving the health care provider/patient relationship and infusing medicine with better approaches to patient-centered mind-body-spirit care, the DCIM will provide a rigorous scientific inquiry of this area that has been previously lacking. Through its academic leadership, the DCIM will serve to bring integrative medicine into the mainstream, and will have an important salutary effect on the future of medicine.

Tab 12



White House Commission on Complementary and Alternative Medicine Policy

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

February 5, 2001

Dr. Andrew Weil, Director
Program in Integrative Medicine
University of Arizona
6700 South X9 Ranch Road
Vail, AZ 85641

Dear Dr. Weil:

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 combining 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.

Chair

James Gordon, MD

Commissioners

George Bernier, Jr, MD

David Butler, PhD, LAc, OMT

Thomas Chappell

Ellen Glick, PhD, RN, DMLA

George DeVries, III

William Fair, MD

Joseph Fins, MD, FACP

Veronica Gutierrez, DC

Wayne Jonas, MD

Lisnea Larson, LCSW, LMFT

Tieraona Low Dog, MD, AHG

Charlotte Kerr, RSM

Dean Ornish, MD

Conchita Paz, MD

Joseph E. Pizzorno, Jr, ND

Balford Rolin

Julia Scott

Xiaoning Tian, MD, LAc

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Geraldine Pollen, MA

Consultant Staff

Kenneth Fisher, PhD

Maureen Miller, MPH

James Snyers, MA

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?

In addition, we would appreciate the following information on your program:

- What is your program's educational philosophy and mission? How and why did you arrive at these?
- Provide a brief description of your program and the educational approach for preparing students/providers for an integrative health care practice.
- What are the strengths of your program? Are there any weaknesses that may need to be addressed? What resistance, issues, problems have you encountered?

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006. letter	Stephen Groft to Andrew Weil (partial) (1 page)	02/05/2011	b(6)

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Federal Records

White House Commission on Complementary and Alternative Medicine Policy [WHCCAMP]

OA/Box Number: 43231

FOLDER TITLE:

WHCCAM Briefing Book, Discussion Group III, February 22-23, 2001 [2]

2011-0568-S

kc798

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]

[006]

- Can you provide us with the names and phone numbers of 3 graduates who would be willing to share their experiences and observations with the Commission staff.

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

Responses to the White House Commission's Inquiry on
Integrative Medicine Education

Victoria Maizes MD Medical Director
Andrew Weil, MD, Director
Program in Integrative Medicine
University of Arizona

February 13, 2001

Q1. *Is there currently enough science available on CAM to establish educational programs in integrative health care? (Integrative is defined as combining conventional western medicine with "alternative" therapies.)*

- A. At the Program in Integrative Medicine at the University of Arizona, we define Integrative Medicine more broadly than the White House Commission's definition of combining conventional western medicine with alternative therapies. We define Integrative Medicine as healing oriented medicine, which reemphasizes the relationship between patient and physician, and integrates complementary and alternative medicine with conventional medicine when appropriate. Rather than simply assimilating alternative therapies into mainstream care, this integrative model is a new system with unique characteristics.

The evidence base for broadening the paradigm of medicine from its current bio-medical model to a much broader model is substantial. Whether one looks at herbal medicine for prostatism being as effective yet having less side effect than a commonly used medication, functional MRI study which shows that an acupoint traditionally used for visual problems "lights up" the same area as a light that has been shone in the eyes, or studies which suggest that prayer may improve a large set of physical parameters, the evidence for a broader definition of health and medicine exists. There is also considerable amount of information about specific alternative therapies such as St Johns' Wort for mild to moderate depression, or acupuncture for nausea and vomiting.

However, there is clearly a dearth of evidence in many areas. Given a western 'scientific' perspective, that demands randomized controlled trial evidence, there is little evidence for integrative health care. If one considers evidence from the thousands of years of traditional use of medical systems such as Chinese medicine and Ayurveda the body of evidence grows substantially. We are concerned that much of the current research focus appears to be reductionistic. It focuses on single modalities at a time, often isolated from the philosophical and diagnostic systems in which they originated. It does not reflect the systems thinking that is at the core of integrative medicine. Integrative medical research must move beyond reductionism to a systems model. We must stop looking at isolated therapies and study healing, and the complex mix of treatments most patients use.

Q2. *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?*

- A. The first step in assuring that integrative health providers have the appropriate knowledge and skills is to agree upon a curriculum for Integrative Medicine education. At the Program in Integrative Medicine we have spent the past 5 years developing curriculum. An outline follows:

Program in Integrative Medicine: Curriculum in Integrative Medicine

Philosophical Foundations shifts the orientation from a disease-oriented model to a healing-oriented model. Practitioners are asked to confront their own world-view, and face the uncertainty of not knowing. Courses include:

Healing Oriented Medicine focuses on the nature of the body's healing system; case studies of spontaneous healing; the placebo response as a therapeutic ally; lifestyle medicine; healing versus curing; and strategies for protecting, enhancing, and activating the healing system.

Philosophy of Science addresses the philosophical heritage and current structure of science as well as alternative perspectives; the impact of major discoveries on the prevailing paradigms of science and the philosophical setting in which they operate; and the strengths and limitations of the current scientific method and paradigm, especially as applied to medicine.

Medicine and Culture teaches the origins and development of conventional medicine as well as other major systems of healing; culture-specific diseases; cultural definitions of health and illness; cultural influences on medical thinking; the role of ceremony and ritual; and anthropological perspectives.

Art of Medicine reflects on the doctor as a facilitator of healing; effective communication and the art of suggestion; relationship-centered care; the role of intuition; techniques for motivating behavior change; and matching therapeutic approaches with individual patients.

Research Education helps physicians to master critical thinking about research, including how to assess existing research and evaluate its validity and significance, how to formulate valuable questions, and how to design experiments and methodologies that effectively address these questions.

Lifestyle Practices is a basic principle of Integrative Medicine; how we live our lives clearly affects our health and disease, and lifestyle practices and prevention are central to this approach.

Spirituality and Medicine discusses the spiritual dimension of human life and its relevance to health, illness, and healing; the distinction between spirituality and religion; how to take a spiritual history; the relationship of spirituality and medical outcomes; and spiritual healing techniques.

Mind Body Medicine addresses the scientific basis of mind-body interactions; a critical review of existing therapies; the role of the mind in health and illness; the identification of diseases with prominent mind-body components; and how to assess the moods and belief systems of patients.

Nutritional Medicine addresses the contributions of diet to health and disease; specific information on benefits and risks of common foods and dietary patterns; the therapeutic role of vitamins, minerals, and other nutritional supplements; and nutritional therapies for specific diseases.

Physical Activity focuses on the role of physical activity in health and illness, and teaches how to make an exercise prescription.

Therapeutic Systems and Modalities. — There are many systems, modalities, and ways of knowing. Therapeutic systems and modalities explore the distinction between alternative and integrative medicine; the history of CAM; the history,

underlying philosophies, scientific basis and practical applications of various systems of medicine; and the scientific evidence as it pertains to these systems.

- Botanical Medicine
- Manual Medicine
- Chinese Medicine
- Homeopathy
- Energy Medicine
- Allopathic Medicine

Personal Development and Reflection — Central to this approach to medicine is that practitioners commit to their own process of self-exploration and personal development. This is often underdeveloped or damaged as a result of medical education, and often translates into less than optimal interactions with patients.

Clinical Integration — The process of integrating different systems of medicine into one comprehensive treatment plan for an individual patient is a central feature of the practice of Integrative Medicine.

Core competencies are assessed in the Program in Integrative Medicine via an Integrative Medicine assessment, an attitude assessment and sequential videotaping of the doctor-patient interaction. We would expect all Integrative Medicine clinicians to develop competency in the areas of spirituality and medicine, lifestyle medicine, mind-body medicine, nutrition, botanical medicine, the doctor-patient relationship, and physician wellness. For clinicians who develop an area of clinical expertise in CAM a variety of assessment tools are available. Some CAM skills have accredited programs such as the 150-hour Academy for Guided Imagery program. There is a state exam for homeopathy in Arizona. Acupuncture licensure for physicians are being developed in many states. We support the continued development of these standards.

Q3. *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)?*

A. We would recommend criteria be set for anyone to be a primary care provider. Agreed upon standards could be met in a variety of ways yet would be required of any allopathic or CAM provider who undertook the role of a primary care provider

The Prince of Wales Initiative¹ listed the following elements for common curriculum:

- Basic anatomy, physiology and pathology
- Fundamentals of medical diagnosis and guidelines for patient referral
- CAM therapies and their potential uses including principles of diagnosis and practice
- Holistic models of health care
- Professional ethics
- The therapeutic relationship
- Impact of social, cultural, economic, employment, and environmental factors on health

¹ Coates, JR and Jobst, KA. Integrated healthcare: A way forward for the next five years? A discussion document from The Prince of Wales's Initiative on integrated medicine. The Journal of Alternative and Complementary Medicine. 1998. 4(2):209-47.

Counseling skills
Principles of quality management and audit
Organizational skills, including record keeping
Technical skills: Ranging from prevention of cross infection to information management

To these we would add

Preventive guidelines including immunizations, screening tests, and counseling skills.

Q4. Who and what are needed in developing faculty for integrative health training programs? What are the issues in developing faculty, curricula, resources, etc?

- A. Academic educational programs such as the 2-year fellowship and 2-year distributed learning program at the University of Arizona Program in Integrative Medicine offer a model for training of healthcare practitioners and faculty. These programs bring together considerable experience of many practitioners of conventional medicine and alternative medicine to build a working model of integrative healthcare. Support for faculty interested in developing skills in Integrative Medicine is critical.

Curriculum development is a key focus of PIM. It is a time-consuming, expensive, and challenging task, in part, because of the vast area that alternative medicine covers. Balancing evidence based approaches and clinical experience is a challenge for any program until research data can further inform the field. Our approach has been to use the modalities that have the best evidence and/or the longest historical use.

Q5. What recommendations or other guidance can be offered regarding funding for integrative health training programs?

- A. Funding for integrative health training programs has been an enormous challenge. Most programs have a mix of philanthropy, grants, tuition, state and now, just beginning federal support. Given the enormous interest of the public enhanced federal and state funding would appear to be an important priority. NCCAM has begun to fund educational programs and this funding needs to be expanded.

Q6. 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?

- A. Continuing education requirements need to be established and monitored for all integrative health care providers. This should include a measurement of core competency in CAM modalities.

Q7. Should there be national CE standards for integrative health care providers? State standards? Professional standards? If so, who should be responsible?

- A. National continuing education standards for Integrative Medicine need to be developed and validated by an appropriate professional body. We, at the Program

in Integrative Medicine oppose a separate board of Integrative Medicine from being formed, because we believe all of medicine needs to move in this direction rather than Integrative Medicine becoming a subspecialty. Despite this, an interim measure would be to have several boards come together and offer a certificate of added qualification (CAQ). A national professional association would be formed to determine and measure these standards. This would mirror the process for the geriatric CAQ. Ultimately testing for Integrative Medicine should be part of the National Board and all specialty board exams.

Q8. *What issues, unmet needs and problems currently exist for continuing education? (For example, do certain entities such as state licensure boards accept CAM CEUs?)*

A. Currently some specialties, such as the American Academy of Family Physicians do not give category 1 credit for learning to practice CAM. (There is credit for learning about CAM.) This limits the access and attractiveness of study of CAM modalities.

Until a nationally recognized curriculum in Integrative Medicine is established, it is difficult to determine what continuing education should be included.

Q9. *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?*

A. A national professional credentialing body that set standards and administers the certificate of added qualification across conventional disciplines is desirable.

Q10. *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*

- a) Malpractice issues are potentially multiple. For example, there is no official or standard legal definition for CAM or Integrative Medicine. There are a complex mix of licensing statutes, scope of practice statutes, and malpractice cases. There are two potential risks: delivering CAM services and referrals to CAM providers. Referral to an unlicensed practitioner may carry greater risk as it could be defined as aiding and abetting unlicensed medical practice.
- b) In general, physicians practicing Integrative Medicine and alternative medicine are sued less. This is because an important part of their practice focuses on the doctor-patient relationship. Physicians have been pulled into state boards for illegal practices – with alternative medicine being seen as outside the community standard.
- c) Alternative medicine practitioners have been arrested for practicing medicine without a license. Licensed providers of chiropractic, traditional Chinese medicine, and massage tend to have low rates of litigation according to the claims evidence.
- d) JCAHO now requires that pain centers inform patients of options for pain management beyond allopathic – ie. Acupuncture and mind body therapies. Further requirements for less invasive (and less expensive care) seem likely.

- e) Other important legislation includes the State of Minnesota's new law for holistic health care providers; and the State of Arizona's homeopathic medical assistant statute, which allows non-physicians to practice under MD/DO supervision

Q11. *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?*

- A. Quality of care and patient safety must be of highest priority. Establishing and monitoring systems of regulation must be established. The quality of dietary supplements is an example of important quality issue. We believe they need to be regulated as to content and good manufacturing processes.

In addition, we would appreciate the following information on your program:

- (a) Program's educational philosophy and mission*
- (b) Brief description of your program and the educational approach*
- (c) Strengths/weaknesses of your program*
- (d) Names and phone numbers of 3 graduates*

The Program in Integrative Medicine

Educational Philosophy

Our educational approach to Integrative Medicine is innovative and learner-centered. We use a self-directed learning model that emphasizes the acquisition of philosophies, knowledge, and skills for clinical application. We base our educational programs firmly in adult learning theory utilizing appropriate media to achieve our goals, and integrating the most current evidence-based literature into the curriculum. Our instructional design was developed to achieve three major objects: (1) Integration of the learning into the practitioner's personal life, (2) application to clinical and patient care, and (3) establishment of a sense of community among practitioners committed to the philosophies of integrative medicine.

Mission

Our mission is to offer excellent integrative medicine education to all health-care providers in order to transform the practice of medicine. This will lead to healthier individuals, clinicians and society.

Our Program

The Program in Integrative Medicine has four major initiatives:

Education:

1. A two-year residential fellowship which trains 4 physicians each year. The intention of the residential fellowship is to not only educate physicians in integrative medicine but also to train future leaders who will go on to start other integrative medicine programs
2. A two-year distributed learning associate fellowship program. The intention of this program is to train physicians and nurse practitioners in integrative medicine. The focus is on clinical application rather than leadership. The majority of this program is Internet based, with three residential weeks in Tucson.
3. We offer a 4th year medical student rotation for 2 students each month. We also offer a 1st and 2nd year medical student elective in Integrative Medicine.
4. We offer a resident rotation in Integrative Medicine.
5. Senior Integrative Medicine fellows serve as co-attendings in Family Practice introducing integrative medicine in a busy primary care practice.
6. Annual or biannual week-long Integrative Medicine program for physicians is offered at Canyon Ranch.
7. Annual collaborative conferences include Botanical Medicine with Columbia University and Pediatric Integrative Medicine conference with the University of Minnesota and Harvard. The Botanical conference draws over 100 physicians, the Pediatric conference, 350 physicians.

Research:

We believe that a well-balanced research portfolio in integrative medicine currently should emphasize effectiveness studies of full programs of care and/or multi-arm investigations involving not only each single modality in a separate arm, but also a combination of modalities as typically prescribed in clinical practice. The field needs cost-effectiveness research that goes beyond immediate outpatient expenditures to examine potential downstream benefits such as reduced emergency visits and hospitalizations, shorter lengths of stay, fewer or delayed complications of chronic diseases. In studying the process of integrative medicine, we need studies of decision-making in both provider and patient in the evolution of a care plan. Finally, we need novel interdisciplinary collaborative studies that utilize the tools of conventional medical and biobehavioral research (e.g. functional neuroimaging, electrophysiology) to explore the correlates and mechanisms of healing under various integrative treatments.

Existing projects in the Program in Integrative Medicine include:

- NIH National Center for CAM, "Pediatric Center for Complementary and Alternative Medicine." Projects on cerebral palsy, recurrent abdominal pain, otitis media.
- National Institutes of Health National Center for Complementary and Alternative Medicine, K24: "Midcareer Investigator Award in Patient-Oriented Research on Complementary and Alternative Medicine." Studies of a) nonlinear analyses of physiological signals as markers of healing in patients treated with alternative therapies or integrative medicine; b) development of multidimensional outcomes tools for clinical research
- National Institutes of Health National Center for Complementary and Alternative Medicine, R21 (revised): "Biomarkers of Homeopathic Treatment in Fibromyalgia."
- "Health Outcomes Evaluation of the Program in Integrative Medicine Outpatient Clinic." Measures include: Demographics, SF-36 Quality of Life scale (Patrick & Southerland), FACIT, Arizona Integrative Outcomes Scale, Utilization of Health Care Services (Lorig et al), Patient Satisfaction Scale (DiMatteo et al), and Clinician Global Improvement Rating.
- Development and validation of a scale to assess integrative health attitudes and beliefs in medical students and health care providers."
- "Development and validation of a visual analogue scale for patient self-rating of overall sense of well-being."
- Collaborative pilot study of CAM use in University of Arizona Arthritis Clinic outpatients.
- Dept. of Veterans Affairs Health Services Research grant: "Complementary Medical Treatment among Veterans Receiving VA Primary Care."
- G & P Foundation grant: "Evaluating Effectiveness of an Integrative Approach to Treatment of Lymphoma and Leukemia, Utilizing a Comprehensive Retrospective and Prospective Study Design."
- Dept. of Veterans Affairs Merit Review: "Cross-Sensitization as a CNS Model for Gulf War Chemical Intolerance."
- Department of Veterans Affairs small grant: "Diet and Oxidative Stress Biomarkers of Cerebrovascular Disease Risk in Hispanic Veterans."

Integrative Medicine Clinic

We offer consultative Integrative Medicine care in the University Medical Center. Patients are seen by fellows and faculty. Outcomes research is in place for the clinical care.

Patient Conference

The Integrative Medicine Patient Care Conference is a unique, multidisciplinary meeting. It provides a rich, interactive teaching experience. The conference serves as an essential training component of the Integrative Medicine Fellowship. New patients who have been seen for Integrative Medicine consultation by physician-fellows are presented to a team composed of Integrative Medicine physicians, a Chinese medicine expert, a homeopathic practitioner, a naturopathic physician, an energy medicine practitioner, a spiritual counselor, a nutritionist, pharmacist,

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mind/body psychologist, medical students, and residents. The diversity of these clinicians and teachers brings an unparalleled wealth of knowledge and experience.

Strengths and Weaknesses

Introducing Integrative Medicine into a conservative medical establishment is not an easy task and there have been pockets of substantial resistance. We have been very fortunate to have the support of the Dean of the College of Medicine and the head of the department of medicine. Our main challenges have been financial and living in a larger University setting with different values and a highly bureaucratic organization which challenges innovation.

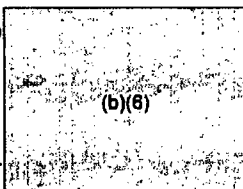
The strengths of the Associate Fellowship are the strong learner focus we are able to achieve through interactive web-based material; the sense of community we can achieve between the participants, even if they are on different continents; and the larger number of people who can participate in this type of education. The problems are mainly logistical; keeping a large group in synchrony; the expense of developing web-based interactive education and the administration over several time zones. Good content providers are difficult to find.

Names of Three Graduates

Russ Greenfield MD

Wendy Kohatsu MD

Karen Koffler MD —



The first graduates of the Associate Fellowship will be in August 2002